Quality and Health Outcomes Committee
Agenda
May 11,2015

DHS Building Room 137A-D, Salem, OR
Toll free dial-in: **888-278-0296** Participant Code: **310477**
Parking: Map ◦ Phone: 503-378-5090 x0

Medical Director Workgroup			
Time	**Topic**	**Owner**	**Related Documents**
9:00 – 9:05 a.m.	Welcome -Consent Agenda -April QHOC meeting notes	Tracy Muday, Chair	April meeting minutes PH update
9:05 – 9:15 a.m.	Legislative Update	Brian Nieubuurt	Handout – 5/11/2015
9:15 – 9:25 a.m.	MAP Update	Chris Norman, Chris Barber	None
9:25 – 9:35 a.m.	HERC Update	Cat Livingston	None
9:35 – 9:50 a.m.	Metrics Update	Sarah Bartelmann	May metrics update
9:50 – 10:00 a.m.	**Break**		
10:00 – 10:25 a.m.	Decision Support for Patients	Moira Ray Valerie King	Decision Support Tool presentation slides
10:25 – 10:40 a.m.	QHOC redesign	Tracy Muday, Lisa Bui	
10:40 – 11:00 a.m.	Statewide PIP	Chris Barber, Lisa Bui	-Survey Results -PIP FAQ -PIP Discussion Tool
Joint Session: Medical Directors and QPI Workgroup			
11:00 – 12:30 p.m.	Learning Collaborative: Tobacco Cessation	See detailed agenda	-Willamette Valley -Douglas, Coos & Advantage Dental -IHN & Benton Co. -Trillium & Lane Co.
12:30 – 1:00 p.m.	**Lunch Break**		
QPI Workgroup			
1:00 – 1:10 p.m.	QPI Updates	Chris Barber, Lisa Bui	-CCO Quality Strategy review timelines
1:10 – 1:30 p.m.	Complaints and Grievance workgroup recommendations	Keri Mintun Barbara Carey	Templates: -Complaint log -NOA Appeal log -Grievance Type
1:30 – 2:30 p.m.	Summary of Annual EQRO findings	Jody Carlson Chris Barber	

Division of Medical Assistance Programs

Quality & Health Outcomes Committee

Meeting Notes

April 13, 2015 9:00 a.m. –3:00 p.m.

Human Services Bldg. 500 Summer St. NE, Salem, Oregon

Room 137 A-D

In Attendance:

Anne Alftine (Jackson Care Connect), Gary Allen (Advantage Dental); Susan Arbor (MAP); Joell Archibald (OHA); Chris Barber (MAP); Sarah Bartelmann (OHA); Michelle Benson (MAP); Summer Boslaugh (OHA); Graham Bouldin (Health Share); Stuart Bradley (WVCH); Mark Bradshaw (AllCare); Amy Bruce (CareOregon/YCCO); Lisa Bui (OHA); Jim Calvert (Cascade Health Alliance); Emileigh Canales (FamilyCare); Barbara Carey (Health Share); Jody Carson (Acumentra); Christine Castle (Yamhill/CareOregon); Kristin Chatfield (WEBCO); Tom Cogswell (OHA); Laurence Colman (GOBHI); Emilee Coulter-Thompson (OHA); Peg Crowley (WOAH); Chris Demars (OHA); Sherri Dybdahl (Washington Co.); David Engen (IHN CCO); Kevin Ewanchyna (IHN CCO); Melinda Garcia (WEBCO); Jim Gaudino (OHSU/Gaudino Consulting); Linda Hammond (OHA); Walter Hardin (Tuality); Jenna Harms (Yamhill CCO); Maria Hateliffe (PacificSource); Holly Jo Hodges (WVP/WVCH); Suzanne Hoffman (OHA); Matthew Hough (Jackson Care Connect); Leann Johnson (OHA/OEI); Jennifer Johnstun (PrimaryHealth); Angela Kimball (OHA); Charmaine Kinney (Multnomah Co/Health Share); Laura Kreger (OHA); Deborah Larkins (DHS/PAU); Lynnea Lindsey-Pengelly (Trillium); Deborah Loy (Capital Dental Care); Kathryn Lueken (WVCH); Andrew Luther (OHMS); Pam Martin (OHA/AMH); Laura Matola (AllCare); Laura McKeane (AllCare); Keri Mintun (MAP); Tracy Muday (WOAH); Adrienne Mullock (OHA); Brian Nieubuurt (OHA); Katie Noah (Willamette Dental); Chris Norman (MAP); Dennis Perala (FDC); Jennifer P (Clackamas Co.); Ellen Pinney (OHA); Jordan Raweins (Moda/EOCCO); Dan Reece (OHA); Jim Rickard (Yamhill CCO); Ryan Rushig (Kaiser); Christine Seals (Umpqua Health Alliance); Jennifer Sheppard (CareOregon); Lillian Shirley (OHA); Matt Sinnott (Willamette Dental); Jeanene Smith (OHA); Ariel Smits (HSC); Dayna Steringer (WOAH/Advantage Dental); Ron Stock (OHA); Priscilla Swanson (Acumentra); Jed Taucher (AllCare); Denise Taray (HERC); Corinne Thayer (ODS); Melanie Tong (Washington Co.); Laura Walker (PacificSource); Matt Walker (Clackamas Co.); Melinda West (Access Dental); Liz Wintczak (Clackamas Co.)

By phone:

Ellen Altman (IHN-CCO); Todd Jacobsen (GOBHI); Rebecca Ross (UHA), Colleen O'Hare; Kristie DePriest (UHA); Roseanne Harksen (MAP); Suzanne Hart (MAP); Ann Fork (Options)

	Medical Directors Segment Chair: Tracy Muday	
Topic Items – Updates	**Presentations / Discussions**	**Action Items, Materials, & Resources**
Introductions & Announcements:	Introductions were made in the room, and with those on the phone. March meeting notes were reviewed.	**Materials:** ▪ Agenda ▪ March Meeting Notes ▪ OHA/PHD Updates
MAP Updates: Chris Barber/Chris Norman	Deliverables due in March and April have been received. TCM Implementation has been delayed; new implementation date has yet to be determined. The Redeterminations Dashboard update was given by Chris Norman. Chris reported that hiring and training staff for processing applications, answering calls, and addressing additional bodies of work continues. -Plan representatives were directed to ask their leadership for copies of the dashboard, which is distributed weekly.	

Metrics Update: Sarah Bartelmann	2014 Metrics Timeline (Due dates from April 30, 2015-June 30, 2015) was discussed. ***Reminder:*** *2014 chart review submissions are due to OHA on April 30th.* Sarah reported that there may be a request to plans for information on how to extract tobacco use data from medical records. She also noted that a survey is being conducted and is available online at the following URL. (*This is not a required survey*) https://www.surveymonkey.com/s/TobaccoEHR	**Materials:** ▪ April Metrics Update
Legislative Update: Brian Nieubuurt	Live Bills list was distributed and reviewed. Brian reported that the number of bills has been decreasing, and the OHA Ways and Means presentation has been completed. He will provide another update at the May QHOC meeting.	**Materials:** ▪ Live bills list

HERC Update: Ariel Smits	Ariel's update included discussion on — Guideline changes for Cochlear Implants — Back condition line reorganization — Opioid prescribing for conditions of the back and spine, limiting prescriptions — Surgical interventions for conditions of the back and spine, scoliosis -January 1st review list, new line for joint conditions Next HERC meeting is on May 7th, agenda is full for this meeting. Topics include: — Changes to lumbar epidural steroid injections — Smoking Cessation — Penile Anomalies Guidance Following the May meeting, the next meeting for HERC will be in August. Please contact Ariel (ariel.smits@state.or.us) with any agenda items for August.	**Materials:** ▪ HERC Minutes ▪ VbBS Minutes ▪ Back pain handout ▪ IVC filter ▪ TURP Alternatives
QPI Updates: Chris Barber	Statewide PIP update was given. A Survey Monkey survey was sent out by Lisa Bui. Please complete the survey by the end of next week. Lisa will bring the results of the survey to the May meeting. Selection process/timeline for the Statewide PIP is in development. The OHP Section 1115 Quarterly Report was discussed. Complaints and Grievances are divided by CCO. MAP will meet with plans to discuss the results. The reports and all attachments are posted at:	

	http://www.oregon.gov/oha/healthplan/pages/waiver.aspx	
CCO Learning Collaborative-Leading Change: Ed O'Neil, PhD	CCO Learning Collaborative: Leading Change Workshop was conducted from 10:30am-3:00pm.	**Materials:** ▪ Leading Change Leadership Lab Book

Next meeting:

Date: **May 11, 2015**

Time: **9:00 a.m. – 3:00 p.m.**

Place: **Human Services Building**
500 Summer St NE, Room 137 A-D
Salem, OR

PUBLIC HEALTH DIVISION
Office of the State Public Health Director

Kate Brown, Governor

Oregon Health Authority

800 NE Oregon St., Ste. 930
Portland, OR 97232-2195
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Quality and Health Outcomes Committee
Public Health Division updates – May 2015

Updates

Meningococcal disease at University of Oregon

Since mid-January, six students at University of Oregon have contracted meningococcal disease, resulting in one student death. Meningococcal disease is rare, but the consequences are often devastating. The University of Oregon, Lane County Public Health, the Oregon Health Authority, and pharmacy chains are working to prevent further infections by partnering to vaccinate more than 20,000 students. More information about the University of Oregon meningococcal cases is available at: http://healthcenter.uoregon.edu/getthevax or https://public.health.oregon.gov/DiseasesConditions/DiseasesAZ/MeningococcalDisease/Pages/Meningococcal-Update.aspx.

Data and reports

Oregon School Health Services Fact Sheet

School Nurses and School-Based Health Centers are partners in providing comprehensive health services at school and work together to build a health safety net for Oregon students. This fact sheet provides some basic information around school nursing services and services provided at SBHCs. The fact sheet also includes some data regarding the health of Oregon's youth.
http://public.health.oregon.gov/HealthyPeopleFamilies/Youth/HealthSchool/SchoolBasedHealthCenters/Documents/SBHC__Pubs/SHS_flyer_FINAL.pdf

Resources

***Prevent Diabetes STAT* – New AMA/CDC nationwide initiative launched**

The CDC and the American Medical Association have launched a nationwide initiative called *Prevent Diabetes STAT: Screen, Test, Act - Today*™. The goal of *Prevent Diabetes STAT* is to raise awareness about prediabetes and to increase screening, testing and referral to evidence-based diabetes prevention programs that are part of CDC's National Diabetes Prevention Program. The *Prevent Diabetes: STAT* website, www.PreventDiabetesSTAT.org, provides information and tools including a link to organizations delivering CDC-recognized diabetes prevention programs by state, an online screening tool to help people determine their own risk for type 2 diabetes, and a toolkit for health care providers on the best methods to screen and refer high-risk patients to CDC-recognized community based or virtual diabetes prevention programs in their communities. This toolkit is also posted on the Oregon Public Health Division website, along with a list by county of diabetes prevention programs in Oregon, at http://public.health.oregon.gov/PreventionWellness/SelfManagement/Pages/index.aspx#D

PP. Information about CDC's National Diabetes Prevention Program is available at http://www.cdc.gov/diabetes/prevention/. For more information or technical assistance related to prediabetes and development of diabetes prevention program referral policies and protocols, contact Andrew Epstein at andrew.d.epstein@state.or.us.

Metrics Updates for QHOC

May 2015

Final 2014 Metrics

On April 30, OHA released full year 2014 incentive measure results to the CCOs. This report reflects what OHA believes is final CY 2014 performance and kicks off the validation process before distribution of the 2014 quality pool. OHA also released the final 2014 quality pool amounts, available online at: http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

➢ Validation

CCOs can submit questions or potential corrections to the CY 2014 data until May 31, 2015 by emailing metrics.questions@state.or.us.

➢ Office Hours

OHA has scheduled "office hours" on Thursday, May 14th from 2:00 – 3:00 pm with staff on hand to answer questions about the April 30th report, measure validation, and the upcoming quality pool distribution. To join, please use conference line 1.877.810.9415 and code 1773452.

➢ Reporting

OHA will be publishing the next Health Systems Transformation report reflecting CY 2014 performance and quality pool distribution in late June. CCOs will receive notification of their final results and quality pool payments in advance of publication.

CCO Metrics & Scoring Committee

The Metrics & Scoring Committee will meet on Friday, May 15th from 9 am – 1 pm. The meeting will primarily be informational, with presentations from Dana Hargunani on adolescent well care visits and confidentiality and Nicole Merrithew on patient-centered primary care homes, as well as results from the metric "deeper dive" survey on emergency department utilization and developmental screening.

The agenda and materials will be available online at:
http://www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx

Questions

Please contact us at Metrics.Questions@state.or.us

Statewide Performance Improvement Project (PIP) 2015-2017: Quality Managers

Rank			
	1st	2nd	3rd
Maternal Medical Home	1	3	0.5
Opioid Management	2	1	
Tobacco Prevalence and Cessation Program			
One Key Question: Effective Contraceptive Care	1	1	
CCO Incentive metric: Assessments for Children in DHS Custody	2	1.5	
QHOC QPI session held 3/2015 (1/2 votes for tie)			

Statewide Performance Improvement Project (PIP) 2015-2017

Rank					
	1st	2nd	3rd	4th	5th
Maternal Medical Home	4	2	2	5	6
Opioid Management	11	3	3	1	1
Tobacco Prevalence and Cessation Program	1	5	8	3	2
One Key Question: Effective Contraceptive Care	2	3	4	6	4
CCO Incentive metric: Assessments for Children in DHS Custody	1	6	2	4	6
19 total responses (12 CCOs, 3 unnamed CCO)					

Comments/Write - Ins

Prenatal Dental Care
Anything that aligns with Incentive Metrics
Dental care for adults with mental illness
Obesity
Flu Shots
Access to Care
Substance Abuse
Psychotropic Medication: Inclusion of 711s in CCOs

CCOs Participated

All Care
Cascade Health Alliance
Eastern Oregon CCO
Family Care CCO
Health Share of Oregon
Jackson Care Connect
Pacific Source Central Oregon
Pacific Source Columbia Gorge
Primary Health of Josephine County
Trillium Community Health Plan
Willamette Valley Community Health
Western Oregon Advance Health

Performance Improvement Project (PIP) FAQs

Part A: Performance Improvement Projects

Q. What is the purpose of the CMS Performance Improvement Projects (PIP) protocol?

- According to the 2012 CMS PIP Protocol, the protocol is "used to determine whether a health care quality performance improvement project (PIP) was designed, conducted and reported in a methodologically sound manner."

Q. What is the purpose of the CMS Performance Improvement Projects (PIP)?

- 42 CFR §438.240 states: "These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollees satisfaction."

Q. What are the criteria for a CMS Performance Improvement Projects (PIP) topic?

According to the 2012 CMS PIP Protocol:

- Topics should address a significant portion of the enrollees, and have the potential to have a significant impact on enrollee health, functional status or satisfaction
- Topics should address high-volume or high-risk conditions
- Topics should be selected through data collection and analysis of local enrollee needs, care and services
- The PIP topic should be consistent with the demographics and epidemiology of the enrollees
- The PIP topic should include input from enrollees with special health needs, especially those with mental health and substance abuse problems

Part B: Requirements

Q. What is the OHA requirement for Performance Improvement Projects (PIPs)?

- CCOs are required to conduct three PIPs and one focus study that target improving care in at least four of the seven areas.
- One of the 3 required PIPs is the statewide PIP, monitored by Acumentra Health.
- The Statewide PIP is conducted, scored, and reported in the standard PIP format according to the 2012 CMS PIP Protocol

Focus Areas:

1. Reducing preventable re-hospitalizations
2. Addressing population health issues (such as diabetes, hypertension, and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, and aligned federal and state programs
3. Deploying care teams to improve care and reduce preventable or unnecessarily costly utilization by "super-users"
4. Integrating primary care and behavioral health
5. Ensuring that appropriate care is delivered in appropriate settings
6. Improving perinatal and maternity care
7. Improving primary care for all populations through increased adoption of the Patient-Centered Primary Care Home (PCPCH) model of care throughout the CCO's network

Q. What are the Acumentra Health PIP Review Standards?

- The Acumentra Health PIP Review Tool has been revised in order to be in compliance with the September 2012 CMS PIP protocol and to incorporate feedback and address challenges from past PIP reviews. The PIP Review Standards are as follows:

1. Study Topic
2. Study Question
3. Study Population
4. Study Indicator
5. Data Collection and Data Analysis Plan
6. Study Results
7. Interpretation of Study Results
8. Improvement Strategies
9. Repeated Measurement of Study Indicator
10. Sustained Improvement

2015 – 2017 Statewide PIP

Top 3 topic suggestions: (April survey monkey)

- Opioid Management
- CCO Incentive Metric: Assessments for Children in DHS Custody
- Tobacco Prevalence and Cessation Programs

Key Questions:

What specific impact will the statewide PIP have that cannot be otherwise achieved by individual CCOs or regions?

Are there communities who will be less impacted by the statewide PIP?

What are the potential measurement goal(s)?

Are the policies in place to support improvement?

Is CCO leadership and operation foundations prepared?

Selection Considerations

- Strategic alignment to CCO
- Data needed for improvement monitoring
- Accessibility of data
- Improvement feasibility
- Promotion of integration
- Degree of prevalence

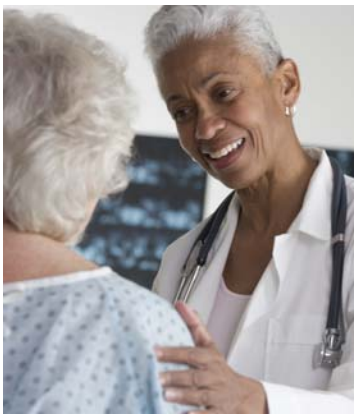
TRANSFORMATION CENTER

Oregon Health Authority

Patient Decision Support Tools

CCO Quality and Health Outcomes Meeting

May 11, 2015



CENTER for EVIDENCE-BASED POLICY
Oregon Health & Science University

OUTLINE

- Defining patient decision support
- Project history & purpose
- Project plan & timeline
- Emerging themes from the needs assessment
- Decision support as a core metric
- Brief overview of the evidence
- Categories of content for the Medical Director's Guide
- Opportunities for collaboration

PATIENT ENGAGEMENT for PREFERENCE SENSITIVE CARE DECISIONS

- Conditions for which multiple, legitimate treatment options exist
- Patient preferences & values, with clinician expertise, should help inform treatment decision
- Can involve significant trade-offs (e.g., small risk of death for improved function)

SHARED DECISION MAKING

"A collaborative process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient's values and preferences."

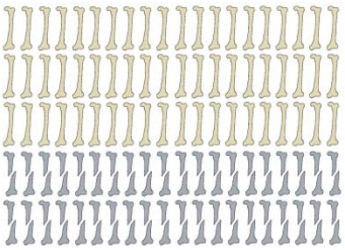
– Informed Medical Decisions Foundation

DECISION AIDS

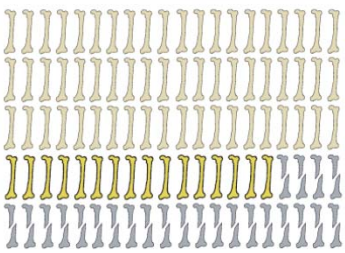
- Provide evidence-based information about:
  - Screening, diagnosis & treatment options
  - Benefits & harms
  - What is known & what is uncertain
  - Role of patient preference
  - Relative risks of various outcomes

Benefits

Without Medication
40 in 100 have a fracture within the 10 years. 60 will not.



With Medication
24 in 100 have a fracture within the 10 years. 76 will not. 16 have avoided a fracture because of the medication.



Drawbacks

This medication must be taken
- Once a week
- On an empty stomach in the morning
- With 8 oz of water
- While upright (sitting or standing for 30 min)
- 30 minutes before eating

Possible Harms
Abdominal Problems
About 1 in 4 people will have heartburn, nausea, or belly pain. However, it may not be from the medication. If the medication is the cause, the problem will go away if you stop taking it.

Osteonecrosis of the Jaw
Fewer than 1 in 100,000 will have bone sores of the jaw that may need surgery.

Out of Pocket Cost
with insurance $30 | without insurance $70-90

What would you like to do?

MINIMALLY DISRUPTIVE MEDICINE

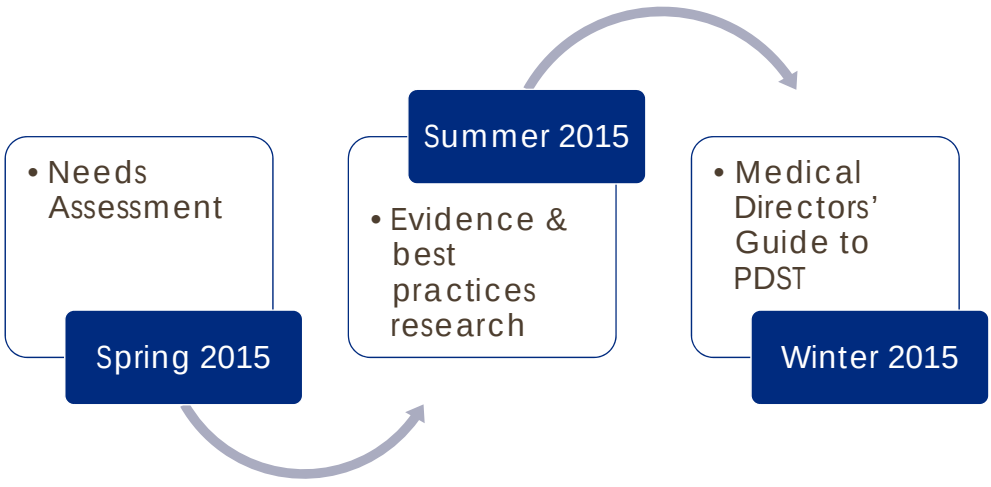
- Accounts for patient capacity to incorporate medical care into their lives
- Exceeding patient capacity can lead to non-adherence & poor outcomes
- Presents medical care options in relation to the patient's lived experience

MINIMALLY DISRUPTIVE MEDICINE

PROJECT HISTORY & PURPOSE

- Oregon SIM grant
- Collaboration with HERC & Transformation Center
- How can CCOs support & encourage their use

PROJECT PLAN & TIMELINE



NEEDS ASSESSMENT

- 20-30 stakeholder interviews:
  - CCO Medical Directors
  - Private payer Medical Directors
  - Primary care & behavioral health practices
  - Community Advisory Council members
  - Self-insured organizations

EMERGING THEMES

- Clinician and community education and buy-in
- Identifying high quality tools that are realistic for use at the practice level
- Time, workflow, and reimbursement issues
- Importance of team-based care in using PDSTs
- Engaged patients are a prerequisite
- Provider or clinic champions
- Need for consistent expectations across payers

Decision Support as a Core Metric

- Institute of Medicine **Committee on Core Metrics for Better Health at Lower Cost** recently outlined 15 measures, including:
  - "Care match with patient goals—measure of the extent to which patient and family goals have been ascertained, discussed, and embedded in the care process."
- Performance measurement of this sort is expected to become increasingly common under Medicare payment reforms included in HR 2 (Medicare Access and CHIP Reauthorization Act of 2015)

EVIDENCE OVERVIEW

Decision aids for people facing health treatment or screening decisions (Review)

Stacey D, Légaré F, Col NF, Bennett CL, Barry MJ, Eden KB, Holmes-Rovner M, Llewellyn-Thomas H, Lyddiatt A, Thomson R, Trevena L, Wu JHC

THE COCHRANE COLLABORATION®

- Updated June 2012 & published January 2014
- 115 RCTs with 34,444 patients
- Outcomes:
  - "Choice-made" attributes
  - Decision process attributes
  - Health & health-systems effects

EVIDENCE OVERVIEW

Exposure to a decision aid was associated with:

- Increased knowledge of condition & treatment options
- More accurate risk perceptions
- Higher rates of values-congruent decisions
- Lower rates of decisional conflict or indecision
- Improved perceptions of provider-patient communication and patient satisfaction
- Fewer people choosing elective invasive surgery (RR 0.79, 95% CI 0.68 – 0.93)
- Fewer people choosing PSA screening (RR 0.87, 95% CI 0.77 – 0.98)
- Fewer people choosing menopausal HRT (RR 0.73, 95% CI 0.55 – 0.98)

OUTLINE of the MEDICAL DIRECTOR'S GUIDE

- Conceptual Models & Types of Tools
- Evidence Review & Best Practices
- Identifying & Assessing PDSTs
- Implementing & Evaluating PDST Projects in Practices & Communities
- Opportunities for Collaboration & Future Directions

REFERENCES

American Institutes for Research (April 2013). Shared decision-making and benefit design: Engaging employees and reducing costs for preference-sensitive conditions. Primer/Brief from *Aligning Forces for Quality.* Retrieved from: http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf405304

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Ottawa Hospital Research Institute (n.d.). Patient Decision Aids. Retrieved from: https://decisionaid.ohri.ca/

Rollnick S., & Miller, W.R. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy*, *23*: 325-334.

Verdoorn, A. (2012, January 10). Minimally Disruptive Medicine comes alive! Retrieved from: http://minimallydisruptivemedicine.org/2012/01/10/minimally-disruptive-medicine-comes-alive/

Questions and Comments?

obley@ohsu.edu

Statewide CCO Learning Collaborative: 17 CCO Incentive Measures

Quality and Health Outcomes Committee Meeting
500 Summer Street NE, Salem, OR 97301, Room 137 A-D
May 11, 2015
11:00 a.m. – 12:30 p.m.

Toll-free conference line: 888-278-0296
Participant code: 310477

Clinical and Community Interventions to Reduce Tobacco Use

Session Objective:
Share success Stories from around the state that could inspire or help other CCOs with implementing similar activities in their communities to reduce tobacco use

1. **Introductions and reflection** (Summer Boslaugh, MBA, MHA, Scott Montegna, MA) (5 minutes)

2. **Presentations**

   Clinical Strategies (20 minutes)
   - **Willamette Valley Community Health changes to cessation drug benefit formulary** (Kathryn Lueken, MD)

   - **Collaborative work between Douglas and Coos County and Advantage Dental** (Marilyn Carter, PhD, ADAPT)

   Community Strategies (20 minutes)
   - **CCO and public health partnership to reduce tobacco use among county residents** (Sara Hartstein, MPH, Benton County, Kevin Ewanchyna, MD, IHN)

   - **Trillium and Lane County Public Health's partnership for cessation and prevention** (Jennifer Webster, MPH, CHES, Lane County)

3. **Knowledge café: Two discussion sessions** (15 minutes each session)

   Session Topics
   1. Changes to cessation drug benefit formulary
   2. Collaboration with dental care
   3. Benton County: CCO and public health partnership
   4. Lane County: CCO and public health partnership

4. **Wrap-up** (Scott Montegna) (5 minutes)

5. **Next steps** (Summer Boslaugh) (10 minutes)
   - **Oregon Health System Innovation Café**: June 8 and 9, Salem Convention Center
   - **Retrospective evaluation**

Presenter Bio's:

Cindy Shirtcliff, LCSW
Regional Manager/Community Liaison
Advantage Dental

Cindy is a Licensed Clinical Social Worker. She has a B.S. in psychology from the University of Oregon. She completed her Master's in Social Work at University of Nevada, Reno. She worked at Douglas County Mental Health in the Crisis Intervention and Evaluation Unit until starting private practice in 1999. During her 13-years in private practice she focused on children and families. During that time she also worked part-time as a Behavioral Specialist in the elementary school setting. She has also taught at Umpqua Community College and continues as Adjunct Faculty. She joined Advantage Dental as a Regional Manager/Community Liaison in 2011. She is also as certified trainer in the "Bridges Out of Poverty" constructs. She enjoys helping to develop outreach resources, programs and protocol to decrease barriers for those accessing healthcare.

Marilyn Carter, Ph.D.
Policy & Systems Grant Director
Adapt

Marilyn is a skilled public health professional with more than 15 years of experience in community organizing and health policy. Marilyn currently serves as a Policy & Systems Grant Director for Adapt, a regional addictions medicine, behavioral health and primary care provider in Southern Oregon. Prior to joining Adapt, Marilyn served as the Health Promotion Manager for Douglas County Public Health, where she designed and managed a number of public health initiatives to promote population health. Marilyn has served on local, regional and statewide committees, including the CLHO Healthy Communities Committee. In 2014, Marilyn received the Maurine Neuberger Award for Distinguished Career Achievement for her contribution to Oregon's tobacco control efforts.

Jennifer Webster, MPH, CHES
Community Health Analyst
Prevention Program, Lane County Public Health

Jennifer is a Senior Community Health Analyst in Lane County Public Health's Prevention Program. Her work is focused on developing and implementing prevention strategies for Lane County's Coordinated Care Organization, Trillium Community Health Plan. Prior to her work at Lane County, Jennifer worked on ensuring reducing disparities in health care access as the director of the state's largest independent abortion fund. Jennifer also has extensive experience in addressing a variety of social and economic justice and health issues. She has put her passion for women's and children's health and reducing health disparities to work in many arenas, from the local to the global and is thrilled to be part of Oregon's health transformation in Lane County.

Sara Hartstein
Health Policy Specialist
Benton County Health Department

Sara is the Health Policy Specialist at Benton County Health Services. In her position, Sara works with community partners and decision-makers to adopt and implement tobacco-free policies and screening & referral systems, and provides technical assistance to County departments on policy development and implementation. Along with her counterparts in Linn and Lincoln Counties and the Regional Project Coordinator, she is responsible for implementing the regional project's community and health system interventions. For the past two years, Sara has convened a multi-jurisdictional stakeholder group which recently led to the City of Corvallis and Benton County amending their local ordinances to prohibit use of electronic smoking devices where smoking is currently prohibited by law and ban the sale of the devices to minors.

Evidence-Based Strategies for Reducing Tobacco Use Guide for CCOs

This guide is a resource to help CCOs think through their approach to reducing tobacco use. CCOs play an important role in helping their members quit, including: accurate assessment of member tobacco use status; benefit design (expanding coverage and reducing barriers); benefit promotion; implementing tobacco-free campus policies; and fostering partnerships with local public health agencies and other community stakeholders in order to create tobacco-free community environments.

CCOs have submitted comprehensive information about their cessation benefits to OHA via the 2014 cessation benefits survey; the results of the survey are reported in the Tobacco Cessation Services: 2014 Survey Report and can be accessed at *https://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/tob_cessation_services_2014_survey_report.pdf*

The strategies are focused on CCO quality improvement activities and initiatives that will affect tobacco use among CCO members in 2015 and beyond. When reviewing the strategies CCOs are encouraged to work with internal and external partners as applicable including administrators, quality improvement staff, clinicians, hospitals, clinical advisory panels, community advisory councils and local health department administration and Tobacco Prevention and Education Program (TPEP) staff.

Things to consider include:

- ✓ Who needs to be included within your CCO or among contracted providers to develop and implement strategies to reduce tobacco use among your CCO members?
- ✓ What resources may be needed to support the tobacco reduction strategies outlined in this guide?
- ✓ What external partnerships could help support or lead your efforts to implement tobacco reduction strategies for your CCO?

Links to resources to support strategy implementation are provided where applicable. Tobacco Prevention and Education Program (TPEP) staff are available in every county and are ready to support CCO efforts to develop and implement policies and protocols to reduce tobacco use.

LOCAL CONTACTS:

Directory for Local Public Health Authorities: *http://public.health.oregon.gov/ProviderPartnerResources/LocalHealthDepartmentResources/Pages/lhd.aspx*

STATE CONTACT:

Oregon Public Health Division's Health Promotion and Chronic Disease Prevention Section, Scott Montegna, 971-673-0984, scott.p.montegna@state.or.us

Strategy: Identify Individuals Who Use Tobacco

Tobacco cessation interventions begin with identifying tobacco users. Health care delivery systems and providers should consistently identify and track tobacco use status and treat every tobacco user that seeks services in a health care setting. It is essential for CCOs to adopt systems for providers to identify tobacco users and use an evidence-based intervention each time a patient that uses tobacco is seen.

Plan-level steps to identify individuals who use tobacco include:	*We do this now*	*We are planning to do this*
• Reviewing medical and/or pharmacy claims data	☐	☐
• Intake assessments at office visits	☐	☐
• Health risk assessments	☐	☐
Encourage and incentivize your contracted providers to ask about and document tobacco use at every visit.		
• Educate all staff by offering trainings on tobacco dependence treatments and provide continuing education (CE) credits	☐	☐
• Provide resources to ensure ready access to cessation support services (Quit Line cards and information about effective tobacco use medications (e.g., establish a clinic fax-to-quit service, place medication information sheets in examination rooms).	☐	☐
• Provide feedback to clinicians about their performance. Evaluate the degree to which clinicians are identifying, documenting, and treating patients who use tobacco.	☐	☐

RESOURCES:

These resources provide guidance for providers asking about tobacco use status during intake assessments at office visits.

- ✓ **Treating Tobacco Dependence Practice Manual: Through a Systems-Change Approach -** This manual from the American Academy of Family Physicians takes a step-by-step approach in assessing tobacco cessation activities in your practice, implementing a system to ensure that tobacco use is systematically assessed and treated at every clinical encounter. *http://www.aafp.org/dam/AAFP/documents/patient_care/tobacco/practice-manual.pdf*
- ✓ **Treating Tobacco Use and Dependence: A Toolkit for Dental Office Teams -** This packet is designed to assist dental offices with integrating the brief intervention recommended by the guideline into standard office procedures and successfully intervene with their patients that use tobacco. It provides tools and resources to help you, help your patients, quit. *http://www.ctri.wisc.edu/HC.Providers/dentists/toolkit.pdf*
- ✓ **Treating Tobacco Use and Dependence: 2008 Update. Quick Reference Guide for Clinicians -** The guideline was designed to assist clinicians; smoking cessation specialists; and healthcare administrators, insurers, and purchasers in identifying and assessing tobacco users and in delivering effective tobacco dependence interventions. *http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/references/quickref/tobaqrg.pdf*

Strategy: Offer Comprehensive Cessation Benefits and Reduce Access Barriers

The majority of tobacco users want to quit. CCOs, federally qualified health centers, behavioral health agencies, dental clinics and other health care systems have an important role in offering comprehensive, accessible cessation benefits to their employees and clients. Evidence shows that by providing both medication and counseling as a paid or covered benefit by a health insurance plan, there is an increase in the proportion of smokers who use cessation treatment, attempt to quit, and successfully quit.

Improve your plan's covered cessation benefits	*We do this now*	*We are planning to do this*
• Expand coverage to include all three forms of evidence-based counseling (individual, group, telephone) and all seven FDA approved medications (nicotine replacement therapy –gum, patch, lozenge, nasal spray, inhaler – and Bupropion SR and Varenicline).	☐	☐
• Remove lifetime or total cost limitations on benefits	☐	☐
Eliminate barriers for easier access		
• Remove requirements for prior authorization to access medications	☐	☐
• Remove requirements that members must participate in counseling to access medications	☐	☐

RESOURCES:

- ✓ **Helping Benefit Oregon Smokers: Health Plan Benefit Recommendations to Help Oregon Smokers Quit -** A resource that provides recommendations to guide health plans, employers, health care purchasers, health care providers, employees, and advocates as they embrace a standard of care and create a more effective cessation benefit. *http://smokefreeoregon.com/wp-content/uploads/2010/11/HBOS-brochure-web.pdf*
- ✓ **Checklist of recommended tobacco cessation benefits -** *http://www.smokefreeoregon.com/wp-content/uploads/2010/11/Health-Plans-HBOS-benefits.pdf*
- ✓ **Tobacco Cessation Service: 2014 Survey Report -** This report is the third time the Public Health Division has assessed the tobacco cessation benefits offered to members of Oregon's Medicaid program, the Oregon Health Plan. This report summarizes the services and benefits offered to Medicaid members as reported by each CCO. *https://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/tob_cessation_services_2014_survey_report.pdf*

Strategy: Communicate and Promote Tobacco Cessation Benefit to All CCO Members

Evidence shows that it is essential to embed tobacco dependence strategies in the health care system to help tobacco users quit. Health care insurers should consistently promote the cessation benefits they offer and systematically refer tobacco users to the Quit Line to help tobacco users be successful in their quit attempts. Actively promoting these resources is a vital component to connecting tobacco users to evidence-based cessation resources, increasing quit attempts, and reducing smoking prevalence. Examples may include, providers' use of brief motivational interviewing with patients, establishing Quit Line e-referrals, mailings to identified tobacco users, and promotion of benefits in member handbook and newsletters.

Pro-actively reach out to all identified tobacco users to encourage them to quit or take advantage of their benefits.

	We do this now	*We are planning to do this*
• Providers' use of brief motivational interviewing with patients	☐	☐
• Establishing Quit Line e-referrals	☐	☐
• Mailings to identified tobacco users	☐	☐
• Promotion of benefits in member handbook and newsletters	☐	☐
• Promote quitting as a New Year's resolution, or connected to national campaigns, including World No Tobacco Day or the Great American Smokeout?	☐	☐

RESOURCES:

- ✓ **How to Design a Tobacco Cessation Insurance Benefit -** It is crucial that all health insurance plans and employers cover all of these treatments. But deciding to establish this coverage is only the first step. This document outlines the questions and issues plans and employers should consider after taking this critical first step, including communicating to plan members and providers about the benefit, and promoting the benefit to encourage tobacco users to quit. *http://www.lung.org/stop-smoking/tobacco-control-advocacy/reports-resources/tobacco-cessation-affordable-care-act/assets/how-to-design-a-tobacco.pdf*

Strategy: Support Effective Delivery of Cessation Benefits by Providers Through Quality Improvement Initiatives and Training

Clinicians must be adequately trained and prepared to treat tobacco dependence in their patients. Health care systems can ensure that clinicians and patients have the appropriate resources to address tobacco use and that a system is in place to provide feedback to clinicians on their tobacco dependence practices. CCOs can encourage or incentivize providers to use brief intervention strategies, such as the 5As or 2As & R. Clinic work-flows should be assessed to understand where best to use these strategies, and providers should have thorough knowledge of referral pathways to help tobacco users quit. Examples include staff trainings, provider manuals, provider newsletters, and provider website/handbook.

	We do this now	*We are planning to do this*
Ensure your provider network is aware of the existing benefits		
Information is shared by way of:		
• Staff trainings	☐	☐
• Provider manuals/handbook	☐	☐
• Provider newsletters	☐	☐
• Provider website	☐	☐
Provide tobacco-related trainings to contracted providers		
Training topics include:		
• Tobacco cessation benefits	☐	☐
• Systematic tobacco use assessment and documentation	☐	☐
• Referral strategies	☐	☐
• Motivational interviewing/behavioral counseling models (5A's or 2A's + R)	☐	☐
Systematically embed referral systems in clinic work-flows and electronic health records		
• Provider reminders incorporated into electronic health record	☐	☐
• Establish electronic referrals to Quit Line	☐	☐
• Establish referral system to community resources	☐	☐
• Implement closed-loop referrals	☐	☐
• Embedding decision support schematics or scripting in the EHR to help guide clinicians through an evidence-based intervention approach	☐	☐

RESOURCES:

- ✓ **Strengthening health systems for treating tobacco dependence in primary care. Part III: Training for primary care providers: brief tobacco interventions -** The purpose of this training guide is to improve primary care providers' knowledge, skills and confidence to routinely identify tobacco users and provide brief tobacco interventions to assist them in quitting. *http://apps.who.int/iris/bitstream/10665/84388/4/9789241505413_eng_Part-III_service_providers.pdf*
- ✓ **Five Major Steps to Intervention (The "5 A's") -** Successful intervention begins with identifying users and appropriate interventions based upon the patient's willingness to quit. The five major steps to intervention are the "5 A's": Ask, Advise, Assess, Assist, and Arrange. *http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/5steps.html*

Strategy: Tobacco-Free Campus Policy

There is no safe level of exposure to tobacco smoke. Tobacco smoke is toxic and contributes to deaths of smokers and non-smokers. Exposure to secondhand smoke can cause heart disease, cancer and worsen respiratory conditions such as asthma. Many of those that routinely seek health care services are especially vulnerable to the effects of secondhand smoke, including pregnant women, the elderly and people with chronic illness. In addition to the health risks associated with exposure to secondhand smoke, smoking and the use of other tobacco products in public places can normalize smoking behavior for youth. Establishing tobacco-free places creates a healthy environment and promotes social norms that support wellness. Several CCO administrative, contractor, and hospital campuses in Oregon have already gone tobacco-free to promote better health and a safer environment for patients, providers and other staff.

Adopt and Implement a Tobacco-Free Campus Policy

	We do this now	*We are planning to do this*
• Implement a tobacco-free campus policy for CCO administrative offices	☐	☐
• Require contracted providers to adopt tobacco-free campus policies	☐	☐
• Implement supportive practices, such as providing information about tobacco use and treatment, secondhand smoke, and local/ statewide cessation resources to patients, staff, and visitors	☐	☐

How can your CCO require contracted providers to adopt tobacco-free campus policies and encourage effective implementation practices, such as providing information about tobacco use and treatment, secondhand smoke, and local/ statewide cessation resources to patients, staff, and visitors?

RESOURCES:

- ✓ **Keeping Your Hospital Property Smoke-Free: Successful Strategies for Effective Policy Enforcement and Maintenance -** This how-to guide offers hospitals and other health care organizations useful strategies for implementing and enforcing a successful smoke-free or tobacco-free policy. *http://www.jointcommission.org/assets/1/18/Smoke_Free_Brochure2.pdf*
- ✓ **Implementing a Tobacco-Free Campus Initiative in Your Workplace -** This toolkit provides guidance for implementing a tobacco-free campus (TFC) initiative that includes a policy and comprehensive cessation services for employees. It is based on the Centers for Disease Control and Prevention's (CDC) experience with implementing the U.S. Department of Health and Human Services (HHS) Tobacco-Free HHS initiative. *http://www.cdc.gov/nccdphp/dnpao/hwi/toolkits/tobacco/index.htm*
- ✓ **Smoke-Free Hospital Toolkit: A Guide for Implementing Smoke-Free Policies -** Created by the University of Arkansas, a guide for implementing smoke-free hospital policies. Tobacco Free Nurses is the first national program created with the objectives of helping nurses quit, providing resources to nurses who want to help their patients quit and to promote tobacco control in the agenda of nursing organizations. *http://www.uams.edu/coph/reports/smokefree_toolkit/Hospital%20Toolkit%20Text.pdf*

Strategy: Work with Partners to Reduce Tobacco Prevalence in Communities Served By the CCO

CCOs/CACs can partner with local public health authorities to address tobacco prevention and cessation in the communities they serve. There are numerous evidence-based community interventions that are effective in reducing tobacco use and preventing youth initiation. These include: raising the price of tobacco through a tax, implementing tobacco retail environment interventions, tobacco-free work places and public spaces, and implementing cessation referral systems in social service agencies. By restricting access, promoting tobacco cessation and industry denormalization, we promote healthy, smokefree communities.

How can your CCO/Community Advisory Council (CAC) partner with your local public health authority (LPHA) to reduce tobacco prevalence in the communities you serve through cessation activities or policy change, including supporting the state and local implementation of comprehensive tobacco control programs? These programs are based on CDC best-practice recommendations, such as increasing the price of tobacco and increasing the number of tobacco-free environments.

RESOURCES:

- **Directory for Local Public Health Authorities -** Contact your local health department to connect with a local Tobacco Prevention and Education Program. *http://public.health.oregon.gov/ProviderPartnerResources/LocalHealthDepartmentResources/Pages/lhd.aspx*
- **OHA Public Health Tobacco Prevention and Education Program –** Learn about the statewide comprehensive program and policy approaches to reduce tobacco use. *http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Pages/index.aspx*
- **CCO Community Advisory Councils -** CCOs are required to have community advisory councils who oversee the community health assessment and adopt the community health improvement plan. *http://www.oregon.gov/oha/OHPB/Pages/cac.aspx*
- **CDC The Community Guide Toolbox -** The Community Guide Toolbox is a collection of online public health materials that will help users assess and carry out evidence-based public health strategies and interventions to meet their community's critical health needs. *http://www.thecommunityguide.org/toolbox/index.html*

Strategy: Improve Outreach and Delivery of Cessation Benefits to Special Populations

The tobacco industry has invested billions of dollars in marketing tobacco to specific populations. Certain racial and ethnic groups, LBGTQ population, and those with serious and persistent mental illness have higher rates of tobacco use than the general population. The specific tobacco-related health risks for people in these groups must be considered in the design of tobacco control programs and strategies. Effective and culturally appropriate messaging and outreach to special populations can denormalize tobacco use and help existing tobacco users understand the resources to help them quit.

Communicate and outreach to members from special population groups, including those known to use tobacco at higher rates

	We do this now	*We are planning to do this*
• Special populations include:	☐	☐
• Native American	☐	☐
• African-American	☐	☐
• Latinos	☐	☐
• Asian and Pacific Islanders	☐	☐
• LGBTQ	☐	☐
• Non-English speaking	☐	☐
• Pregnant women	☐	☐
• Individuals with mental health conditions	☐	☐
• Youth	☐	☐

RESOURCES:

- ✓ **Tobacco Use and Pregnancy: Resources** - This website from the Centers for Disease Control and Prevention provide links to a variety of resources for smokers and their families and providers. *http://www.cdc.gov/reproductivehealth/TobaccoUsePregnancy/Resources.htm*
- ✓ **Smoking Cessation for Persons with Mental Illnesses: A Toolkit for Mental Health Providers** - This toolkit was developed for a broad continuum of mental health providers. The toolkit contains information and step-by-step instruction about low burden means of assessing readiness to quit, possible treatments, strategies for reducing relapse, and referral to community resources. *http://www.integration.samhsa.gov/Smoking_Cessation_for_Persons_with_MI.pdf*
- ✓ **National Native Network: Keep it Sacred -** The National Native Network website serves as a resource hub for culturally appropriate resources pertaining to tobacco cessation, tobacco products, chronic disease prevention, and the difference between commercial tobacco usage and sacred tobacco traditions among this population. *http://www.keepitsacred.org*
- ✓ **Regional Health Equity Coalitions -** Regional Equity Coalitions support local, culturally-specific activities designed by communities to reduce disparities and address the social determinants of health. *http://www.oregon.gov/oha/oei/Pages/rhec.aspx*

Smoking Cessation

- Overview of Plan Interventions

Seth Adams, PharmD

May 11th 2015

Formulary Options Prior to December 6th 2014

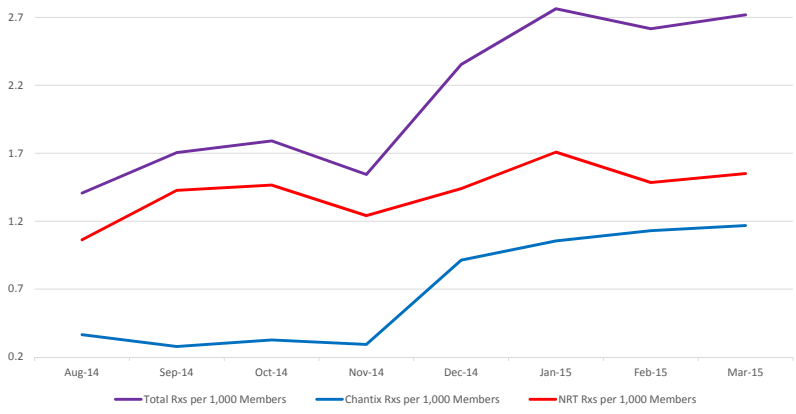
Name	Doses	Restrictions
Nicotine Transdermal Patches	7 mg/24 hr, 14 mg/24 hr, 21 mg/24 hr	None

Formulary Options as of December 6th 2014

Name	Doses	Restrictions
Nicotine Polacrilex Gum	2 mg, 4 mg	None
Nicotine Polacrilex Lozenges	2 mg, 4 mg	None
Nicotine Transdermal Patches	7 mg/24 hr, 14 mg/24 hr, 21 mg/24 hr	None
Chantix Tablets	0.5 mg, 1 mg	Quantity limit of 336 tablets per year

Utilization Trends

Smoking Cessation Prescriptions per 1,000 Members



Future Interventions on the Horizon

- Provider Education Materials
- Patient Education Materials
- Provider Incentive Measures
- Patient Incentive Measures
- Inclusion of smoking cessation education and opportunities in the Living Healthily Program

Strategies for Policy and Environmental Change

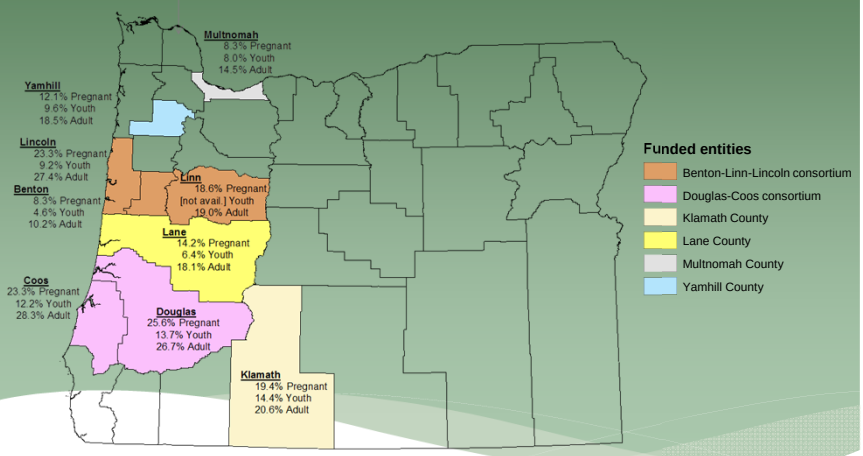
Marilyn Carter, PhD, Adapt
Coos/Douglas SPArC Grant Director

Cindy Shirtcliff, LCSW, Advantage Dental
Regional Manager Community Liaison

April 2015

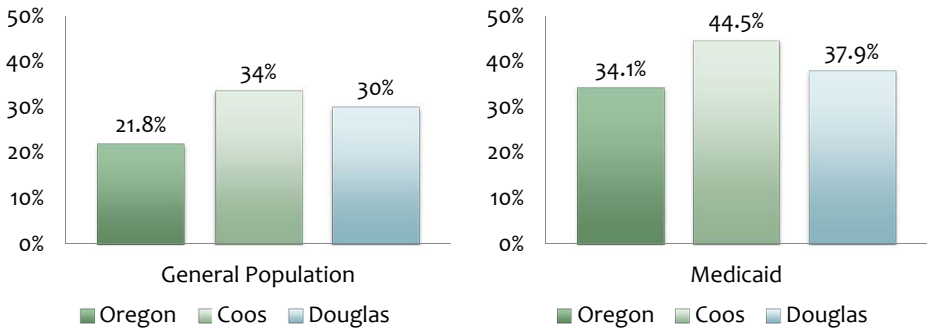
Adapt

Tobacco Master Settlement Agreement OHA/Public Health SPArC Grant Recipients



Sources:
Pregnancy: Birth certificate data files 2008-2011, accessed by Oregon Public Health Assessment Tool (OPHAT)
Youth: Oregon Healthy Teens 2013 (11th grade students).
Adults: Behavioral Risk Factor Surveillance System (BRFSS) 2008-2011. Results calculated using "classic weighting" system.

Adult Tobacco Use Status (Cigarettes + Smokeless Tobacco)



Source:
General Population: *Behavioral Risk Factors Surveillance System: County combined 2010-2013; age-adjusted to the 2000 standard population;*
Medicaid: *Oregon Health System Transformation, 2014 Mid-Year Performance Report, Oregon Health Authority*

3 SPArC Project Strategies

Strategy 1 Policy

Work with CCO partners to **establish or strengthen tobacco-free campus policies** to meet the 100% gold standard

Strategy 2 Treatment

Provide training to **increase local capacity to address tobacco and nicotine dependence**

Strategy 3 Systems

Engage selected clinics in **systems change process to address tobacco consistently and effectively***

*Addressing Tobacco Through Organizational Change developed in the 1990's by Douglas M. Ziedonis, MD, MPH, Director of University of Massachusetts Medical Center Dept. of Psychiatry

Milestones Achieved

Strategy 1 Policy

8 CCO affiliated partners adopted or affirmed enhanced **tobacco-free campus policies**

Strategy 2 Treatment

6 Behavioral Health professionals trained and certified by Mayo Clinic as Tobacco Treatment Specialists

Strategy 3 Systems

3 primary care clinics and 1 dental clinic completed assessment, planning and implementation of organizational change strategies

Unexpected Milestones Achieved

Adapt

Addictions/behavioral health provider in Southern Oregon—integrating tobacco treatment as clinical standard of care

Advantage Dental tobacco-free policy and systems changes for all 34 clinics in Oregon

Advantage Dental
Clinical Window of Opportunity

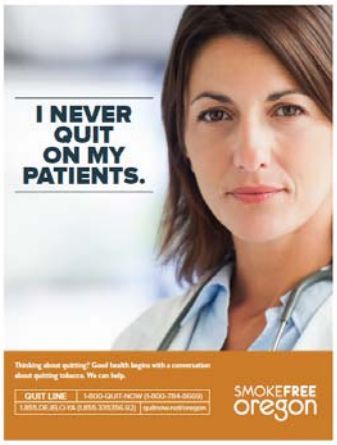
"At least 70 percent of smokers see a physician each year and almost one-third see a dentist."

2008 Clinical Practice Guidelines for Treating
Tobacco Use and Dependence

"The dental office setting can be a first touch point of entry for healthcare. This makes tobacco cessation counseling a perfect fit in the dental office as well as at community oral health screening sites, such as WIC."

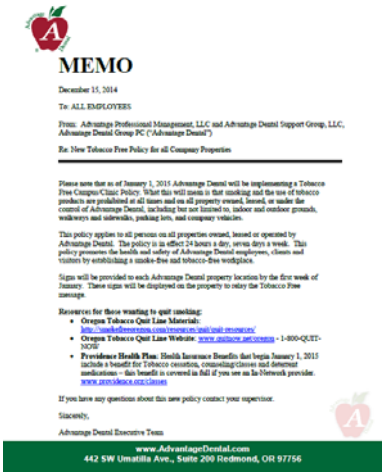
Cindy Shirtcliff, LCSW, Advantage Dental

Systems Change
Assessment & Planning Process



- Clinic systems assessment and planning process:
  - Convene Change Team
  - Physical Environment
  - Clinic Environment
  - Workforce Environment
  - Policy Environment

Systems Change
Comprehensive Tobacco-Free Policy



MEMO

December 15, 2014

To: ALL EMPLOYEES

From: Advantage Professional Management, LLC and Advantage Dental Support Group, LLC, Advantage Dental Group PC ("Advantage Dental")

Re: New Tobacco Free Policy for all Company Properties

Please note that as of January 1, 2015 Advantage Dental will be implementing a Tobacco Free Campus/Clinic Policy. What this will mean is that smoking and the use of tobacco products are prohibited at all times and on all property owned, leased, or under the control of Advantage Dental, including but not limited to, indoor and outdoor grounds, walkways and sidewalks, parking lots, and company vehicles.

This policy applies to all persons on all properties owned, leased or operated by Advantage Dental. The policy is in effect 24 hours a day, seven days a week. This policy promotes the health and safety of Advantage Dental employees, clients and visitors by establishing a smoke-free and tobacco-free workplace.

Signs will be provided to each Advantage Dental property location by the first week of January. These signs will be displayed on the property to relay the Tobacco Free message.

Resources for those wanting to quit smoking:

- **Oregon Tobacco Quit Line Material:** http://quitlinereferrals.com/resources/quitline-resources/
- **Oregon Tobacco Quit Line Website**: www.mylnow.net/orteen - 1-800-QUIT-NOW
- **Providence Health Plan**: Health Insurance Benefits that begin January 1, 2015 include a benefit for Tobacco cessation, counseling/classes and deterrent medications – this benefit is covered in full if you see an In-Network provider. www.providence.org/classes

If you have any questions about this new policy contact your supervisor.

Sincerely,

Advantage Dental Executive Team

www.AdvantageDental.com
442 SW Umatilla Ave., Suite 200 Redmond, OR 97756

- January 1, 2015, Advantage Dental implemented a Tobacco Free Campus Policy for all 34 clinics statewide
- Smoking and the use of tobacco products are prohibited at all times and on all property.

Systems Change
EHR Prompts, Reporting, Feedback

- Upgrades to Dentrix to include health history "pop up" prompts to **ASK** about nicotine use at every dental visit
- System-wide process to **ADVISE** and **REFER** patients to the Quitline or other quit services
- QI monitoring of monthly Quitline Fax referral report and by billing code D1320
- Feedback to providers to encourage intervention

83 D1320 in 14 clinics in one week

Source: 2008 Clinical Practice Guidelines for Treating Tobacco Use and Dependence

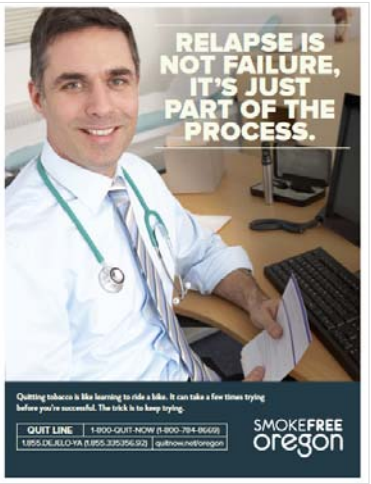
Systems Change
Staff Training & Education

"The policy change will be accompanied by systematic processes for educating patients and employees about the new policy, as well as training opportunities to help all Advantage Dental employees support patients who may be thinking about quitting, including proactive FAX referral to the Quitline."

Cindy Shirtcliff, LCSW, Advantage Dental

- Train Regional and District Managers
- Train Dental Care Providers
- Webinars, e.g., motivational Interviewing, poverty
- Tobacco Treatment Specialists
- New employee orientation

Systems Change
Cessation Support for Patients, Employees and Community



- Tobacco Quitline Fax Referral
- Printed educational materials
- Employee benefits include tobacco cessation counseling, classes and medications
- WIC and Mental Health

Systems Change Communications

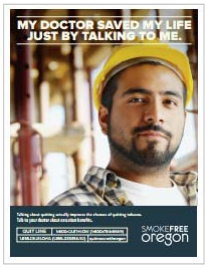
- English and Spanish language signs at all 34 Oregon clinics
- Advantage memo to employees
- Advantage newsletter article
- CCO newsletter article
- Media outreach

Lessons Learned

- **Respect competing priorities and capitalize on quality improvement initiatives** to raise priority of tobacco dependence treatment
- **Participation at all levels** is critical to facilitate systems change
- **EMR limitations** exist, but they can be managed to keep systems change moving forward
- **Ongoing training** needed to help maintain strong processes for treating tobacco dependence
- **Technical Assistance** is critical to elevate priority of health systems change

Collateral Materials Produced

www.adaptoregon.org/services/tobacco/



- Tobacco-Free Model Policy
- Systems Change Assessment Tools
- Systems Change & Cessation Webpages
- Clinic Poster Series
- Change Team Reports

Questions / Contacts

Policy & Systems Change Initiative

Marilyn Carter, PhD, Adapt
marilync@adapt-or.org

Working with Advantage Dental Clinics

Cindy Shirtcliff, LCSW, Advantage Dental
Regional Manager Community Liaison
cindys@advantagedental.com

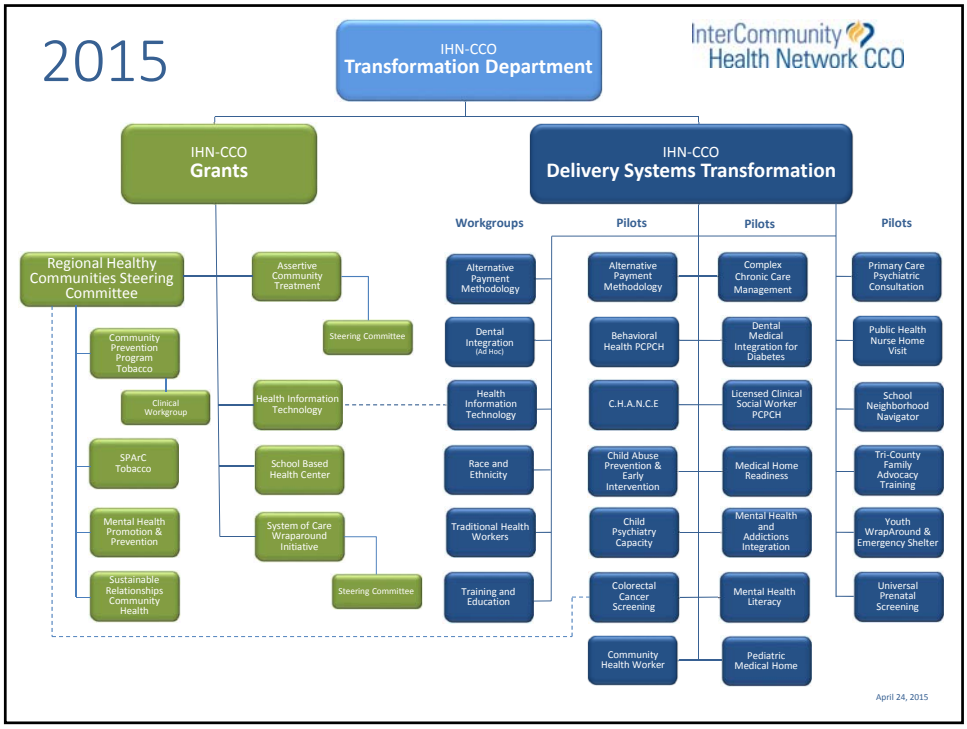
Regional Healthy Communities Initiative:

Building CCO-Public Health Collaborations and Infrastructure to promote community health

Kevin Ewanchyna, MD
Chief Medical Officer
InterCommunity Health Network-CCO

Sara Hartstein
Health Policy Specialist
Benton Co. Health Dept.

Quality and Health Outcomes Committee Meeting
May 11, 2015


2015
IHN-CCO
Transformation Department
InterCommunity Health Network CCO
IHN-CCO
Grants
IHN-CCO
Delivery Systems Transformation
Workgroups
Pilots
Pilots
Pilots
Regional Healthy Communities Steering Committee
Assertive Community Treatment
Steering Committee
Community Prevention Program Tobacco
Clinical Workgroup
Health Information Technology
SPArC Tobacco
School Based Health Center
Mental Health Promotion & Prevention
System of Care Wraparound Initiative
Sustainable Relationships Community Health
Steering Committee
Alternative Payment Methodology
Dental Integration (Ad Hoc)
Health Information Technology
Race and Ethnicity
Traditional Health Workers
Training and Education
Alternative Payment Methodology
Behavioral Health PCPCH
C.H.A.N.C.E
Child Abuse Prevention & Early Intervention
Child Psychiatry Capacity
Colorectal Cancer Screening
Community Health Worker
Complex Chronic Care Management
Dental Medical Integration for Diabetes
Licensed Clinical Social Worker PCPCH
Medical Home Readiness
Mental Health and Addictions Integration
Mental Health Literacy
Pediatric Medical Home
Primary Care Psychiatric Consultation
Public Health Nurse Home Visit
School Neighborhood Navigator
Tri-County Family Advocacy Training
Youth WrapAround & Emergency Shelter
Universal Prenatal Screening
April 24, 2015


Collective Impact: Overview
FSG.ORG
There are Five Conditions to Collective Impact Success
Common Agenda
All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions
Shared Measurement
Collecting data and measuring results consistently across all participants ensures efforts remain aligned and participants hold each other accountable
Mutually Reinforcing Activities
Participant activities must be differentiated while still being coordinated through a mutually reinforcing plan of action
Continuous Communication
Consistent and open communication is needed across the many players to build trust, assure mutual objectives, and appreciate common motivation
Backbone Support
Creating and managing collective impact requires a separate organization(s) with staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies
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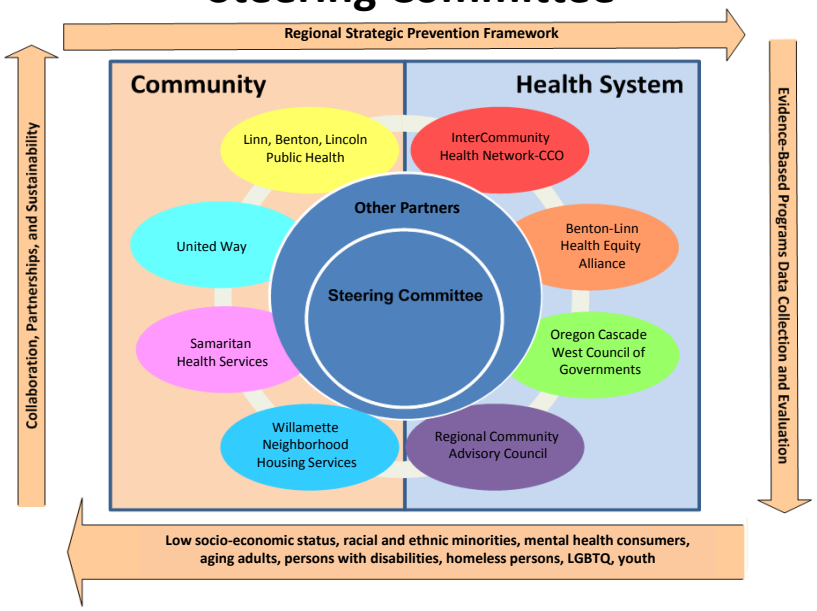
Regional Healthy Communities Steering Committee



Identifying Key Health Issues

- County and IHN-CCO Community Health Assessments
- Prioritized areas in Community Health Improvement Plans and other key stakeholder plans
- Inventory of regional tobacco prevention past and current efforts

Tobacco Intervention Areas

Health system:

- Systematic tobacco screening & referral
- Smoking among pregnant women

Community:

- Tobacco-free social service agencies
- Smokefree workplace expansion
- Tobacco retail license system

Systematic Tobacco Screening and Referral

- Convene clinical team made up of public health, CCO, Samaritan Health Services, Federally Qualified Health Centers, Health Navigation
- Clinic level assessment currently being conducted
- Results will influence recommended improvements

Smoking among Pregnant Women

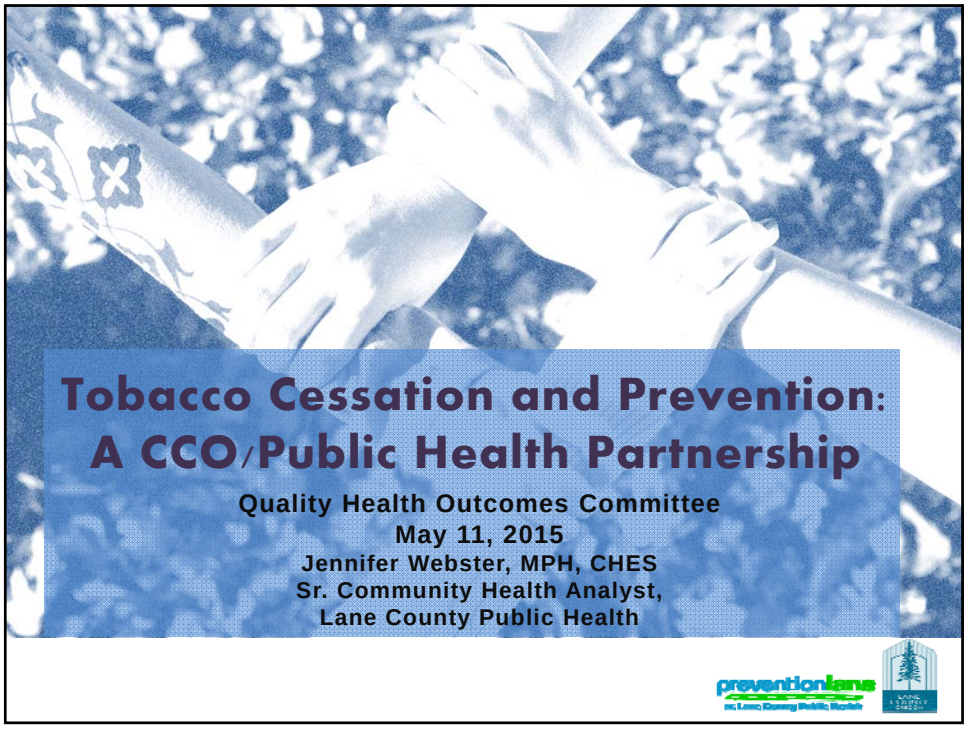
- Assessment of factors related to smoking among pregnant women
- Parish Nurses trained to provide group tobacco cessation counseling with primary focus of WIC clients
- Universal SBIRT (5P's) Screening Pilot Project

Tobacco Free Social Service Agencies

- Social Service Agency assessment (n=146, 62% response rate)
  - 14% had some form of tobacco screening and referral process
  - 38% had a tobacco-free campus policy
  - 34% had policy with e-cigarettes included
  - 48% requested Oregon Tobacco Quit Line materials
  - 22% requested other follow up or technical assistance
- Presentations and follow-up
- Relationship building phase

Tobacco Ordinances

- Smokefree Workplace expansion
  - Prohibit hookah lounges and other smoking bars
  - Prohibit e-cigarette use where smoking is not allowed
  - Prohibit sales of e-cigarettes to minors
- Tobacco Retail License
- Outreach to other jurisdictions in the region



Tobacco Cessation and Prevention: A CCO/Public Health Partnership

Quality Health Outcomes Committee
May 11, 2015
Jennifer Webster, MPH, CHES
Sr. Community Health Analyst,
Lane County Public Health

Primary Prevention Priorities

- Reduce Tobacco Use
  - Pregnant women
  - People being treated for behavioral health conditions
- Reduce Childhood Obesity
- Improve Immunization Rates

Reduce Tobacco Use

- Incentivize pregnant women to quit
- Support providers in offering cessation assistance
- Prevent youth addiction

Quit Tobacco in Pregnancy

- Graduated incentive – the longer the quit, the bigger the incentive
- Incentivize utilization of cessation services (quit line, counseling, etc.)

Support Providers

- Comprehensive cessation benefits
- 5As Training
- Tobacco Treatment Specialist Training

Prevent tobacco addiction

- Good Behavior Game
  - "Behavioral vaccine" - classroom management in first grade
  - Reduces substance use, including tobacco at age 21 by 25-50%
- Retailer Reward/Reminder
  - Reduce underage sales of tobacco in rural communities

PAX Good Behavior Game

The PAX Good Behavior Game is an evidence-based classroom management tool that has over 20 years of research supporting its effectiveness in preventing smoking initiation, drug and alcohol abuse, and social/psychological disorders in young people. Longitudinal studies have demonstrated up to 50% reduction in smoking initiation by age 15 for students who 'played' the game during the first grade. *(Kellam, S., et al. (2011) The Good Behavior Game and the Future of prevention and treatment. Addiction Science and Clinical Practice 6(1) 73-84.).*

Table 1

Evaluation Question	**Indicators**	**Data Sources/ Methods (How Measured / Case Definition)**	**As of June 2014**
Have we increased the number of elementary schools serving low-income populations with teachers trained in GBG?	Number of elementary school teachers trained	Registration information Attendance information	85 teachers have been trained
	% of eligible schools* with at least 1 teacher trained	# of schools with teachers who have attended GBG trainings/total # eligible schools	50% of eligible schools have at least one teacher trained (6/12); up from 30% prior to trainings
	% of kids in classrooms with trained teachers	# kids in classrooms with trained teachers/# kids in eligible schools**	An estimated 21% of kids in eligible schools are in classrooms with a trained teacher (731/3415); compared to 9% prior to trainings (340/3415)

*Eligible schools are those with 75% or greater enrollment in free/reduced lunch

** # kids in classrooms is an estimate based on average class size

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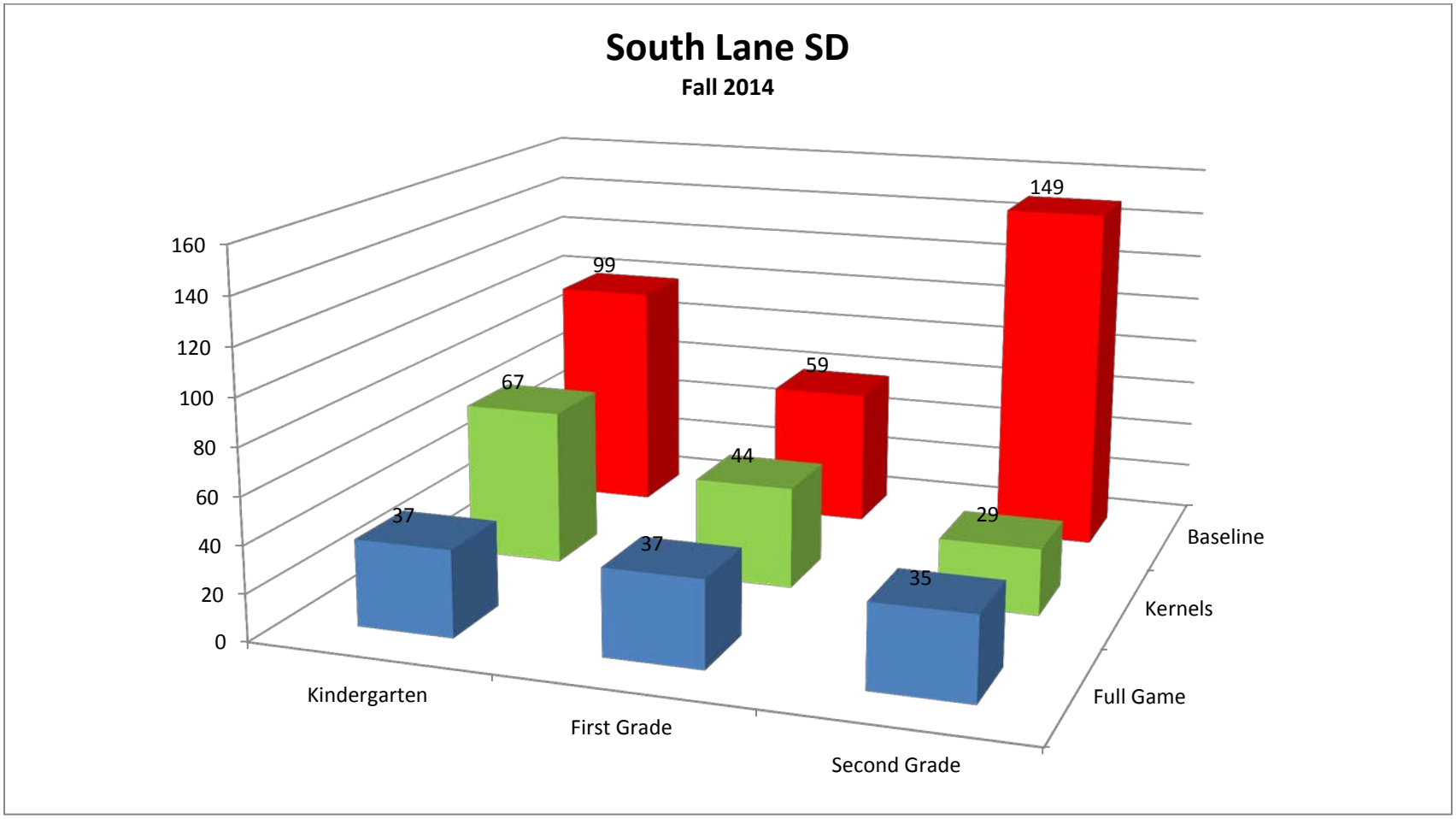
4/27/15

Average spleem[1] Counts: South Lane School District



[1] Spleem is a made up word used in PAX classrooms to describe any behavior that is disruptive to teaching and/or learning. Spleem counts are a process measure used to determine the effectiveness of implementation. As spleems decrease, the likelihood of participants engaging in health risk behaviors over the long-term also decreases.

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PAXIS Institute™ passion into action science to practice promoting solutions

The Power of Teachers to Better the World With PAX in Lane County, OR for 3,478 First Graders

Each of us knows teachers who changed our lives. Each of us, as teachers, aspires to change lives of our students for the better. When teachers and students stayed in a community for a long time, teachers had a chance to see the fruit of their labors.

Modern mobility makes it difficult to follow our students through adulthood, yet modern science can track the impact of one teacher on many lives. Modern science has repeatedly tested PAX GBG—a daily practice invented by teachers that you can use during any instructional activity—that changes lives for the better.

Consider a simple analogy. You know that having a child use a car-safety seat can save lives. You know that teaching children to wash their hands can save them from illness—even serious illnesses. How do you know that? Typically from scientific studies and public-health messages, based on rigorous studies of the benefits of car seats and hand washing. You know that the benefit is when you create the Miracle of self-regulation, positive peer relations, and ability to delay gratification by using PAX GBG each year. This calculation shows what might happen in this district if every first grade teacher in the district used PAX GBG well. We cannot say for certain, of course. But we can predict increased ***probability*** of greater peace, productivity, health and happiness on the part of your students—based now on multiple long-term studies of the impact of the PAX GBG strategies when those same students reach the age of 21. And the worse your students' prior histories coming to your classroom, the greater the probability that using the strategies of PAX GBG will have these benefits. This estimate of your lifetime miracle worker status hinges on you actually using PAX strategies each year, with some supports and materials along the way.

Impact	Long Term Outcome Indicator at Age 21
299	**Fewer young people will need any form of special education services**
194	**More boys will likely graduate from high school**
232	**More boys will likely attend college**
309	**More girls will likely graduate from high school**
241	**More girls will likely attend college**
34	**Fewer young people will likely commit serious violent crimes**
334	**Fewer young people will likely develop serious drug addictions**
229	**Fewer young people will likely become regular smokers**
123	**Fewer young people will likely develop serious alcohol addictions**
169	**Fewer young women will likely contemplate suicide**
229	**Fewer young men will likely attempt suicide**

*Note: If the first-grade teachers just use PAX GBG for one year, the ROI is 92-to-1, and the total savings of **$45.2 million**. If teachers use this more years, that produces even better rates of return. These benefits accrue to the child, family, and community.

P.O. Box 31205, Tucson, AZ 85751 (p) 520.299.6770 (f) 520.299-6822 www.paxis.org

If you are like most teachers, you've imagined your making lifetime differences for your students. Chances are you can recall one teacher who made a lifetime difference to you or to your own children.

While we imagine making such lifetime differences, teachers rarely have the opportunity to learn about and how to use strategies that are scientifically proven to benefit children for their lifetimes. The strategies inside PAX GBG are among one of the few such proven strategies, and it is rather easy to use. Additionally, once you really learn to use these strategies well, you can apply them.

Today, you are learning to use these powerful skills during any academic or school activity. PAX GBG is not a curriculum, a fortunate thing since curricula come and go as fads, with new administrators, or election cycles.

Skills are portable and improvable. You can use your learned skills of PAX in any classroom, as well as in the community. The knowledge about the skills inside PAX GBG are subject to constant study around the world, which means you and your students can gain more from the skills if you continue to sharpen or polish the skills.

New knowledge about those skills underlying PAX GBG can be found in the best scientific journals, many of which are accessible via the U.S. National Library of Medicine at www.pubmed.gov.

You can contribute to those improvements by sharing your successes and challenges at www.GoodBehaviorGame.org and related sites. You can also use social media like FaceBook (befriend PAX GBG), and you can even use Twitter to share your successes or challenges by using the hashtag #saveallkids.

Remember, PAX is like seatbelts, tooth brushing, and physical activity: PAX only works if you work PAX. Thousands of teachers have now used PAX GBG. Like seatbelts, tooth brushing and physical activity, those teachers who have really used PAX GBG have the results to show to themselves and others that can benefit children for their lifetimes.

References used for calculating benefits

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NREPP
National Registry of Evidence-Based Programs and Practices
Please visit http://bit.ly/NREPP

pax Good Behavior Game
Visit GoodBehaviorGame.org for learn more about saving our children's futures

QTiP: Quit Tobacco in Pregnancy

QTiP is an incentive program to help Trillium members quit smoking during pregnancy and remain quit beyond pregnancy

How it works

The QTiP Coordinator, who has an office in the WIC program, receives referrals and meets with pregnant smokers to educate them about the dangers of smoking during pregnancy and how to participate in the program. At the time of enrollment, a carbon monoxide reading is taken to determine a baseline. Information is also collected about the woman's tobacco use history and the QTiP Coordinator discusses strategies for quitting. Just for enrolling, women are offered a gift (valued at approximately $10).

Each participant is scheduled for a follow-up visit and CO monitoring 4-6 weeks after the first appointment and at least 2 other subsequent appointments during pregnancy. At these appointments, women can receive an incentive for having utilized the quit line, participating in a cessation group or speaking with a tobacco treatment specialist during the previous 4-6 weeks. Each participant is eligible for up to 3 of these during pregnancy and 2 during the first six months postpartum.

Smoking during pregnancy is linked to low birth weight and premature birth.

Low birth weight has been liked to higher hospitalization costs at birth as well as higher first year of life costs.

According to the CDC, an 18% quit rate could result in cost-savings of $3.50 for every $1 spent on getting pregnant smokers to quit.[1]

At these follow-up visits, the QTiP Coordinator also checks CO levels and if the participant has successfully abstained from smoking, she is also given a Fred Meyer gift card. Gift card values increase the longer the participant remains abstinent: $20 the first visit, $30 the second visit, $50 third visit during pregnancy and $50 each for two postpartum visits.

Who qualifies

Pregnant Trillium members who are at more than 4 weeks from their estimated date of delivery and interested in quitting tobacco are eligible to enroll.

Progress update

From August 2013-July 2014, a total of 74 women participated in the first iteration of this program. Since switching to the QTiP program in November 2014, 76 women have enrolled.

[1] *CDC, Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC): MCH SAMMEC software, 2002b*

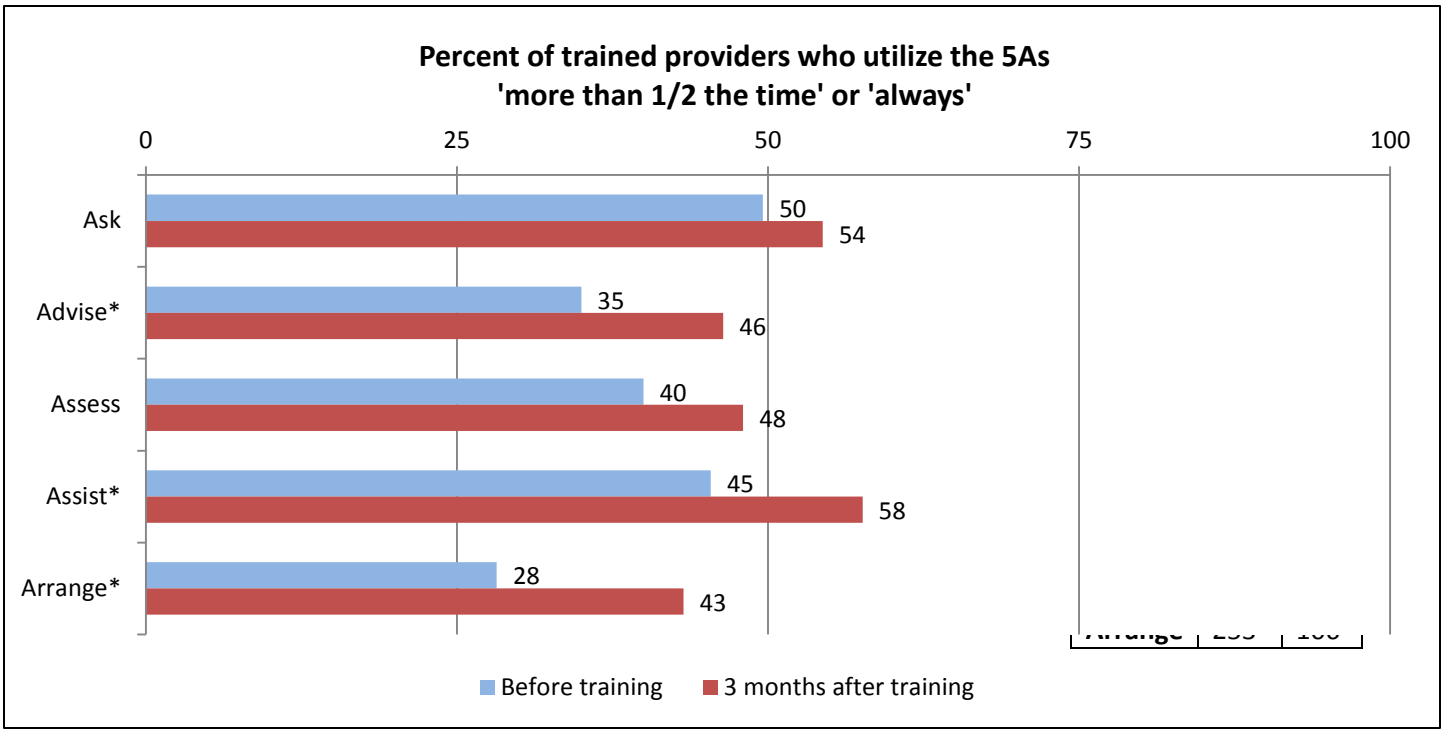
j. webster
4/23/15

Provider Training for Tobacco Cessation

Three provider training opportunities were offered between June 2013 and December 2013; all three emphasized use of the 5As, an evidence-based screening and brief intervention for assisting tobacco users with cessation efforts.

1. Training for Tobacco Treatment Specialists (TTS) was offered in June 2013 to 36 providers, most of whom were behavioral health specialists. This intensive four-day training helped create a cadre of specialists who could work intensively with Trillium members who needed assistance with tobacco cessation.
2. 50 staff members at 5 prenatal care clinics were given a brief introduction to use of the 5As as part of the training for the Tobacco Cessation Incentive Program in June 2013.
3. Two hour trainings on medications and counseling for the treatment of tobacco dependence were offered in November 2013 at multiple locations. Approximately 230 medical and/or behavioral health providers participated in at least one of these training opportunities.

- Trainings increased use of the 5As by an average of 10%
    - Significant increases in Advise, Assist and Arrange
    - Consistent use of Ask and Assist suggests that tobacco users ready to quit are getting the assistance they need
    - Less frequent use of Advise, Assess, and Arrange suggests that ambivalent tobacco users may need more attention
- Use of the fax referral service to the Oregon Quit Line has increased:
    - 19 Lane County providers used the service between July-December, 2012.
    - 48 Lane County providers used the service between July-December, 2013.



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6/3/14

CCO Quality Strategy Review

Purpose

To outline a process for reviewing and approving the annual CCO Quality Strategy' this is required by OHA's CMS demonstration waiver.

Goal

1. Broad feedback from internal OHA programs
2. Timely selection and communication to CCOs

CCO Quality Strategy

January 1, 2015 – December 31, 2015

Review Process Timeline

Activity	Owner	Due Date
CCO Submit Quality Strategy (Assessment and Evaluation)	CCO	March 16, 2015
MAP Compliance review (Evaluation and CMS compliance)	Chris Barber, QA Team	May 8, 2015
AMH review	Justin Hopkins	May 8, 2015
Long Term care review	tbd	May 8, 2015
CMO Quality Improvement review	Lisa Bui	May 8, 2015
Summary reports – incorporating OHA feedback into one document	Lisa Bui	May 11, 2015
Feedback to CCO	Chris Barber / Lisa Bui	May 15, 2015
Final Drafts to OHA	CCO	June 10, 2015
OHA Approval of CCO Quality Strategies sent to CCO	n/a	July 1, 2015
OHA Approval of CCO Quality Strategies sent to EQRO	n/a	July 1, 2015
OHA revises and edits annual State Quality Strategy	CMO Office / MAP	October 1, 2015

Exhibit I Grievance Log

2/24/15 *FINAL draft*

CLIENT ID	Receipt Date	Grievance Type - See Attachment 1.3 for listing	Service Type (See last line in Att. 1.3)	Date of Resolution	# Days to Resolution	1 PC Resolution	Mental Health	Dental Health	Provider	Clinic	Resolution	Pending
TOTALS:												

Exhibit I NOA-Appeal-Hearing Log

2/24/15 *FINAL DRAFT*

Include all oral and written appeals received by the Contractor for each category.

Report Period: _____ Jan - Mar _____ Apr - Jun _____ July-Sept _____ Oct - Dec

NOA - Appeal - Hearing Log	**Date of Request of Service / Item**	**Date of NOA -OR- EOB complete with Appeal/Hearing Rights**	**Action Category See Attachment 2.2**	**Date of Appeal**	**Expedited Requested Y/N**	**Expedited Granted Y/N**	**Denied Service Upheld**	**Overturned at Appeal**	**Partial Denial**	**Member Withdrew Appeal**	**Dismissed Late Filing**	**Invalid Waiver**	**Continuing Benefits Provided Y / N**	**Mental Health**	**Dental Health**	**Decision Pending Y/N**	**Date of NOAR**	**Date of Hearing Request**	**Date of Hearing**	**Continuation of Benefits Provided Y/N**	**No Show Y/N**	**Not Hearable**	**Member Withdrew**	**Plan Overturned prior to Hearing Date**	**ALJ Affirmed PHP Decision**	**ALJ Overturned PHP Decision**	**Decision Pending Y/N**
Client ID																											

Exhibit I Grievance Summary 2/24/15 ***draft***

ACCESS-"A"		
Provider's office unresponsive, not available, difficult to contact for appointment or information.		
Plan unresponsive, not available, difficult to contact for appointment or information.		
Provider's office too far away, not convenient		
Unable to schedule appointment in a timely manner.		
Unable to be seen in a timely manner for urgent/ emergent care		
Provider's office closed to new patients.		
Referral or 2nd opinion denied/refused by provider.		
Referral or 2nd opinion denied/refused by plan.		
Provider not available to give necessary care		
Eligibility issues		
Female or male provider preferred, but not available		
NEMT not provided, late pick up resulting in missed appointment, problems with coordination of transportation services		
Dismissed by provider due to past due billing issues		
Dismissed by clinic due to past due billing issues		
INTERACTION WITH PROVIDER or PLAN STAFF-"IP"		
Wants to change providers; provider not a good fit		
Provider rude, inappropriate comments or behavior		
Plan rude or inappropriate comments or behavior		
Provider explanation/instruction inadequate/incomplete		
Plan explanation/instruction inadequate/incomplete		
Wait too long in office before receiving care (> 44 mins for QI purposes)		
Member not treated with respect and due consideration for his/her dignity & privacy.		CFR 438.100(b)(2)(ii)
Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity, interpreter services not available,		
Plan's office or staff exhibits language or cultural barriers or lack of cultural sensitivity		
Member has difficulty understanding provider due to language or cultural barriers.		
Lack of communication and coordination among providers		
Dismissed by provider (member misbehavior, missed appts, etc)		
Dismissed by Clinic (member misbehavioral, missed appts. Etc)		

CONSUMER RIGHTS - "CR"	http://www.nlm.nih.gov/medlineplus/ency/article/001947.htm	
Provider's office has a physical barrier's is not ADA compliant (preventing access from street level or to lavatory or to examination room or no special adaptations for doors)		
Concern over confidentiality		
Member dissatisfaction with treatment plan (not involved, didn't understand, choices not reflected, not person centered, disagrees, tooth not restorable, preference for individual settings vs. group, treatment options not explained)		
No choice of clinician or clinician of choice not available		
Fraud and financial abuse (services billed not provided, service provided in two appointments that should have been provided in one appointment, etc)		
Provider bias barrier (age, race, religion, sexual orientation, mental/physical health**,** marital status, Medicaid/Medicare)		
Plan bias barrier (age, race, religion, sexual orientation, mental/physical health status)		
Complaint / appeal process not explained, lack of adequate or understandable NOA		
Not informed of consumer rights		
Denied member access to medical records (other than as restricted by law)		
Did not respond to members request to amend inaccurate or incomplete information in the medical record (includes right to submit a statement of disagreement)		
Advanced or Mental Health Directive not discussed or offered or followed		
Restraint or seclusion used other than to assure members immediate safety.		
Quality-of-Care - "QC" **A concern that the care provided did not meet a professionally recognized standard of health care and a Member may have been exposed to serious harm as a result or may potentially be exposed to imminent future harm as a result of the quality of care provided.**		
Received appropriate care, but experienced an adverse outcome, complications, misdiagnosis or concern related to provider care.		
Testing/assessment insufficient, inadequate or omitted		

Concern about prescriber or medication or medication management issues (prescribed non-formulary medication, unable to get prescription filled or therapeutic alternative recommend by Provider or Plan)		
Member neglect or physical, mental, or psychological abuse		
Provider office unsafe/unsanitary environment or equipment		
Lack of appropriate individualized setting in treatment		
QUALITY OF SERVICE-"QS"		
Delay in receiving or concern regarding quality of materials and supplies (DME) or dental		
Lack of access to medical records or unable to make changes		
Benefits not covered.		
CLIENT BILLING ISSUES-"CB"		
a) Co-Pays,		
b) Premiums		
c) Billing OHP clients for services without approved waiver		
MISCELLANEOUS Use to capture issues not related to quality of care. Brief description of complaint is required.	**NEW**	
SERVICE TYPE **Drop Down Menu:**		
1) DME		
2) OT		
3) PT		
4) Hospital		
5) ER		
6) Ambulance / Medical Transportation		
7) Residential Rehabilitation		
8) Pharmacy		
9) Dental		
10) Mental Health		
11) Pain Management		
12) Alcohol & Drug (A&D)		
13) Specialty Care		
14) Long Term Care		

15) PCP		
16) Outpatient		
17) Other		
18) Diagnostic Studies		
19) Imaging		
20) NEMT		

Oregon Health System Innovation Café

June 8-9, 2015
Salem, Oregon

Register now for the *Oregon Health System Innovation Café* hosted by the Oregon Health Authority Transformation Center on June 8 and 9 in Salem at http://oregoninnovationcafe.eventbrite.com. The goal is to bring together CCOs and other health system transformation champions in Oregon for peer-to-peer learning and collaborative conversation about innovative projects addressing:

- Complex Care
- Behavioral Health Integration
- Traditional Health Workers
- Health Information Technology and Tele-health

This highly interactive two-day meeting will include informal small-group table discussions about projects and learning, as well as plenary presentations from regional and national health care leaders. Participants will have the opportunity to participate in multiple discussions across the four topic areas.

See the draft agenda on the other side of this invitation.

When: Monday, June 8, 2:30 (following the CCO Quality and Health Outcomes Committee meeting) – 6:30 p.m. and Tuesday, June 9, 8:00 a.m. – 3:00 p.m.

Where: Salem Convention Center
200 Commercial Street SE, Salem, OR 97301

If you have questions please contact the Transformation Center at 971-673-3363 or transformation.center@state.or.us.

Lodging is available at the Salem Grand Hotel across from the Salem Convention Center. Learn more about the Grand Hotel in Salem by visiting www.GrandHotelSalem.com. For additional lodging options, please contact Travel Salem toll free at 800-874-7012 or www.travelsalem.com.

Oregon Health System Innovation Café
June 8 – 9, 2015
Salem Convention Center, Salem, OR

Meeting Objectives:

- Support the spread of innovative health system models addressing complex care, behavioral health integration, traditional health workers, health information technology and tele-health.
- Promote peer-to-peer learning, information sharing and networking.

June 8, 2015

1:30 – 2:30 p.m.	**Registration**
2:30 – 2:40 p.m.	**Welcome & Introductions**
2:40 – 3:00 p.m.	**Governor's Office** *(Invited)*
3:00 – 4:00 p.m.	**Opening Plenary: Ed Wagner, MD, MPH, Group Health Research Institute Senior Investigator, Director (Emeritus), MacColl Center**
4:00 – 5:30 p.m.	**Café Discussion Session 1**
5:30 – 6:30 p.m.	**Reception**

June 9, 2015

7:00 – 8:00 a.m.	**Registration**
8:00 – 8:15 a.m.	**Welcome**
8:15 – 9:00 a.m.	**Plenary: David Labby, MD, PhD, Project Executive Director, Health Commons Grant, Chief Medical Officer, Health Share of Oregon**
9:00 – 10:00 a.m.	**Topic Affinity Groups** • **Trauma Informed Care** • **Behavioral Health Integration** • **Traditional Health Workers** • **Health Information Technology and Tele-health**
10:00 – 10:15 a.m.	**Break**
10:15 – 11:45 a.m.	**Café Discussion Session 2**
11:45 a.m. – 12:45 p.m.	**Lunch & Funder Panel**
12:45 – 2:15 p.m.	**Café Discussion Session 3**
2:15 – 2:45 p.m.	**Plenary: Lynne Saxton, Director, Oregon Health Authority**
2:45 – 3:00 p.m.	**Closing Comments & Next Steps**