Oregon Health System Innovation Café Project Packet

June 8 – 9, 2015
Salem Convention Center
Salem, OR

Café Discussion Session 1

Café Discussion Session 1
Behavioral Health Integration

Working into the Tipping Point of Healthcare Reform

"In the end, Tipping Points are a reaffirmation of the potential for change and the power of intelligent action. Look at the world around you. It may seem like an immovable, implacable place. It is not. With the slightest push—in just the right place—it can be tipped."
Malcolm Gladwell, *The Tipping Point: How Little Things Can Make a Big Difference*

Our historical approach to caring for patients holds many potential gaps, if not chasms, that leave patients vulnerable and may contribute to their increased acuity. One such large chasm has been in the interface of the physical and behavioral health providers and systems. The majority of physical and behavioral patient care comes from differing payer systems including behavioral health carve-outs, separate sets of providers and most often separate locations of care. The protection of patient information also has contributed to very little, if any, communication about care between the behavioral health care provider and/or system and the physical health care provider and/or system.

Trillium is quickly growing to answer the responsibility of ensuring the provision of quality care to our community. As we have grown to nearly 100,000 members, about 28% of the Lane County population, we know we must support our providers and practitioners in optimal and sustainable models of care. Trillium's commitment to healthcare transformation is rooted in the firm belief that we need and have the opportunity for broad systemic change to be able to deliver integrated behavioral and physical health services. We are on the verge of finding our "tipping point" in healthcare. The Triple Aim mandate of the Affordable Care Act and Oregon Health Authority's commitment to incentivizing medical homes has set the ball in motion for new models of care. This opportunity has been put into action by Trillium in 2014 with the launch of the Trillium Integration Incubator Project (TIIP).

Prior to the start of the CCOs "The Opportunity Conference" convened here in Lane County. The collective hope included improved integration of healthcare services for our community. This vision was carried forward by many practitioner leaders and in the Spring of 2014 Trillium Behavioral Health spearheaded an initiative and Request for Proposal (RFP) that was welcomed and encouraged by the leadership of Trillium.

Many organizations attended the early meetings where the RFP was described. Of the 15 original responders to the RFP, eight programs submitted their concepts for integrated behavioral health and physical health services. Every program presentation was unique, innovative and forward thinking. Four programs proposed to enhance integrated primary care medical homes and four programs were for behavioral health medical homes. The primary

care organizations covered the spectrum of primary care providers in Lane County including Oregon Medical Group, Lane Independent Practice Providers (two), and PeaceHealth. The behavioral health sites include PeaceHealth, The Child Center, Options Counseling, the Center for Family Development, Lane County Behavioral Health and Willamette Family, Inc. Some organizations employed new types of staff, some set up contractual agreements with other organizations, some projects included remodeling and others acquired new space. All are inventive. Trillium made a commitment to support all eight programs.

June 30, 2014 marked the launch of Trillium Integration Incubator Project (TIIP). TIIP has been a rich opportunity to observe and learn from eight programs that are moving forward simultaneously. The TIIP included monthly learning collaborative breakfasts, weekly electronic information (TIIP Sheets), intensive learning opportunities with national experts and the ongoing support of the Trillium clinical and administrative staffs. There are opportunities to learn more about population health and the use of shared data and outcomes to optimize the delivery of care by "the right person, in the right place, at the right time".

The TIIP program sites have committed to providing innovative integrated care for nearly 17,000 Trillium members. The incubator financial model for the TIIP provided over a half million dollars in start-up grants, allowed for ongoing fee for service billing and included an additional per member per month (PMPM) alternative payment methodology to support the innovative and collaborative work required to establish integrated medical home care.

In support of the work of integration a TIIP Operations Team has been convened that meets to address barriers and challenges within the operation work of Trillium that are affected by and affect the work of integration. Additionally there is a TIIP Advisory Committee that includes Trillium staff as well as members from other partner organizations to review the work of the project and assist in the development of a more comprehensive program for integrated medical homes in the future.

The goal of the TIIP has been to discover the optimal models for delivering integrated behavioral and physical health services, the optimal payment models and to determine the best quality of life outcomes for our community. This project was initiated with the hope that it would help to achieve the "tipping point" for change from the historically siloed delivery of physical and behavioral health care to integrated medical homes with improved payment models, population health identified team based care and smooth transitions for the improved health of our patients.

We are currently extending all of our projects through the end of 2015. In addition we are writing a guideline manual for the Trillium Integration Program for Primary Care that we will launch in 2016. This work is based upon our early learning and feedback from our early adopters.

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Oregon Innovation Café' June 2015

Topic Area: Behavioral Health Integration

Project Title: Reducing Impact of Untreated Trauma and Mental Health Issues in a Primary Care Medical Home

Project Location: Samaritan Family Medicine Resident Clinic, Corvallis Oregon

Contact Information: Jana Svoboda, LCSW jsvoboda@samhealth.org 541-768-5349

Description: Medically Unexplained Symptoms and stress related effects on health are behind well over 50% of primary care visits. Strong stigma and misunderstanding persists in public and medical homes around mental health issues. Patients assume that "stress-related" means their physician doesn't believe they are truly having physical symptoms or that they are being dismissed. Trauma histories are present in the majority of medically complex presentations and high service users.

Approximately one in five persons will experience a significant mental health crisis in their lifetime. If they receive care at all, the vast majority will only accept or approach care from their PCP. Current psychiatric intake wait times in our area are over 6 months even if a referral is obtained and the person is willing to access traditional mental health. Wait lists for private or county mental health services (non-medical) are as high, and there are practical and cultural barriers to access.

Health is health. Mental, emotional and behavioral issues impact physical wellbeing. An opportunity exists in primary care for intervention in the early stages, before problems become chronic and impact physical wellness over the lifespan.

This project looks at how mental health care can be integrated into the medical home, culturally as well as in practice. An LCSW with specialty mental health training was placed within a large medical home serving over 8000 patients. This clinician delivered direct and indirect services to patients via scheduled and warm hand-off brief psychotherapy/trauma informed CBT and classes on stress management, communication skills, habit changing, smoking cessation, and via staff training on mental health, stress related illnesses, culturally sensitive care, and more. PHQ, GAD, OARS and ACE instruments are used to measure need for service and improvement in wellbeing.

Key findings: Demand for the service was very clear, as was benefit to patients. Key questions for discussion: How do we implement whole-health care in a way that is sustainable (cost-effective) and sufficient (meets demand)? We'll look at combining education to clinicians, staff and patients as well as ways to meet service needs via group appts, classes and brief psychotherapy models.

Partnering CCOs, Higher Education and Primary Care for Behavioral Health Workforce Development

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Win-Win-Win

- **Purpose: To equip a new generation of Social Workers with the skills and experience to provide mental/behavioral health and substance abuse services to some of Oregon's most vulnerable populations.**
- **Aim: To coordinate CCOs, higher education and primary care to implement an innovative curriculum, training opportunities and field placements for 3 master's-level social work (MSW) students and one Behavioral Medicine PhD candidate.**
- **Focus: To support primary care clinics with integrated services and equip students for careers at the cutting edge of Primary Care Behavioral Health (PCBH)**
- **Goal: Improve overall health outcomes for patients by improving access to efficient and effective behavioral health services within PC clinics AND when needed facilitate effective referrals to outside services.**
- **Due a HRSA grant, PSU will have 32 PCBH "Paid" internships/year over the next three years across the state!**

Celebrations:

- **All 4 interns offered jobs in PC clinics**
- **Clinics offered unique services (e.g. Chronic Pain)**
- **Introduced and/or supported Trauma Informed Care**

Key Learning:

- **Important to have well trained field instructors known to the PC clinics.**
- **"Fit" is important: keeping the cadence of PC, diplomacy, open door (literally), all IBH referrals are a go!**
- **Important to speak the PC language and incorporate evidence based and data driven services.**
- **Traditional Mental Health programs do not train students in PCBH models of care.**

Challenges:

- **Need to make alternative payment methodologies available as codes are appropriate for reimbursement.**
- **Need Learning Collaborative opportunities for all PCBH workers**
- **Difficult to integrate into PC in 16 hours a week of internship**
- **Need more onsite "Task Supervision" of interns**

Café Discussion Session 1
Complex Care

OREGON PAIN ADVISORS

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Innovation Café Project: Pain Resiliency Program

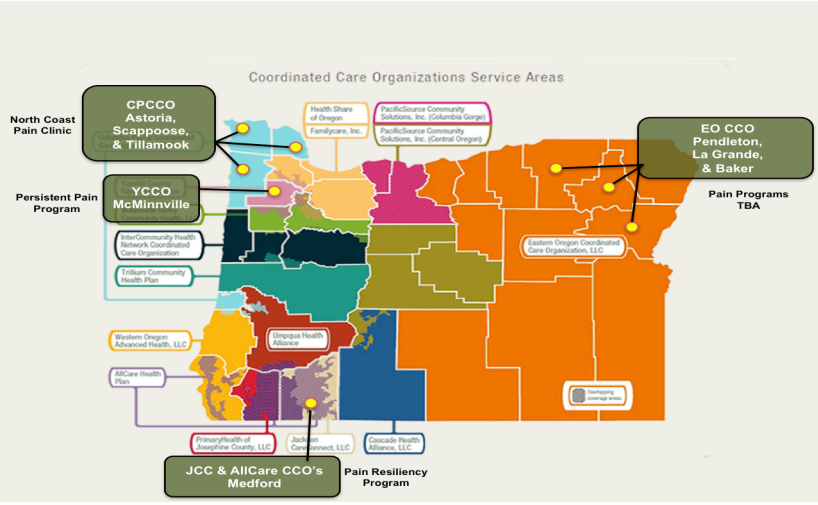
Project Goals:

1. Advance and promote best practices for pain treatment.
2. Reduce prescribing of opiates for persistent pain.
3. Implement evidenced based non-pharmacological treatment programs for persistent pain.

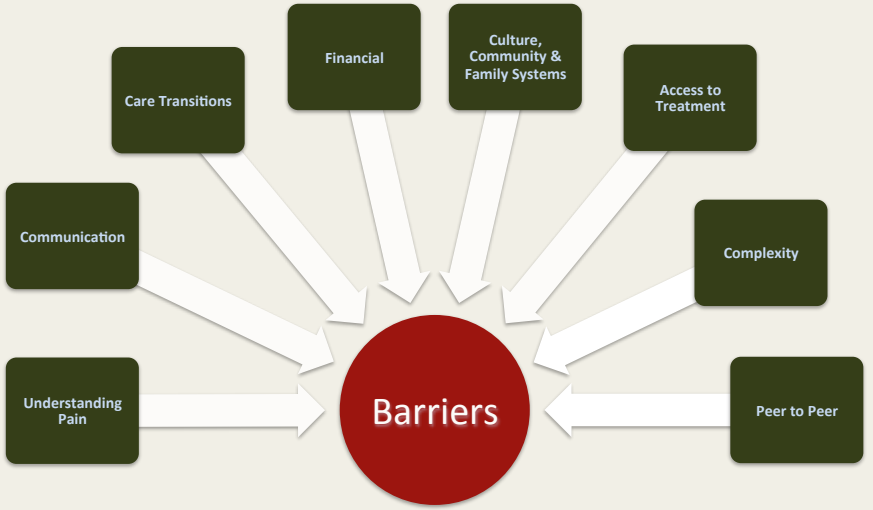
What went well: Strategic planning with local community partners prior to program implementation; piloting of program; pre/post data collection; and building on success of similar models.

Keys to Success: Upfront work with community; marketing / communications plan; financial model & forecasting; hiring staff who understand pain; program & referral workflows; and clear understanding of barriers to treatment.

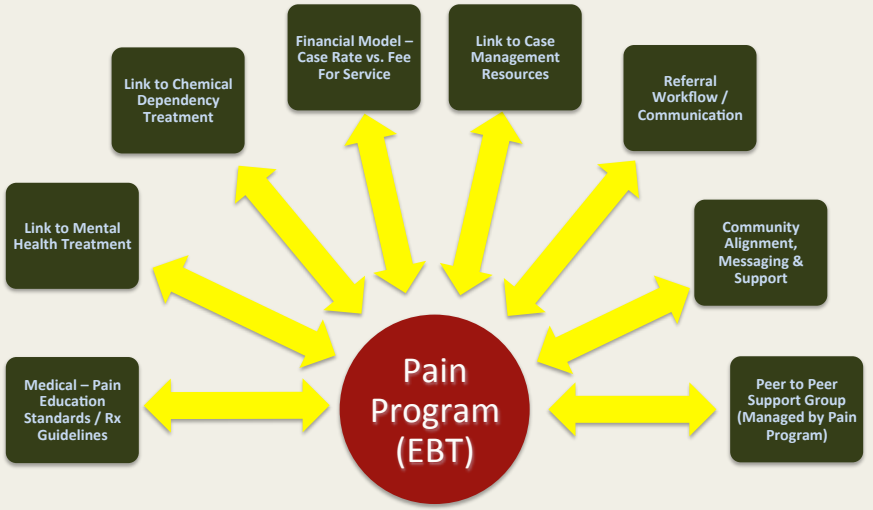
Implementation of Pain Programs within Coordinated Care Organizations



Barriers to Expanded Use of Non-Opioid Therapies for Persistent Pain



Overcoming Barriers to Expanded Use of Non-Opioid Therapies for Persistent Pain



Note: EBT = Evidence Based Treatment for Persistent Pain

Pain Resiliency Program
Clinical Model for Persistent Pain

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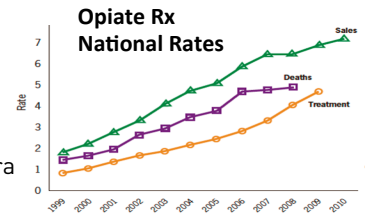
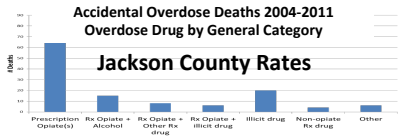
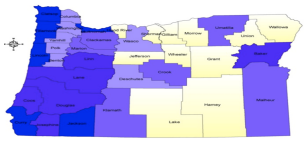
Background

Opioid Issues:
- Increasing death and addiction rates
- No standards of care
- Lack of efficacy for chronic opioid thera
- Weak provider training
- Lack of coordinated care

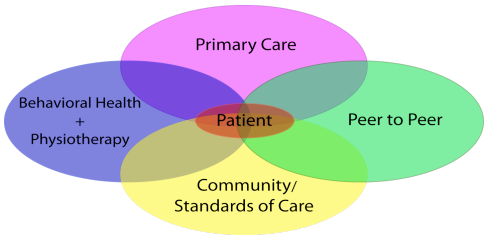






Chronic Pain Issues

- Simple solutions for a complex issue.
- Lack of biopsychosocial programs (interdisciplinary or multidisciplinary)
- Poor understanding of opioids and pain (providers, individuals, community)
- Comorbid PTSD, depression, anxiety
- Comorbid substance abuse



Project Goals

- Decrease opiate prescriptions for chronic pain
- Increase patient function and self efficacy
- Educate, train, & provide tools for providers
- Educate & offer support for chronic pain patients
- Appropriate system utilization
- Work with Community Oregon Pain Guidance Group

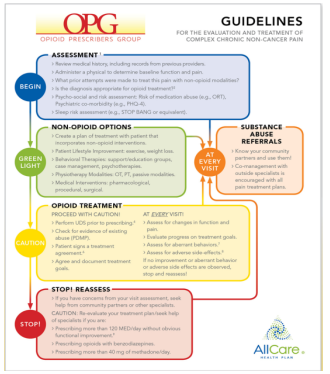
Project Measures

Key measurements, milestones, benchmarks
- Clinical -- Outcomes to improve patient function – Oswestry, self efficacy, fear of movement, PHQ-9
- Financial – Reduction in costs or cost offsets associated with treatment.

- Utilization – Alignment with appropriate healthcare resources.
- Utilization – Appropriate referrals to MH & CD Tx.
- Providers -- Training & standards of care.

Progress to Date/Next Steps

Established to date:
- OPG prescribing & pain treatment guidelines
- 120 Morphine Equivalent Dose (MED) policy
- Provider training on guideline implementation
- Pilot Phase – Pain Resiliency Program (1 year)
- Peer to peer program for chronic pain
- Community outreach
- Provider training on referral and pain program workflow
- Implementation of case rate reimbursement
- Ongoing provider training & community outreach
- Pain Resiliency Program sustainability



CC1 Altenhofen

PEER SUPPORT WITH OHP WILLAMETTE VALLEY COMMUNITY HEALTH MEMBERS AND UNNECESSARY EMERGENCY DEPARTMENT VISITS

EDIT Summary

THE EMERGENCY DEPARTMENT INTERVENTION TEAM, OTHERWISE KNOWN AS EDIT, IS A PEER SUPPORT MODEL THAT SERVES OHP MEDICAID MEMBERS WITHIN THE MARION AND POLK COUNTIES OF OREGON. THE MEMBERS ARE IDENTIFIED WITH 3 OR MORE UNNECESSARY VISITS TO THE EMERGENCY DEPARTMENT WITHIN A 3 MONTHS PERIOD. PEERS OUTREACH TO APPROPRIATE MEMBERS TO ENGAGE WITH EDIT. OVER A MINIMUM ENROLLMENT PERIOD OF SIX MONTHS, MEMBERS ARE TAUGHT HOW TO CIRCUMVENT THE HEALTH AND COMMUNITY SYSTEMS. TO DATE EDIT PEERS HAVE INTERVENED WITH 147 WVCH CCO MEMBER LIVES AND REDUCED TOTAL UNNECESSARY WVCH CCO EMERGENCY DEPARTMENT UTILIZATION BY 26%.

EDIT Staff – (right to left) Jose, Kristi, Jim, Debbie and Heather

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COMPLETE HEALTH IMPROVEMENT PROGRAM (CHIP)

Wallowa Memorial Hospital, Enterprise, OR
Oregon Health Systems Innovation Cafe: June 8-9, 2015
CC 3 Rose

Project Summary:

Current healthcare costs and trends in America are unsustainable. Individuals suffering from chronic diseases use roughly 84% of U.S. healthcare dollars and approximately 99% of Medicare spending. With healthcare costs representing 18% of our GDP ($2.6 trillion) in 2010 and estimated to increase to 20% by 2021 ($5 trillion), a new approach must be taken to curb costs. It has been shown that 70-90% of chronic diseases such as heart disease, strokes, type 2 diabetes, hypertension and obesity are diseases of poor life-style choices. This being the case, it would be reasonable to treat these diseases from a lifestyle point of view. The CHIP program is an evidence-based program which has demonstrated significant results and benefits in the management of cardiovascular disease, weight reduction, along with lowering of cholesterol and triglyceride levels, and better control of type 2 diabetes and hypertension.

The CHIP program is an 8-week, 18-sessions community-based intensive lifestyle intervention program with 36-hours of educational intervention with behavioral and skill development content. Each session is a combination of a live lecture (30 minutes), a video lecture (25 minutes), group discussion (10 minutes), cooking demonstration (20 minutes), and a complete plant-based meal. In addition, there are take-home reading assignments with a text-book and work-book. Such training is needed to develop the skills for adopting and maintaining a better lifestyle and a more optional diet. A total of three CHIP programs with 50 participants in each program were conducted in a one-year period.

CHIP emphasizes the importance of consuming more whole foods as grown, fruits and vegetables, legumes and whole grain products as a means to reduce the intake of fat (< 20% of total calories), cholesterol, salt, and refined sugar, while increasing fiber content (> 30 grams/day). CHIP also promotes the development of a daily exercise program of at least 30 minutes a day of moderate exercise, along with promoting stress reduction techniques and promoting stronger and healthier interpersonal relationships. All these aspects are critical to a whole-person approach to the reduction of chronic diseases.

Prior to the beginning of the CHIP program, a baseline Health Risk Assessment is completed along with biometric testing for all participants. Blood tests include fasting blood glucose, lipid profile (total cholesterol, HDL and LDL cholesterol, and Triglyceride levels), HC-CRP, as well as weight and BMI levels, waist circumference, and blood pressure. These are completed at the beginning, middle (30-day mark), and end (60-day mark) of the CHIP program. After the completion of the 8-week course each alumni is encourage to join a “CHIP Super Club” which is held monthly for educational and support activities.

Measurable Outcomes:

1) **Nutritional Education**: No matter how “knowledgable” a participant may think they are in regard to healthy habits when they start the CHIP program, they always find that there is

so much more to learn and apply practically to their lives. When asked, "***in your own words please describe HOW this program has helped you?*** " by far the most common response could be summarized in these answers:

"*This program has helped me tremendously. I thought I was healthy and very educated. I still learned so much. I also really learned about whole grains, their importance in the diet and how to incorporate more. Before I saw chicken and fish and veggies as healthy. Now I see grains, beans, legumes, fruit and veggies as healthy. The biggest improvement is in my husband - he is on board! This is the healthiest lifestyle he has had for the 1st time ever!!"*

"It has provided very good tools to lean on - rely on - refer back to - after the class ends. I believe I am equipped with knowledge on how to really make this a lifetime change. I would recommend this to anyone that really wants to change their lifestyle for the better."

"*… I think having the meals is a huge motivator - showing healthy dining can taste good. I would never have tried cooking this way on my own, but after seeing the cooking demonstrations and how simple it is to cook a plant-base meal, I am no longer afraid of trying it!"*

2) **Biometric Testing:** The biometric changes seen during the program were remarkable for those who took their lifestyle choices serious. Average changes were as noted:
   - Fasting Blood Sugar in Pre-diabetic and Diabetic participants: average of 15% drop
   - Total Cholesterol: average of 11.5% drop (greatest looser 89 point or 47.3% drop)
   - LDL Cholesterol: average of 15% drop (greatest looser 83 point or 72.8% drop)
   - Average Weight change: average of 7.1 lbs. (greatest looser in 2 months = 28.6 lbs.)

3) **Exercise Activity**: Each participant received a pedometer and was encouraged to complete the 10,000 steps per day goal. When asked, "***on a scale of 1 to 5, (with 1 being LEAST, and 5 being MOST), A) "how strongly they have adopted the CHIP principle for Exercise", and B) if they have "noticed an increase in Exercise Tolerance since starting the CHIP Program***", the average response was a 3.75, and 3.95 respectively. These were the lowest score of all questions in a 14-question questionnaire. It appeared that the most difficult challenge for the participants was to get out and exercise.

4) **Unanticipated Outcomes**: Although we anticipated ripple effects we had not anticipated the growing impact it would make on our community as a whole. After the first session, we did not have to do any further marketing for the program as each successive program was fill and had a waiting list. Grocery stores started stocking items that were being promoted in the cooking classes, and several restaurants in town began adding plant-based items on their menus. It appears that a "critical mass" of "CHIPPERS" has been reached which has created a sustainable change in the community, making healthy lifestyle a priority!

Café Discussion Session 1
Health Information Technology and Telehealth

Project Title: Telehealth connecting nurse case managers to high-utilizing patients with chronic disease

Study Personnel: Marit Bovbjerg, PhD; Terry Crowder, PhD RPh; Jenney Lee; Michael May, MD; Dennis Regan, MD; Robert Wirth, MD; Charlene Yager, RN

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Summary: *This project is sponsored by the InterCommunity Health Network (IHN), the CCO for Linn/Benton/Lincold Counties. The project is a collaboration between The Corvallis Clinic, Kannact, Inc., and Oregon State University.*

The overall goal for this pilot project is to improve health, improve healthcare, and lower costs for high-cost, high-utilizing Medicaid patients with chronic diseases using a telehealth intervention. To be eligible, participants need to be at least 18 years old; receive primary care at The Corvallis Clinic (TCC); not have cognitive impairment requiring a caregiver; have IHN/Medicaid as their primary insurer (dually-eligible Medicaid/Medicare are eligible); have diabetes, COPD, asthma, heart failure, and/or heart disease; and be among TCC's highest-cost patients during 2014, excluding one-time costly events (e.g., motor vehicle injury requiring surgery or PT). We will enroll up to 60 patients in this intervention-only pilot study. Patients receive a tablet computer on which is loaded Kannact's Chronic Disease Management Program. Relevant patient information is pre-loaded into the program (e.g., recent laboratory values, personalized disease management plan). Patients can then use the program to track health indicators, access educational materials, and contact nurse case managers. A TCC complex care management nurse is available 24/7 to respond to direct patient inquiries; the nurse on call also monitors health indicators in relation to each patient's care management plan and offers health coaching as necessary. The evaluation plan utilizes a pre-post design, and will assess patient care costs, clinical outcomes including both physical and mental health, and patient satisfaction. We will also assess feasibility through focus groups with nurses and patients, and an assessment of cost per patient of implementing the intervention.

What is Jefferson Health Information Exchange?

The Jefferson Health Information Exchange (JHIE) was formed to help health care providers electronically communicate with one another to better care for their patients. Established in 2012, JHIE facilitates person-centered care through more efficient and cost effective information exchange. JHIE promotes better health and provides value through secure and trusted information sharing among hospitals, physicians, clinics, behavioral health providers, dentists and Coordinated Care Organizations (CCOs). As a community based non-profit (501c3) Oregon Corporation, JHIE's mission is to *facilitate patient-centered care through a community-driven and provider-led collaboration that promotes better health and provides value through secure and trusted patient information sharing.*

JHIE Governance

JHIE is governed by an all-volunteer Board of Directors, which is comprised of physicians, hospitals, payers, consumers, public health, mental health and community-based organizations. All interested stakeholders are engaged in committees who advise the Board's decision-making process.

Participation

JHIE receives clinical data from the following hospitals and health systems:

- Asante Health System (Medford, Grants Pass, Ashland)
- Mid-Columbia Medical Center (The Dalles - *coming in 2015*)
- Providence Health and Services, Medford Medical Center (Medford)
- Providence Hood River Hospital (Hood River - *coming in 2015*)
- Sky Lakes Medical Center (Klamath Falls)

CCOs that participate with JHIE include:

- All Care (Josephine, Jackson, Coos and Douglas Counties)
- Cascade Health Alliance (Klamath County)
- Jackson Care Connect (a CareOregon Plan)
- Primary Health of Josephine County
- PacificSource Community Solutions (Hood River & Wasco County – *coming in 2015*)

Health Care Providers:
Today, there are over 600 enrolled providers in more than 160 clinics using JHIE's Referrals Network and Direct secure messaging services.

JHIE Services and Functionality

Point-to-Point Health Information Exchange Capabilities

Electronic Referrals: JHIE's electronic referrals application streamlines the referral process by providing a secure and configurable way to manage patient referrals between physical, behavioral and dental health providers. Authorized users electronically communicate about and view the status of any patient referral and share patient information all from one log-in. Alerts can be set to notify providers when a referral or update has been received. The JHIE referrals application provides a closed-loop environment where no patient falls between the cracks and the patient's experience is seamless. Payers use the referral application to facilitate care management activities and expedite patient care in the most appropriate care settings.

Direct Secure Messaging: JHIE serves as a Health Information Service Provider (HISP) for participating hospitals and clinics who do not otherwise have a means to communicate using Direct Trust. As such, JHIE serves as the transport for Meaningful Use (MU) Stage 2 requirements associated with transitions of care. Direct communication is not limited to those who participate in JHIE. Anyone using JHIE's HISP can send/receive Direct messages to anyone in the Direct Trust Bundle (including CareAccord) and across state lines.

Robust Health Information Exchange Capabilities

Community Health Record: Data received by JHIE from contributing health systems, providers and facilities is available for search by authorized (role based) JHIE users. A provider caring for a patient can search for the patient's information in JHIE. Access to patient information is based on a clinical or payer-patient relationship and is subject to all State and Federal privacy laws.

Results Delivery: Interfacing with hospitals and health systems, JHIE delivers clinical results and reports in standardized formats to physicians' electronic health records (EHRs) and to payers' care management systems. JHIE fully automates the delivery and receipt of clinical results and reports, which benefits all those involved in the patient's care by providing a single interface for all data to/from the JHIE provider community. JHIE users without an EHR or care management system can utilize web-based tools to access their patient results/reports.

Care Summary Exchange: JHIE supports continuity of care document (CCD) (i.e., care summary) exchange using federal standards (XDR, XDS, XCA) for eligible hospitals and providers to meet MU Stage 2 requirements for transitions of care. JHIE collects and stores CCDs from ambulatory and inpatient facilities and makes them available upon a patient search.

Notifications: Care management teams as well as other JHIE users (e.g., primary care providers) receive hospital notifications when their patient is admitted to and discharged from an emergency department or inpatient hospitalization.

Care Management: Care management teams may access JHIE to coordinate care across physical, behavioral and dental health systems of care via a web-based application or through automated delivery of clinical results for use within an authorized user's existing care management systems.

What are the Benefits of Joining JHIE?

- ✓ **Patient Care –** Missing information at the point of care negatively impacts patient care, causing delays in care 25% of the time, and additional tests and visits 54% of the time[1].
- ✓ **Patient Safety –** Nationally, serious preventable medication errors occur in 3.8 million inpatient admissions and 3.3 million outpatient visits each year[2]. Inpatient preventable medication errors cost approximately $16.4 billion annually[3]; and outpatient preventable medication errors cost approximately $4.2 billion annually[4].
- ✓ **Closing the Referrals Loop** – One place and mechanism to electronically create, manage and track referrals; communicate with other members of care team and streamline process for patient. Efficiencies result in specialty clinic projected savings between $150K and $250K per year.
- ✓ **Hospital Readmissions** – In a study of 12 Memphis hospitals participating in a community HIE, $2 million was saved with HIE data use over a 13-month period, with reduced admissions accounting for 97.6 percent of the total savings[8].
- ✓ **Results Distribution** – More than $2 million realized on the average cost for labs, radiology facilities and hospitals to send results using traditional methods of fax and mail.
- ✓ **Quality Reporting –** Analytics through the HIE for a community can improve care, support monitoring for disease management and improve public health preparedness[5].
- ✓ **EHR Interoperability** – Most clinicians receive laboratory results from multiple labs all sending results to them in a different format and method, making it difficult to efficiently manage the receipt of information[6]. A single EHR interface to the HIE realizes implementation cost savings of between $18,500 and $28,500 per practice[7].

[1] Smith, P. C., et.al. (2005). Missing Clinical Information During Primary Care Visits. *Journal of the American Medical Association*; (293(5)),565-571.
[2] New England Healthcare Institute (NEHI). (2008). How Many More Studies Will It Take? A Collection of Evidence That Our Health Care System Can Do Better, Cambridge, MA. Retrieved from http://www.nehi.net/publications/30/how_many_more_studies_will_it_take
[3] Massachusetts Technology Collaborative (MTC) & New England Healthcare Institute (NEHI). (2008). Saving Lives, Saving Money: The Imperative for Computerized Physician Order Entry in Massachusetts Hospitals, 44 pgs. Retrieved from www.nehi.net/uploads/full_report/cpoe20808_final.pdf
[4] Center of Information Technology Leadership (CITL). (2007). The value of computerized physician order entry in ambulatory settings. Retrieved from http://www.partners.org/cird/pdfs/CITL_ACPOE_Full.pdf.
[5] HealthData Management (2012). Health Information Exchange: Doing What It Takes To Realize The Vision. *Health Information Exchange 2012*. Retrieved from http://www.healthdatamanagement.com/digital_edition/Doing-What-it-Takes-to-Realize-the-Vision-45118-1.html
[6] Hammond, W. Edward, III, Ph.D. (2004). Electronic Medical Records – Getting it Right and Going to Scale. *Commonwealth Fund background paper* (695). Retrieved from www.cmwf.org
[7] DHIN, June 2011
[8] Frisse, Mark E., M.D. Johnson, Kevin B., M.D., Nian, Hui, Ph.D., et. al. (2011). The Financial Impact of Health Information Exchange on Emergency Department Use. J*ournal of the American Medical Informatics Association (*November 2011 online edition).

TELEDERMATOLOGY *IN* PRIMARY CARE

Yamhill CCO Embeds Teledermatology Services in Primary Care Clinics

Situation

Yamhill Community Care Organization (Yamhill CCO) has approximately 25,000 members traditionally served only by a single regularly practicing dermatologist in the local provider network.

Access to specialty care requires significant travel distance & time.

Primary care providers push their envelope of professional skills to manage dermatologic conditions.

Background

Yamhill CCO is a rural geographic area with constrained specialty resources.

Annually limited numbers of dermatologists are trained.

Assessment

Recruiting new dermatologists is costly & time consuming.

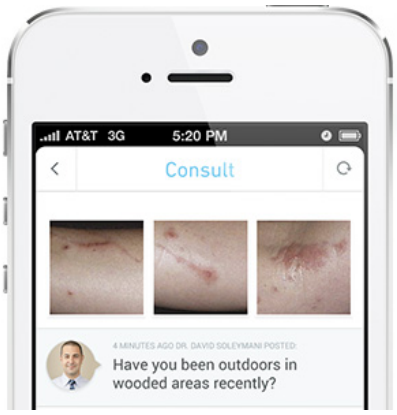
Local consensus exists among primary care providers in use of a teledermatology adoption.

Members deserve improved access to specialty care.

Yamhill Community Care Organization

PROJECT OUTCOMES

- Nationwide tele-dermatology provider, Dermio, was credentialed and contracted by the Yamhill CCO.
- Primary care clinics are provided with mobile devices (iPad mini's) to use in their clinics to facilitate teledermatology consultations for their patients.
- Superuser model was developed in primary care clinics whereby one or two staff champion and manage consultations.
- Images of patient's skin conditions are acquired in clinic and transferred to the tele dermatologist with relevant history via a HIPPA secure web platform using the device.



- Diagnosis and recommended management are provided to the referring provider within 24 hours.
- Five primary care clinics in the Yamhill CCO network have devices and are using the service since March of 2015.
- Over 20 virtual consultations have taken place with resounding satisfaction form providers and members.
- Dr. Rickards was supported in performing this project as a member of the OHA Council of Clinical Innovators.

Jim Rickards, MD **Health Strategy Officer Yamhill CCO** jrickards@yamhillcco.org

The Virtual Dental Home comes to Polk County

Capitol Dental Care (CDC) is launching an innovative pilot project that utilizes teledentistry technology to connect a dentist in the dental office with licensed allied dental professionals working with underserved populations. The specific aims of this project are to:

- Demonstrate the ability to create and deploy telehealth-connected oral health teams capable of reaching children who have not been receiving dental care on a regular basis and providing community-based dental diagnostic, prevention and early intervention services;
- Undertake on-site data collection for diagnostic records and perform preventive procedures designed to keep children from developing advanced dental disease;
- Demonstrate a reduced need for most children to be seen by dentists in stationary dental practices or clinics (the Virtual Dental Home);
- Achieve the Triple Aim in oral health care in Oregon with people having better experiences of care, better oral health and doing so at a lower the cost per-capita; and
- Develop lessons that can be used to disseminate the Virtual Dental Home concept throughout Oregon

The pilot project will comprise around 1,500 children in a school district in Polk County, Oregon, where CDC provides children dental care in a school based setting. Oregon has yet to study the efficacy of the tele-dentistry model. However, the use of a "virtual" dentist to direct care has proven highly effective in other states. Studies in California and Arizona have shown that a remotely located dentist, working with an Expanded Practice Dentist Hygienist (EPDH), who is seeing a patient at a different location, can collaboratively deliver quality dental care. Secure technology delivers health information between EPDH and dentist, allowing the dentist to diagnose and develop a specific treatment plan comparable to a face-to-face evaluation done in a bricks and mortar dental office, but at far lower cost. It is the hypothesis of this project that a tele-dentistry model is a solution that will be appropriate for Oregon's many dental professionals' shortage areas as a component of the ongoing health care transformation. Start-up costs are low, the technology is readily available and the model is infinitely scalable to any demographic or population. Embraced by 50 medical sub-specialties, telemedicine is a keystone of America's next-generation medical model. CDC and its partners intend to bring this innovative model into mainstream dentistry, and to the state of Oregon, whose leadership has a long history of embracing technologies that improve the health of its citizens.

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Oregon Coordinated Care Organizations' Health Information Technology Efforts

Oregon Health Authority, Office of Health Information Technology

June 2015

This overview describes the health information technology (HIT) initiatives underway in Oregon's 16 Medicaid coordinated care organizations (CCOs), based on information collected summer/fall 2014 and revised spring 2015.

Health Information Technology (HIT) and the Coordinated Care Model

Oregon's coordinated care model is designed to improve health, improve care, and lower costs (the "Triple Aim"). HIT plays a critical role in realizing these goals of transforming Oregon's health care delivery system.

The collection, sharing, and use of health information can facilitate improved:

- Care coordination and population management throughout the system
- Integration of physical, behavioral, and oral health
- Accountability, quality improvement, and metrics
- Alternative payment methodologies
- Patient engagement

The coordinated care model relies on access to patient information and the Health IT infrastructure to share and analyze data. Each of Oregon's 16 Medicaid CCOs has committed to a variety of HIT initiatives to assist them in pursuing the Triple Aim.

Overview of CCO HIT Efforts

All 16 CCOs have made an investment in HIT in order to facilitate healthcare transformation in their community. Nearly all CCOs are pursuing and/or implementing both:

- health information exchange/care coordination tools as well as
- population management/data analytics tool.

Even with those similarities, each of the 16 CCOs chose to invest in a different set of HIT tools.

Through their implementation and use of HIT, CCOs reported early successes in achieving goals such as:

- Increased information exchange across providers to support care coordination
- Supporting providers by making new data available to assist with identifying patients most in need of support/services and to help providers target their care appropriately
- Improved CCO population management and quality improvement activities, through better use of available claims data, while pursuing access to and use of clinical data

CCO Approaches to Developing and Implementing HIT Efforts

In general, CCOs sought to understand what HIT and EHR resources were in place in their community and provider environments, identify what HIT capabilities were needed to support the CCO's efforts, and identify strategies to meet those needs including leveraging existing resources or bringing in new HIT tools to fill priority needs Ultimately, the combination of different CCO community, organizational, geographic and provider contexts as well as the variation in EHR and existing HIT resources led to a number of differing approaches to HIT. Some examples of the diverse HIT approaches CCOs have taken include:

- Implementing a coordinated care management system for CCO staff including utilization, disease, and case management which integrates data from disparate sources.
- Providing a community-wide EHR operating as a community health record, which includes data on over 85% of the CCO's members and is available to both physical and behavioral health providers.
- Leading the collaborative development of a regional health information exchange tool, which will collect patient data from various sources and make it accessible to providers at the point of care.

- Pursuing a Community Data Warehouse pilot project to develop and implement a population health management, data aggregation, and analytics tool.
- Investing in a tool that allows for gathering/aggregating/sharing of clinic-level EHR data to identify gaps in care and specific health data points in the population.

Changing Approaches and Next Phases for CCO's HIT Efforts

Many CCOs are in the process of building upon their progress to date and are pursuing additional and/or improved HIT tools to add to (or replace) what they initially implemented:

- Connecting providers to HIT/HIE through integration with their EHR workflows
- Moving from administrative/claims based case management and analytics to incorporating and extracting clinical data from provider's EHRs.
- Incorporating behavioral health information, long-term care and social services in order to increase care coordination across different provider types
- Working with providers and providing technical assistance to establish clinical data reporting
- Supporting providers in new ways with providing data and dashboards back to them
- Investing in new tools for patient engagement and telehealth

CCOs' various investments in telehealth include:

- Teledermatology
- Genetic counseling via telehealth
- Behavioral health telemedicine/telemental health
- Telementoring
- Text 4 Baby
- Tablet-based CAHPS survey
- Virtual Provider Triage (supports delivery of care in the most appropriate setting)
- Gladstone by Kannact (providing high-risk individuals with tablets to facilitate remote patient monitoring)
- Tablet/laptop-based needs and health risk assessments
- Provision of post-hospital discharge tablet/laptop by which member can contact care support

New Relationship to Data

CCOs have developed a new relationship with data and their provider network. CCOs report that they have become more sophisticated with data, and, in some cases, have supported a culture change with their provider networks who are also learning to become more sophisticated with data. Many CCOs are distributing regular reports to their providers which might include a variety of information on the provider's patient panel, such as:

- risk scores
- quality metrics measures
- top utilizing members
- patients in need of screenings
- basic ED and inpatient utilization
- top 10% members at risk for poor outcomes
- diagnoses
- prescription drug use

Barriers to HIT Effectiveness

CCOs discussed various barriers encountered in the CCOs' implementation of their HIT initiatives.

Top Barriers to HIT Effectiveness	CCOs Who Included Description of Barrier (n=16)
Technology, Interoperability and EHRs	88%
Workflows/ Staffing/Training	81%
Clinical Data Collection/ Reporting	75%
Data Analysis, Processing, Reporting	44%
HIPAA, Privacy, Security	31%
Metrics	31%

Most CCOs also have significant concerns regarding the issues surrounding behavioral health information sharing.

Summary of CCO HIT Investments

	Health Information Exchange	Case Management & Care Coordination	Population Management, Metrics Tracking, Data/Analytics	EHR Hosting Via Affiliated IPA
AllCare	Medicity: JHIE	Essette: case management; Vistalogic: Community Connected Network (C2)	Milliman: MedInsight	MRIPA: Greenway PrimeSuite EHR
Cascade Health Alliance	Medicity: JHIE	*Pursuing new CM tool;* EZCap has CM module		
Columbia Pacific			SAS BI	
EOCCO		*Provider Portal (in development)*	SAS Data Store	
FamilyCare	Collective Medical Technologies (CMT): PreManage	McKesson: VITAL	Milliman: MedInsight; Inovalon: Indices	
Health Share	Alignment across EPIC CareEverywhere installations; *Pursuing CMT: PreManage*	PopIntel: Care Coordination Registry	The Big Kahuna/PopIntel	
IHN	*InterSystems: Care Team Link (Regional Health Information Collaborative; RHIC)*	*InterSystems: Care Team Link (Regional Health Information Collaborative; RHIC)*	IBM: Cognos Data Marts, BI, Query Studio	
Jackson Care Connect	Medicity: JHIE	Vistalogic: Community Connected Network (C2)	SAS BI	
PacificSource Central OR CCO	RelayHealth: Central Oregon Health Connect; CMT: PreManage	IMA Technologies: CaseTrakker Dynamo	Truven Health Analytics; Internally developed tools, SAS, Tableau, Microsoft BI	
PacificSource Gorge CCO	Medicity: JHIE; CMT: PreManage	IMA Technologies: CaseTrakker Dynamo	Truven Health Analytics; Internally developed tools, SAS, Tableau, Microsoft BI	
PrimaryHealth	Medicity: JHIE	*Exploring CareManager solution*	Inteligenz: CCO Metrics Manager	
Trillium	*Pursuing CMT: PreManage*	The Advisory Board: Crimson Care Management; Internally developed: Care Timeline	Optum: Impact Intelligence and ImpactPro; SAS, SPSS	
Umpqua	GE Centricity: Umpqua One Chart (Community-wide EHR)	Plexis Case Management	Inteligenz: CCO Metrics Manager; Inteligenz Reporting	DCIPA: Umpqua One Chart EHR
Western Oregon Advanced Health	*BACIA; In development: tool to exchange clinical data with PRM*	Milliman: Patient Relationship Manager (PRM)	Milliman: Patient Relationship Manager (PRM)	
WVCH	*Pursuing CMT: PreManage*		Arcadia: Community Data Warehouse	MVIPA: NextGen EHR
Yamhill County	CMT: PreManage	*The Advisory Board: Crimson Care Management*	Crimson Care Registry; Crimson Population Risk Management (Milliman analytic support); SAS BI	

Cafe Discussion Session 1
Traditional Health Workers

Use of Community Health Workers

Health Navigation & Medical Transportation

Background

In September 2014, Sky Lakes Medical Center and Cascade Health Alliance (CHA) worked to repurpose the existing non-emergency medical transportation system for high-risk populations. Rather than deploying the traditional taxi service, populations with high hospital-based utilization rates, high outpatient no-show rates, and populations disproportionately affected by chronic disease are paired with Community Health Workers (CHWs) to provide medical transportation and health navigation services.

The new department, Outpatient Care Management, focuses on members with:

- Frequent emergency department visits and hospital admissions
- Unmanaged or poorly controlled chronic disease
- Limited social support

Program Infrastructure

Our team is currently staffed with three CHW and a Certified Nursing Assistant. Each CHW is responsible for managing approximately 45 members. The department is recruiting for an RN Care Management supervisor to expand available services.

The team works closely with CHA RN Case Managers, primary care physicians, mental health providers, and other members of the care team to coordinate care.

Focus Areas

- Improving member understanding of the healthcare system
- Providing social support
- Helping effectively and appropriately manage illness
- Connecting member with additional community resources
- Ensuring basic needs are met
- Serving as a member advocate
- Providing education to help members understand lifestyles that promote overall good health
- Setting and achieving personal health goals

Impact

- Actively engaged with over 130 members
- Reached over 400 members
- Improved care coordination between physical and behavioral health
- Preliminary six-month analysis shows a dramatic reduction (83%) in Emergency Department utilization among participants
- Preliminary results improved awareness of CHA benefits among participants

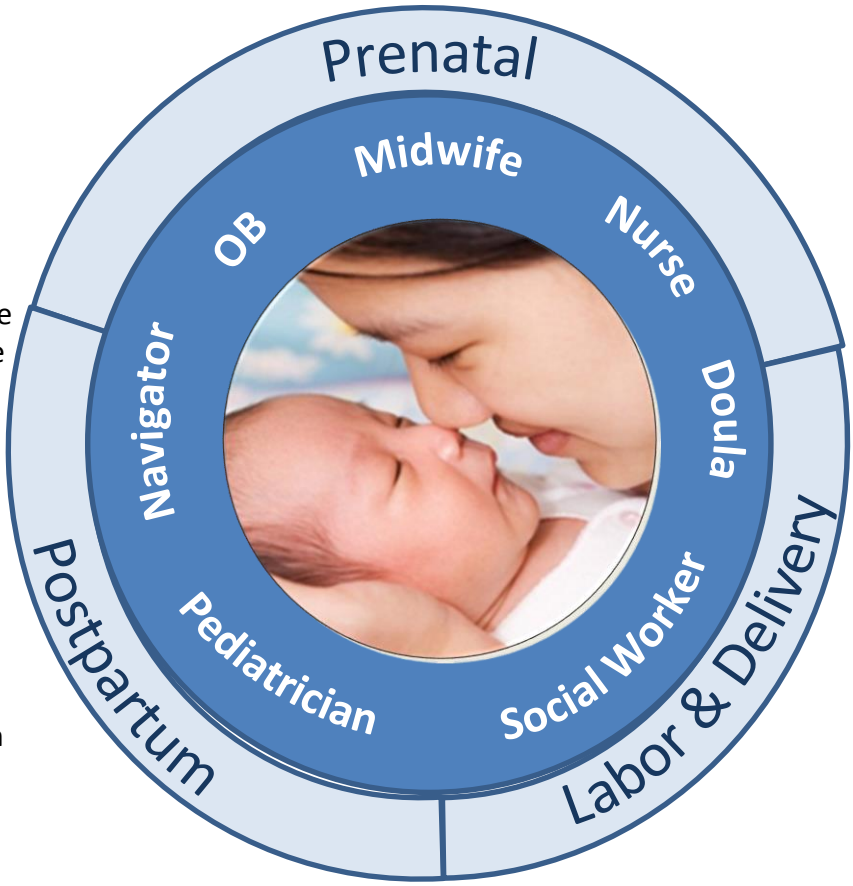
Molly Jespersen, MPH Director of Care Management molly.jespersen@skylakes.org

Integrated Maternal Care Model Including Doulas & Patient Navigators

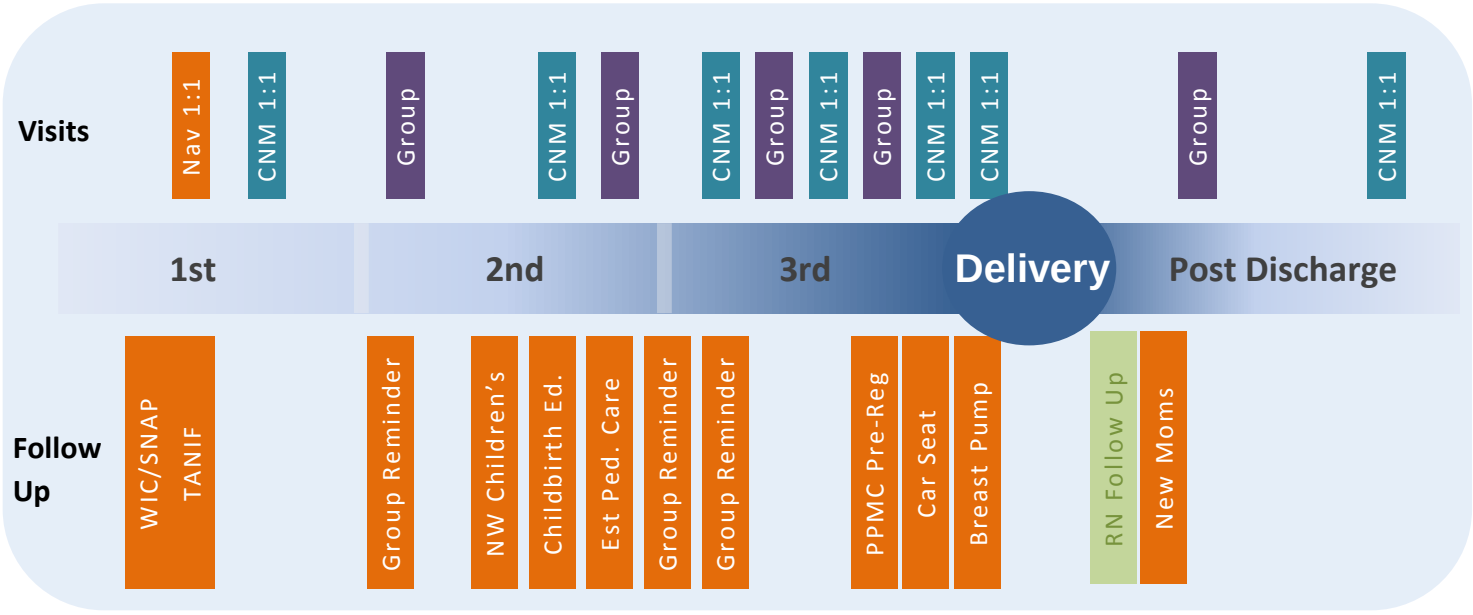
The Providence pregnancy care package is an evidence-based model that spans prenatal, birth, postpartum and post-discharge care. Anchored by Certified Nurse Midwives and utilizing traditional healthcare workers including doulas and patient navigators, the care package has reduced inpatient costs by 15% while improving mother and newborn health outcomes and enhancing patient experience.

Program Structure and Staffing

- Patient centric product development was used to design care package
- Integrated practice unit model of care
- Patients receive connected care across the entire continuum
- Equipment is provided to support physiological birth



- Five doulas and two navigators are staffed at each clinic location
- Doulas are non-exempt, full-time, benefited employees, working 12 hour shifts



Team-based Care

Pregnancy Care Package patients receive care from certified nurse midwives, registered nurses, certified doulas, patient navigators, social workers, and medical assistants.

Better Outcomes and Patient Experience

Metric	Baseline	2014 Results
Reduce overall cost of pregnancy care	---	-15.2%
Total C-section rate	32%	20.5%
Elective deliveries: 39 weeks ≥ ≤ 41 weeks	N/A	0.8%
Epidural use	85%	47.5%
Patient satisfaction Overall prenatal care	90.7%	98.4%
Patient satisfaction Overall inpatient care	75.5%	88.0%

Financially Sustainable

- Allows team to work at top of license
- Reduces costly interventions
- Seeking Medicare reimbursement

Contact Information

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PROVIDENCE Health & Services

Community Health Spotlight

Creating Healthier Communities, Together

Community health meets innovation -- Providence Promotores connect Washington County Latinos with affordable health care

The Promotores de la salud de la iglesia (Promotores – parish health promoters) and Providence Teleheath received a $14,000 Providence Innovation Challenge grant in 2014 to pilot virtual health care visits with a licensed health care provider in our local partnering parishes. To date, there have been twelve Health eXpress Mobile Community Clinics at the parishes from June to December 2014.

The Health eXpress Mobile Community Clinics provide convenient community access to trained patient navigators/promoters that provide health risk screenings. Patients can also share their health concerns and questions with a telehealth nurse practitioner who provides an after visit treatment plan. At each clinic, the Promotores serve as patient navigators and conduct screenings for blood pressure, body mass index, total cholesterol and glucose. Promotores educate their peers on the significance of their health screening numbers, whether their numbers are within normal limits, and offer other culturally specific services including dental care, diabetes prevention and self-management of chronic conditions workshops. For those patients that meet with a telehealth nurse practitioner, they have an opportunity to review their after visit care plan with the provider to make sure they don't have any barriers to following the care plan after they leave.

Health eXpress Mobile Community Clinic outcomes

In the twelve clinics of 2014, 220 Latino community members completed health risk screenings; an average of 18.3 per clinic and 79 had virtual visits with a nurse practitioner, an average of 6.6 per clinic. Of the 220 patients screened, 62 or 28% had at least one health indicator outside of normal range. Additionally, 38 were referred onward, 20 were referred to a primary care provider, 27 were referred to apply for Providence financial assistance and 33 were given prescriptions for medications.

A 100% satisfaction rate was given by those served and 100% of those served were confident they understood the next steps in the care plan. These twelve clinics also provided navigation to and facilitation of the following culturally specific care:

- 58 preventative dental hygiene appointments
- 48 urgent dental care appointments
- 99 completed or are scheduled to complete a 6 week evidence based chronic condition self-management workshop
- 17 are scheduled to complete the yearlong National Diabetes Prevention Program

Keys to success

There were important cultural components incorporated into the Promotores Health eXpress Mobile Community Clinics to make them a success. The cultural components were:

- Trust and privacy
- Relationships
- Language and communication
- Value and affordability

Click on the link below to see a video about the Promotores telehealth clinics:

http://www.providenceoregon.org/video/?view=65f6325805ecbx480x293

In 2015, the plan is to continue with one monthly telehealth clinic in a Washington County parish and train another cohort of Promotores to bring two monthly telehealth clinics in Multnomah County parishes to continue to reach out to our uninsured and under-served Latino community.

FamilyCare Health

Asian Health & Service Center
華人服務中心
아시안 보건 복지 센터
Trung Tâm Y Tế & Dịch Vụ Châu Á

Asian Wellness Connection Program

The Asian Wellness Connection is a partnership between FamilyCare Health and the Asian Health & Service Center (AHSC). This program provides culturally and linguistically appropriate system navigation and delivers integrated and wraparound services to 1,800 of FamilyCare's Asian members.

The Asian Wellness Connection is a value added program. Members who enroll into the program have access to a multilingual and culturally specific approach to helping Asian immigrants adjust to a new culture, access health services, participate in social activities, and connect to their cultural heritage.

An Overview

The Asian Wellness Connection aligns FamilyCare Health with the goals of healthcare transformation by increasing access to care, effectively using traditional health workers, improving health literacy, building trust in the healthcare system, decreasing health disparities, and assisting in the navigation and coordination of healthcare.

The population-based Asian Wellness Connection provides three primary services:

1. Culturally and linguistically appropriate system navigation
    a. Clients are welcomed to FamilyCare, usually in their preferred language
    b. FamilyCare's benefits and services are explained
    c. A comprehensive needs assessment is provided
    d. Care coordination is performed, including establishing links to primary care
    e. Health literacy and an understanding of Oregon's evolving health care landscape are promoted, helping members become active participants in their care

2. Culturally and linguistically appropriate wraparound services, as needed
    a. Members are enrolled in AHSC's Integrated & Holistic Services
    b. Health education and prevention programs are provided with the intention of keeping the population healthy and promoting health literacy

3. Seamless referral to culturally specific mental health services, as needed
    a. Screenings and early interventions are provided for clients with mild behavioral health issues
    b. Members with higher level of needs are enrolled in the mental health program at AHSC or in OHSU's Intercultural Psychiatric Program (IPP)

Asian Wellness Connection Program

A Mutually Beneficial Partnership
Through this program, our joint community members have benefited and Family Care Health and AHSC have gained greater knowledge and appreciation for each other. This alliance has led to the following unexpected achievements:

- AHSC hosted a cultural competency training at FamilyCare to educate staff members about cultural traditions and differences in working with Asian communities
- FamilyCare assisted AHSC staff in developing a better understanding the Oregon Health Plan
- FamilyCare hosted a well-attended multi-lingual Member Event at AHSC to educate members about benefits and healthcare navigation

FamilyCare Health and Asian Health & Service Center: A unique partnership
Since 1984, FamilyCare Health has supported the health of Oregonians through innovative systems that increase access to care, improve quality, and lower healthcare costs for those with Medicaid and Medicare. FamilyCare Health was the first health plan in Oregon to integrate models of mental and physical health coverage, allowing our members' health to be viewed comprehensively.

AHSC has been serving the Asian community in the Portland region since 1983. AHSC's deep roots in the Asian community, its integrated and holistic services model, and its traditional health worker staff make it perfect match for FamilyCare Health. Even before this partnership, AHSC provided behavioral health service to Family-Care Health members.

<u>FamilyCare Health</u>
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<u>Asian Health & Service Center</u>
Operations and Community:
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Cafe Discussion Session 2

Cafe Discussion Session 2
Behavioral Health Integration

Cascadia
PEER WELLNESS

Peer Wellness I & II Training

A Peer Wellness Specialist I Participates In:

•60 hour training program
•Class room instruction
•Student lead process groups
•Mindfulness and movement techniques
•Role play
•Peer Support Specialist equivalent practicum

Additional 60 hour Peer Wellness III training program that reviews:

•Chronic physical health conditions and outcomes
•Working with primary care providers
•Person-centered health home teams
•Taking vitals and their importance

If you are interested in becoming a PWS, or have any questions about the program, contact: Meghan Caughey at (503) 963.7772 or Braunwynn Franklin 503-963-7773.

OPHI Staff

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Renee Boak, MPH, CADC I

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Contact us for more information on integrated healthcare today!

OREGON PARTNERSHIP FOR HEALTH INTEGRATION

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Phone: (503) 261-6388
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ophi
Oregon Partnership for Health Integration

Get Wellness Soon!

Helping you reach your goals and stay healthy!

A partnership of:

Cascadia BEHAVIORAL HEALTHCARE

Outside In
The point of return.℠

Oregon Partnership for Health Integration, we believe that overall wellness means healthy minds and healthy bodies, that is why we offer an array of integrated health care and health and wellness services.

What is involved?

Our partnership includes mental health, primary care, and wellness services at easily accessible locations so that you have one health team who knows you and supports you in your overall health and wellness.

Behavioral Healthcare

- Maintain your behavioral healthcare with primary counselor and group therapy
- Maintain your behavioral healthcare with psychiatric prescriber

Nurse Care Management

- Triage and assessment
- Coordination of care with providers
- Medication management
- Health education
- Appointment scheduling

Physical Health Care

- Onsite/in house primary care services
- Lab services
- Specialty care referrals
- Dental/vision referrals

Wellness

- Learn how your health condition impacts your body, your mind, and your daily life
- Physical activities, recreation, and nutrition classes
- Become tobacco free
- **Peer Wellness Coaching**

Peer Wellness Coaching

We are working to improve the quality of your care and your overall health. Your Peer Wellness Coach will be meeting with you to:

- Set, track, and achieve your health goals
- Assure you have the tools you need to stay or get healthy
- Learn ways to make your physical and behavioral healthcare work better
- Find ways to manage and/or prevent physical and behavioral health conditions
- Support accessing community resources for you and your family
- Support obtaining benefits (Oregon Health Plan)

Saint Alphonsus Medical Center - Ontario

Behavioral Health Navigation/ Health Resource Center

EOCCO Grant:
Project start date: July 01, 2014
Project end date: June 30, 2015

Goals:

- Identify patient with mild to moderate mental health in the ED
- Enhance patient follow up
- Increase access for behavioral services
- Increase screening and referrals for depression and substance abuse
- First aide mental health training for staff
- Full Time Social Worker employed through SAMCO
- Part Time Qualified Mental Health Professional (QMHP) partnering between SAMCO and Lifeway's

Year Awarded: 2013
Multi-year Grant

Project Title: Health Resource Center
Staffing: RN Manager, NP, 2 RN's, 1 MSW, 2 RN Health Coaches, Support Secretary, Consultation Services, and a Financial Assistant

Goals:

- Free 30 day Voluntary Program
- Manage chronic medical conditions – COPD, CHF, Diabetes, Pneumonia
- Medication Reconciliation
- Arrange Appropriate Outside Resources- Smoking Cessation, Diabetes/Weight Management, Preventative Care
- Assist with Insurance Applications
- Patient One on One Education
- Assist with Durable Medical Equipment Needs

Program Includes:
Home Visits, Clinic Visits, In-House Patient Visits, Weekly Phone calls with consultations as necessary.

Ultimately the patient will be able to manage their own healthcare needs at the end of the 30 days.

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Primary Care Psychiatric Consultation *(PCPC)* Intercommunity Health Network CCO
Jim Phelps, M.D.; Sandy Kuhns, CMA Samaritan Mental Health 541.768.5235 jphelps@samhealth.org

1. **Problem: Access to Psychiatry**. Having in-clinic behavioral health specialists is *great* (!). But what about medications? They're frequently used, frequently expected/requested by patients. Yet PCP's have little training in their use. When psychotherapy and other non-medication approaches are declined or not effective, medications will be considered. Consultation with a psychiatrist can help make sure medications are used effectively – and not used when other approaches are more appropriate. But stigma and deeply rutted "old ways" inhibit change.

2. **Solutions**: multiple approaches tried around Oregon (see Table on reverse side)

3. **PCPC pilot** :

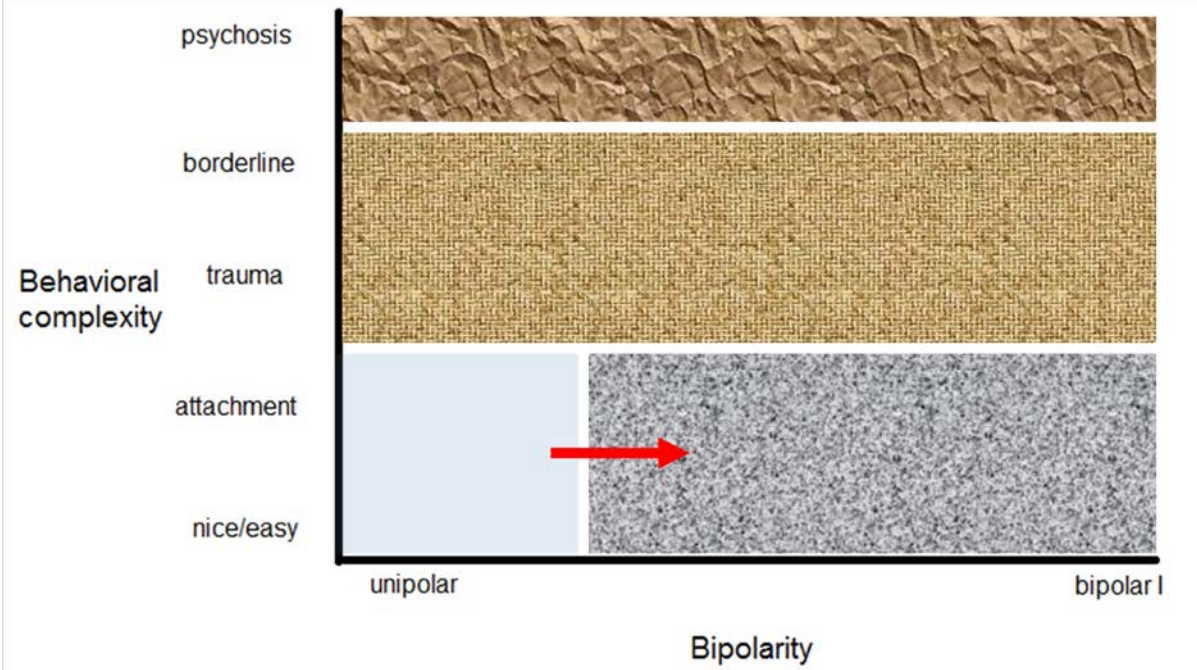
• 7 primary care clinics in East Linn County • Chart-based consultations - requests by PCP or behaviorist - access to meds, labs, notes - respond by chart: **Impression/Recommendations** - 24-48 hour turnaround	• 240 consults in 9 months • Broad range of acceptance/implementation - some PCP's use a lot, some very little - some implement rec's, some don't - if can refer to county MH, most do • "Hotspotting" by care coordinators: stopped - even less implemented; less data to go on • **Overall satisfaction scores high; utilization low**

4. **Lessons learned:**

A. Those referred are complex:
- prior psychotropics (AD's, AP's, benzo's, sedatives) :
avg was **8** (2-24)
- **trauma** frequency very high
- **bipolarity**: 40-60%

B. Being in-clinic increases utilization (face time with PCPs)

C. Face-to-face pt. evals' are better than chart-only:
better data
better med' ed'
but…
all the hard work
no easy, no f/u
inefficient v. clinic



D. Time to go beyond SAMHSA 4- quadrant model
- anything complex behavioral, to county? **no!**
- PCP's are handling *everything*
- with ↑support, more pts. can get rx *in-home*
- compare the 4 "quadrants" above!

E. Need 3 new tools in primary care:
- trauma-informed therapy
- screen/recognize bipolarity
- add lamotrigine, low-dose Li+ to toolkit

5. **Plans**: expand to other clinics. Explore use of LCSW as data-gatherer and in-clinic representative (akin to Collaborative Care model but integrated with psychologist who's focused on health behavior change and diagnostic help with complex cases.) Explore "telepresence". Determine adequate funding/incentives (PMPM): what psychiatrist in her/his right mind will want to do this? Many doing a little rather than few a lot?

Psychiatric Integration Options

Element	*Features*	*Pro's*	*Con's*	*Implementation Challenges*
Curbside consultation (phone, email) • State-wide: OHSU • Local psychiatrists	Longstanding approach Many PCP's use local colleague	Known, familiar.	Need>supply if really used? Consult time not funded: - for psychiatrist; for PCP Liability concerns inhibit?	Identify willing and able psychiatrist(s). Consider funding consultation time for PCP.
ECHO: case review educational support • OHSU • Local/regional?	Case reviews Online resources Learning collaborative	Easy access, expert recommendation on tough cases.	High "energy of activation" req'd. Help re: worst cases, but enough? Preaching to choir effect: those who may most need, don't attend	Available now. Statewide participation might overwhelm and require local spin-off's. Utilization: incentives are needed (Arizona pays PCP's to attend).
In-depth phone consultation • OPAL-K • OPAL-A (develop?)	Available 8-5 M-F Within 30 minutes F/u note Some referral assistance	Easy access, expert recommendation on tough cases.	Can't access chart. Won't know local resources as well. Limited PDX-centric utilization so far. Not ongoing, iterative assistance or integrative pop'n management.	Development and support costs. OPAL-A: Consider a pool/website of vetted psychiatrists who list availability (scheduled and real-time). PCP's could pick favorite or most local available.
Regional, chart-based, consultation • Formal note • Phone or video f/u with providers prn; teaching meetings optional	Remote psychiatrist Requests submitted by chart Consults entered in chart	Fits PCP and psychiatrist work flow More likely to be utilized than above Facilitates long, iterative process. Can be paired with in-house BHP	Relies on relationship with PCPs (else underutilized, rec's unused) Can go underutilized; PCP's prefer "take the patient" No existing payment mechanism	Will go underutilized without systematic in-depth introduction Keep it simple, else underutilized Should integrate with county M.H.: who takes what cases?
Collaborative Care variations • Integrated but remote psychiatrist • Consults primarily with clinic BHP	BHP insures f/u, +/- BAT,PST,MI. Case *registry* of all patients seen, f/u PHQ-9, GAD-7, function. "Treat to target".	Like chart-based system above except more systematic involvement via BHC. Less reliant on PCP consult requests or responses.	Evidence base is primarily *depression* care; trickier for complex trauma, bipolar cases.	Requires BHP to work very directly with (almost "for"?) psychiatrist. Requires BHP for every clinic. But *very* efficient use of psychiatry time.
Consultation plus limited direct patient face-to-face evaluations • Televideo • Onsite	Continuum of virtual and f2f consultation and patient evaluations.	Provides greater access for difficult cases or diagnositc conundrums. Promotes relationships, allows for curbside consults in addition also.	Psychiatrists miss continuity; and do all the complex work, less of the easy work - - so, incentive? Else who will do these?	PCP's who use are already comfortable with mood/anxiety/etc; need to reach those who aren't. How to limit ongoing patient care (else drown)? Avoid co-location tendency: "clinic w/i a clinic".
Psychiatrist Integrated as a PCPCH Team Member • In-clinic • Mix of provider-to-provider consultation and direct pt. care	Work closely with embedded behaviorists/care managers to review active patients, identify care gaps and treatment plan recommendations, available to PCPs in real-time for guidance on less complex cases.	Allows for continuity of care over time. Opportunities for QI including development of registry. Allows for collaborative work with partner agencies. One psychiatrist can work with more than one primary care clinic.	No payment structure in Oregon (WA did it). Fee-for-service won't support full range of integrative work. Not enough psychiatrists to provide one for every clinic.	PCP's already stretched so can resist "yet another change". Train the next generation of psychiatrists to practice thus!

BHC: Behavioral Health Professional BAT/PST/MI: Behavioral Activation Therapy/Problem-Solving Therapy; Motivational Interviewing ECHO: Extension for Community Healthcare Outcomes f2f : face to face f/u : follow-up OPAL-K: Oregon Psychiatric Assistance Line for Kids (-A: Adults?)

PeaceHealth

YOUNG ADULT PROGRAMS – AN INTEGRATED APPROACH TO CARE

Project Description:
Within the same clinic and treatment plan, a young adult can receive a full array of support from drop-in help with homework from a peer to primary care to multi-family group therapy. The team makes regular community, home and school visits to further remove barriers to care. A variety of technology-assisted supports are used from text message check-ins to cognitive behavioral therapy-based smart phone prompts.

Program Philosophy:
Recovery is achievable by all participants, and each individual is empowered to develop goals that reflect their own concept of recovery

Program Goals:
- Improve the chance of recovery from serious mental illness through intensive early intervention and preventive care
- Reduce the barriers and stigma of seeking care for young adults

Innovative Interventions:
- Trans-disciplinary team-based approach
- Peers, participants and graduates integral to program planning and development
- On-stop shop for behavioral and physical health issues
- Family and natural social supports fully included
- Use of youth-friendly technology-based supports
- Integration of care plan across disciplines, including physical and behavioral health
- Engagement strategies including home and community visits

Outcomes:
- Low rates of re-hospitalization and emergency room visits
- Quality of life improvement maintained over time (RAISE project research outcome)
- Higher rate of employment and enrollment in school (RAISE research)
- More likely to stay on medication with lower BMI increase (RAISE research)

Lessons Learned:
- Not well-supported by traditional fee-for-service billing structure
- Commercial insurance does not cover many providers and interventions
- In hiring staff, philosophy and approach are as or more important than direct experience

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Cafe Discussion Session 2
Complex Care

Columbia Pacific CCO™

Behavioral Health & Movement Based Pain Clinic Model

Claire Ranit, Transformation Specialist
ranitc@careoregon.org

Overview

The North Coast Pain Clinic is a non-prescribing, behavioral health and movement based pain clinic for patients with persistent, non-cancer and non-terminal illness pain. Treatment is group based with individual interventions occurring on an as needed basis. Cohorts go through a 10 week program with one day of treatment per week for three hours per session. Each session consists of movement therapy, biopsychosocial overview of pain, and cognitive behavioral therapy in the form of acceptance commitment therapy. After patients complete the third week of treatment, they are given the opportunity to receive a detailed medication review and recommendation. Initial outcomes show positive movement in measureable clinical outcomes including a reduction in morphine equivalent dose per day of graduating CPCCO members as well as overall positive movement in pre and post treatment survey tools.

Surveys

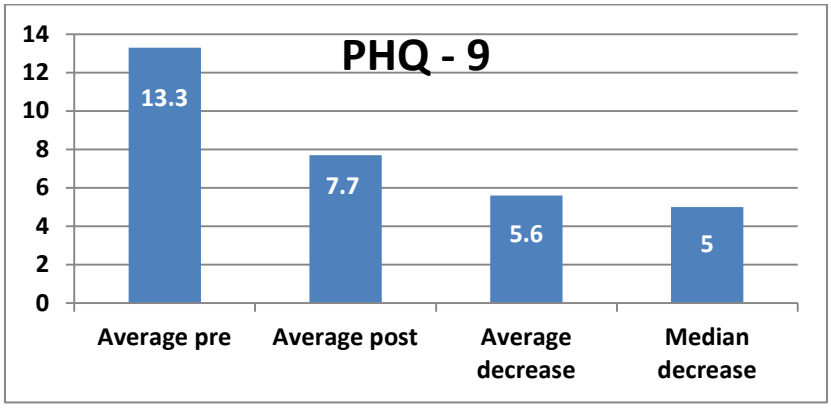
Patient Health Questionnaire – 9 (PHQ-9)

Screening tool with nine questions directly based on the nine diagnostic criteria for major depressive disorder. There is a total of 27 possible points in the scoring system and individuals are categorized on a spectrum as minimally, mildly, moderately, moderately severe, or severely depressed.

Of the 43 individuals that have graduated from the program to date:

- The average decrease in PHQ-9 scores was 5.6 points.
- The median decrease in PHQ-9 scores was 5 points.

Both the average and median decrease in scores for PHQ-9 is the equivalent of an individual going from moderately severe depression to moderate depression or moderate depression to mild depression.



Fear of Movement – (FOM)

The screening tool utilized to assess fear of movement or (re)injury is the Tampa Scale of Kinesiophobia (TSK) which is a 17-item self-report checklist that uses a 4-point Likert scale. The scale is based on the model of fear avoidance and helps to measure the degree of unhelpful thoughts and beliefs about pain. Scores can range between 17 and 68 and the higher the value the higher the degree of kinesiophobia.

Of the 43 individuals that have graduated from the program to date, one individual did not complete pre and post assessments. The results are as follows for the 42 individuals that have completed both pre and post assessments and graduated from the treatment program:

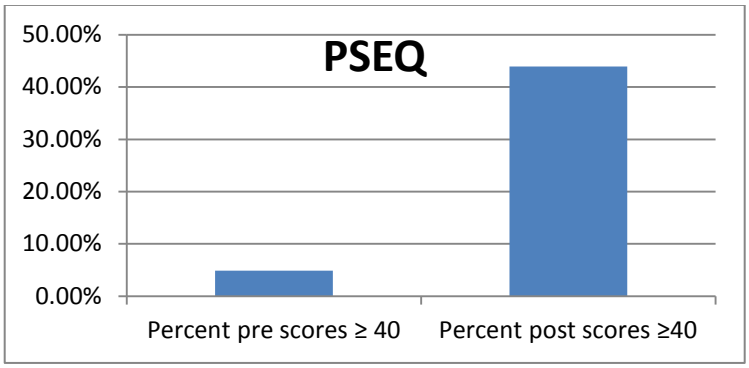
- The average decrease in FOM was 3.6 points.
- The median decrease in FOM was 5 points.
- The mode decrease in FOM was 6 points.

Pain Self-Efficacy Questionnaire (PSEQ)

The Pain Self-Efficacy Questionnaire (PSEQ) is a 10 item screening tool that assess the confidence individual's experiencing persistent pain have in performing activities while in pain. Questionnaire results can range from 0 – 60 with a score of 40 or greater being associated with the ability to maintain functional gains while a score of 30 or lower is associated with a decreased likelihood to sustain gains.

Of the 43 individuals that have graduated from the program to date, two individuals did not complete pre and post assessments. The results are as follows for the 41 individuals that have completed both pre and post assessments and graduated from the treatment program:

- The average pre score was 23.3 points.
- The average post score was 35.2 points.
- The percent of pre scores greater to or equal to 40 was 4.9%.
- The percent of post scores greater than or equal to 40 was 43.9%.



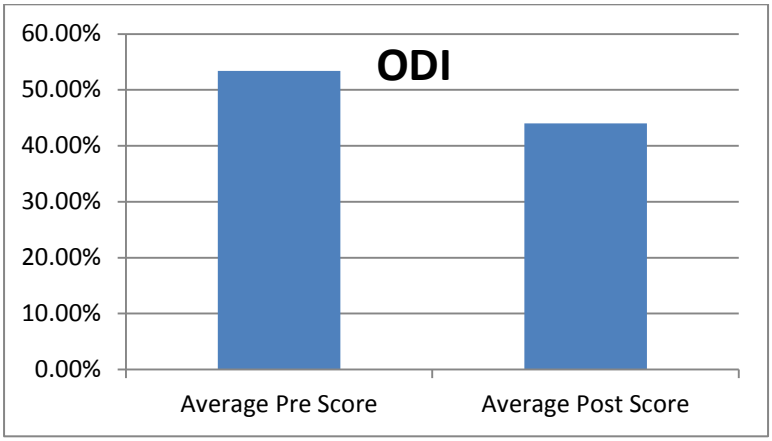
Oswestry Disability Questionnaire/Index (ODI)

The ODI is utilized to measure degree of disability and scores are calculated as a percent. Of the 43 individuals that have graduated from the program to date, four individuals did not complete pre and post assessments.

The results are as follows for the 39 individuals that completed both pre and post assessments and graduated from the treatment program:

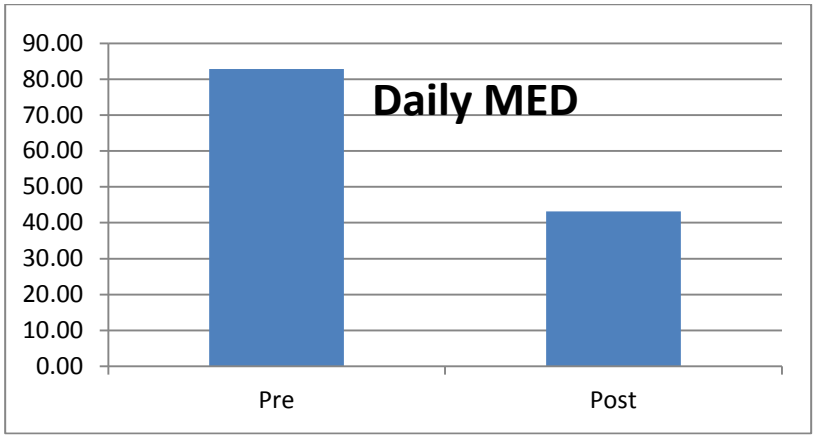
- The average pre score was 53.4%.
- The average post score was 44%.

The above pre and post results consistently fall within the classification of severe disability though there are individuals that have graduated from the program that are categorized in other areas of the disability scale.

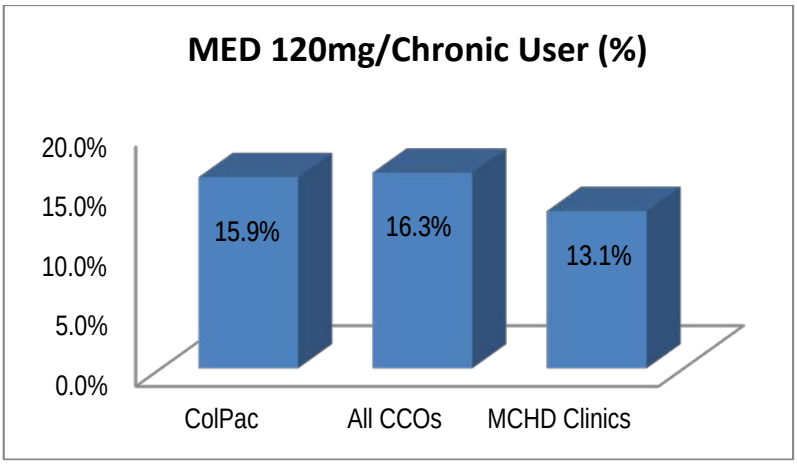


<u>Daily Morphine Equivalence Dose (MED) Outcomes Data</u>

The chart to the right shows aggregate patient outcomes are for individuals that have graduated from the program and have CPCCO medical insurance. While the "n" of this population is relatively small, at a count of 6, it is important to note that all individuals that fall in the denominator population experienced a decrease in daily MED.



The chart to the right shows the percent of chronic opiate users, defined as those individuals that received one or more prescriptions equaling daily MED 120mg or greater during the measurement period, compared to all other CCOs and Multnomah County Health Department Clinics.



Maternal Medical Home Pilot
Women's Health Center of Southern Oregon and PrimaryHealth of Josephine County

Domain	Example of Clinic and CCO Interventions
Leadership	• WHCOSO assembled an internal clinic leadership team for the Maternal Medical Home and other strategic initiatives • WHCOSO and PrimaryHealth participated in training regarding medical home infrastructure • WHCOSO leadership set goals, such as PCPCH certification and SCOPE certification • WHCOSO leadership determined staffing necessary to meet goals, and continually adjusts • WHCOSO leadership shared vision for MMH with staff at all levels • PrimaryHealth and WHCOSO met to identify mutual goals and targets. Some examples are timeliness of prenatal care, coordination with A&D providers, depression screening, and SBIRT (or 5P's) screening. • PrimaryHealth and WHCOSO created a project plan to guide the pilot including clear goals, measure, reporting schedule, and payment structure • Work was conducted together to establish a funding model/source for the pilot • Payment to the clinic was structured as a PMPM allotment, utilizing a risk stratification model to allow higher payments for high risk patients. (Payment was not tied to meeting targets on outcome measures) • The CCO and WHCOSO have both invested in educational resources for CCO and clinic staff that help improve the quality of services and guide the work
Data	• WHCOSO developed a system to capture data, using EMR and other sources • WHCOSO created monitoring systems that reflected on the goals, such as population screening for depression. • WHCOSO created a "master matrix" of incentive measures from all measures they are accountable to (Meaningful Use, PQRS, CCO, etc) • Data is collected reported quarterly to PrimaryHealth, where data is reviewed and trended for analysis by CCO governance • PrimaryHealth spot checks to ensure encounters are all captured • PrimaryHealth and WCHOSO have refined reports originally used primarily for payment reconciliation to share additional outcomes (such as positive drug use, referrals, GA at delivery, etc). This information helps guide coordinated C with outreach services such as Maternity Case Management • The clinic originally cross trained, then dedicated a staff role to QI and data collection/analysis • WHCOSO monitors measures regularly, and provides provider "report cards." As success is achieved and sustained, measures are removed from the matrix.
Empanelment	• All OB patients are assigned to specific providers/care teams • Coverage patterns are established and include a system of introduction to other providers • Empanelment is monitored through reporting
Team-Based Care	• WHCOSO organized set "care teams," including systematic MD cross coverage • WHCOSO organized or refined clear workflows for each team member • WHCOSO shifted work, especially screenings, away from the MD • WHCOSO reorganized the phone system to allow patients direct phone access to their care team. Patient's get a business card with their team's phone number. In addition, patients can talk to their team or the MD over a web based portal • Clear linkages were established with ancillary team members (like the behavioral health coach and mental health provider) • As population screenings increased, workflows responding to these screenings were refined • Additional team members were added or systematically "borrowed" from other organization including a behavioral health coach, mental health therapist, alcohol and drug counselor, and pregnancy coordinator. These team members are all co located

Maternal Medical Home Pilot
Women's Health Center of Southern Oregon and PrimaryHealth of Josephine County

Patient Partnership

- Patient surveys are conducted regularly at WHCOSO
- Patient stories are collected and shared at staff meetings that exemplify the impact of the work on the patient population
- WHCOSO has a process for rapid process improvement of issues
- WHCOSO has streamlined care for patients, delivering as much care "in house" as possible. Many services that used to be administered at the ER or OB unit are now available at the clinic.
- WHCOSO modified the clinic environment to create a serene, yet family centered environment for patients and staff
- WHCOSO is adding a grief support group, and offers other educational services such as childbirth classes at the clinic site

Population Health

- WHCOSO and PrimaryHealth developed a system of risk stratification together that differentiates high risk from low risk pregnancies
- WHCOSO maintains a registry of medically high risk pregnancies seen by the practice. This registry is reviewed monthly at OB provider meetings, so that all providers are familiar with high risk patients being seen at the clinic
- WHCOSO set targets and has created workflows for systematic screening practices, including assessment of alcohol and drug use, tobacco, domestic violence and pre/postpartum depression

Continuity of Care

- The clinic focuses attention towards providing care with the established care team, yet systematically introduces other providers that may be present at delivery
- Continuity of care is monitored through reporting

Access

- Some Saturday hours have been added at WHCOSO.
- WHCOSO has focused on timely prenatal care are a priority focus. Initial prenatal care appts are prioritized, and all staff are aware of this

Coordination of Care

- WHCOSO has refined systems of coordinating care with mental health, CCO and community maternity case managers, A&D treatment providers (including the methadone clinic), and other members of the care team.
- WHCOSO has focused increased attention on stabilizing social determinants of health (such as housing) in coordination with community partners
- WHCOSO systematically coordinates care with other medical providers involved in the patients care, such as pediatricians, PCPs, and specialists. For example, WHCOSO helps proactively assist women with selection of a pediatrician by presenting information at the 36 week visit to help a family choose. Once a pediatrician is selected, WHCOSO coordinates with that provider proactively.

Outcomes

- WHCOSO is currently meeting all targets identified in the project plan. For example, 100% of PrimaryHealth patients received the 5P's screening in 2014

Questions?

- Jennifer Johnstun, RN * PrimaryHealth of Josephine County* jen@ohms1.com
- Lisa Redfern, CEO * Women's Health Center of Southern Oregon* lisar@womenshealthso.com

PrimaryHealth of Josephine County
Your Community Health Plan

WOMEN'S HEALTH CENTER

Trauma-Informed Community Health Care - A local effort of the Trauma Healing Project
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Our Vision and Work

The vision of the Trauma Healing Project is a vibrant and connected community where anyone impacted by violence, abuse or trauma receives the support and attention they need to fully recover and to reach their highest potential. In order to increase capacity among those in the best position to help, we promote trauma-informed care by providing:

- Community education and professional training
- Technical assistance for organizations and professionals
- Holistic trauma-informed complementary and alternative medicine

Trauma-Informed Community Health Care (TI-CHC) - Project Summary

With funds from Trillium Community Health Plans (2013) and PacificSource Foundation for Health Improvement (2014), the goal of TI-CHC was to implement trauma-informed care protocols and practices at the clinics of Community Health Centers of Lane County. Initial work was completed with the Charnelton Community Clinic and has expanded to include two additional clinics. In addition to work with individual clinics, TI-CHC is focused on achieving the following objectives in Eugene and Springfield:

1) Health and social service organizations and providers serving high numbers of people with histories of trauma become trauma-informed
2) Trauma-informed consumer/patients are able to make informed decisions about and more effective use of appropriate resources and supports
3) Accurate information about local trauma-informed and trauma-specific services and resources in Eugene and Springfield is readily available
4) Adequate trauma-informed complementary and alternative medicine (CAM) resources are available and accessible to vulnerable community members living in Eugene-Springfield

Survivor Voices Participatory Action Research

Since 2008 the THP has been listening to and elevating the voices and wisdom of survivors. As part of that effort Northwest Health Foundation funded a community-based participatory action research project to develop, in partnership with survivors, a survey and focus group process that brought together hundreds of survivors and community partners. Among many important findings were the following:

- When survivors said they had been listened to with compassion they were 2.9 times more likely to report being mostly or completely healed.
- When survivors believed that people understood the impact of trauma on their lives they were 2.2 times more likely to report being mostly or completely healed.
- When survivors believed that people knew how to help them heal they were 2.3 times more likely to report being mostly or completely healed.

These findings are in direct alignment with every definition of trauma-informed care and continue to guide every aspect of the work of the Trauma Healing Project.

Cafe Discussion Session 2
Health Information Technology and Telehealth

MosaicMedical
Quality Care For All

MosaicMedical.org

Oregon Health System Innovation Café June 2015

Remote Patient Monitoring in Chronic Care Management

Small Group Discussion Objectives

This small group discussion will aim to provide participants with an opportunity to network with others who are interested in or currently involved with remote patient monitoring, in addition to fostering discussion on the topic. Some key focuses for discussion include the current state of the remote patient monitoring marketplace, programs in Oregon, equipment, implementation, program evaluation, and program sustainability.

Mosaic Project Overview

Mosaic launched their Remote Patient Monitoring program in September of 2013 with funding from HRSA. Partnered with a Community Health Center in North Carolina, Mosaic introduced remote patient monitoring to their rural communities in central Oregon.

The program has had over 275 participants. Average duration on the program is 84 days. Sixty percent of patients have two or more diagnoses. Most prevalent diagnosis is hypertension.

Successes

- 76% of patients have successfully graduated from the program
- 5.2 point reduction in Systolic. 3.4 point reduction in Diastolic. 2.8 point beat reduction in heart rate
- .66 point reduction in A1C
- 7.3 point increase in PAM score
- Reduction in ED visits when comparing 6 months prior to enrollment with 6 months post enrollment

Key Lessons Learned

- Technology choices impact customer satisfaction and flow efficiency
- Staffing structure is dependent upon program scalability
- Strong data & analytics support are crucial for outcome measurement and trend analysis
- Supporting referring providers through lean workflows is paramount

Next Steps

- Continue to enroll patients within our Mosaic system
- Partner with our local hospital to offer devices to recently discharged patients
- Partner with other local primary care providers to support their hospital discharges
- Continue to analyze our staffing structure to maintain optimum ratios
- Implement a comprehensive patient feedback survey for RPM patients

Contact Information

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Risk Stratification

Purpose

As part of the initiative for adopting a risk-stratified care management model, Physicians' Medical Center (PMC) has established a risk assessment model to stratify the patient population and identify the high risk patient segment. Subsequently, PMC can develop and implement strategies which emphasize the use of proactive approaches to improve the desired health outcomes while controlling the cost of care. The purpose of this report is to explain the risk assessment model and present the preliminary results of the second version of the patient risk assessment.

Overview of Patient Risk Assessment Model and Approach

PMC uses a quantitative-based risk assessment model. Each active primary care patient, who is assigned to a PMC primary care provider, is included in the risk assessment. Each patient is assigned an overall patient risk number on a scale from 1 to 5 (with 5 representing the highest risk).

Risk Categorization, Identification, and Quantification

The framework for the patient risk assessment model is based on alignment with two strategic focus areas: 1) improving desired health outcomes while 2) controlling the cost of care. The strategic focus areas are further divided into risk categories. Within- each risk category, risk criteria are defined with a corresponding risk threshold. Each patient is evaluated against the defined risk criteria. If the patient meets or exceeds the risk threshold for a given risk criteria, he/she is assigned the corresponding risk score.

Project ECHO

Overview

University of New Mexico developed a national tele-mentoring model called Project ECHO® (Extension for Community Healthcare Outcomes). Using both didactic and case based learning in video conferencing sessions, specialists help primary care providers learn how to better manage some of the more complex conditions and patients they see in their practices. Easily accessible interactive live video sessions upskill PCP knowledge and skills to reduce barriers to care and promote evidence based standards of care for better population outcomes.

Through support from Oregon Health Authority Transformation Funds, Health Share of Oregon partnered with OHSU to bring Project ECHO to Oregon. OHSU provides the technology platform, infrastructure, and program coordination, as well as the specialist team. Health Share surveyed primary care providers to identify which specialty areas they found most problematic; psychiatric medication management rose to the top. Providers participate in a weekly one-hour ECHO clinic via video conferencing from the comfort of their own clinic. Providers have the opportunity to present cases for review and discussion and receive one hour of free CME each week they participate.

Psychiatric Medication Management

The Psychiatric Medication Management ECHO Clinic helps primary care providers work more effectively with individuals seeking treatment for mood disorders, anxiety disorders, psychotic disorders, ADHD, and other mental health challenges. Each week at ECHO clinic, a fifteen-minute didactic is presented followed by one or two case presentations from the ECHO participants. The specialist team and participating providers have the opportunity to ask questions and suggest treatments to pursue. After the clinic, the specialist team provides a written summary of recommendations to the presenting providers.

"Reviewing meds with a psychiatrist and pharmacist as presenters is wonderful. The little nuggets you offer are helpful and resonate as I am working with patients and their medications."

"I have a better understanding of how to monitor the mood stabilizers which always made me nervous."

"I will remember to try and empower patients with personality disorders to make their own decisions rather than choose treatment options for them."

"This conference provided a reminder for us to be mindful that each one of us has a unique context from which we experience health and the absence thereof."

"I will try to remember that my presumptions about a patient are simply that."

"Great, challenging cases that reflect patients I see and struggle with as well."

"I'm going to be looking more closely at my patients that are on more than one antipsychotic to see if it is possible to evaluate if both are necessary."

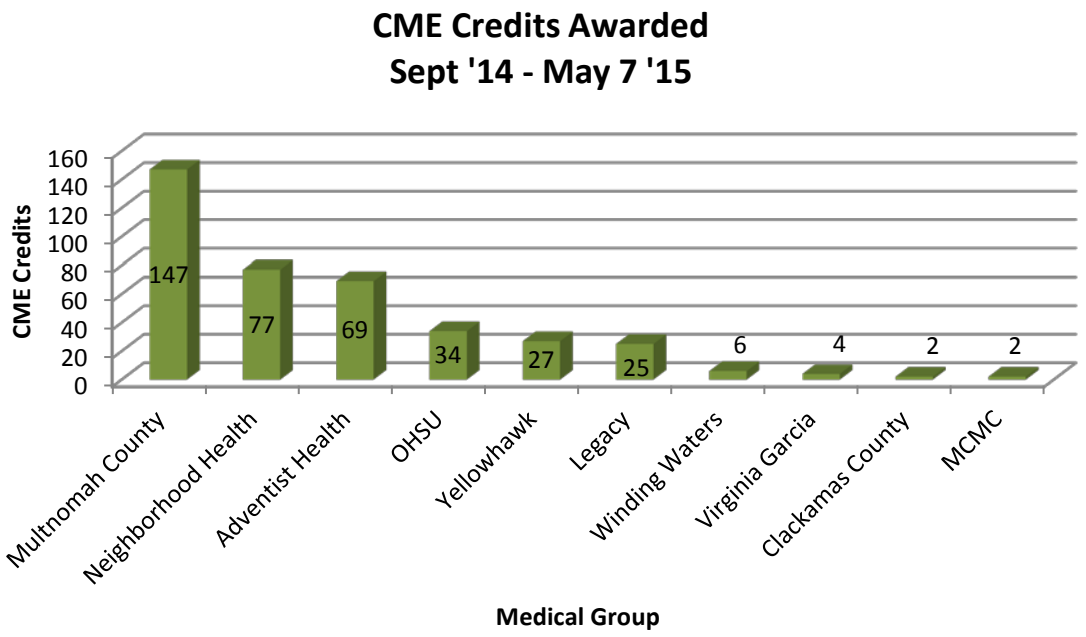
Project ECHO

The lecture topics covered during the psychiatric medication management clinic include:

* Treating Depression with Antidepressants
* Treating Depression without Medication
* Bipolar Disorder & Choices for Mood Stabilization
* Sensible Strategies for Antipsychotic Medications
* Treatment of Dementia: First Steps
* The Spirit of Motivational Interviewing
* Assessing Depression
* Personality Disorders
* Benzodiazepines
* Panic Attacks
* The Recovery Model
* Obsessive-Compulsive Disorder
* Specific Phobias
* Assessing Suicide Risk
* Panic Attacks
* Trauma's Effect

Desired Outcomes

OHSU and Health Share of Oregon distributed ECHO participants a survey to help gauge provider comfort levels with diagnosing and treating psychiatric conditions, including the prescribing of psychotropic medications. This provider self-efficacy score will be reassessed at the conclusion of the first 46 weeks of ECHO clinics to see what impact ECHO had on improving these scores. We will also be looking longer term at the impact ECHO clinic has had on referrals to specialists from the medical home, as well as ED visits, hospitalizations and pharmaceutical spend.



Project Contacts

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- Christine Bernsten, Sr. Mgr Delivery System Transformation, Health Share christine@healthshareoregon.org, 503-416-4968

For more information, please visit: www.ohsu.edu/ohsuecho and www.echo.unm.edu/

NW OpenNotes Consortium

Oregon Health System Innovation Cafe
June 8, 2015

Homer Chin, MD

NW OpenNotes Consortium Physician Champion
We Can Do Better / KP Northwest / OCHIN / OHSU

What is OpenNotes?

- Patients invited to review their providers' visit notes through secure patient portals
- Each patient notified automatically via e-mail message when a note has been signed…and reminded to review it before their next scheduled visit
- "OpenNotes" is an initiative to give patient's access to their EHR notes via the internet. Not a specific vendor product or software.
- Started with a research and demonstration project in 2010, involving more than 100 PCPs and 20,000 patients in Boston (BIDMC), rural Pennsylvania (Geisinger), and the Seattle inner city (Harborview)

Supported primarily by the Robert Wood Johnson Foundation

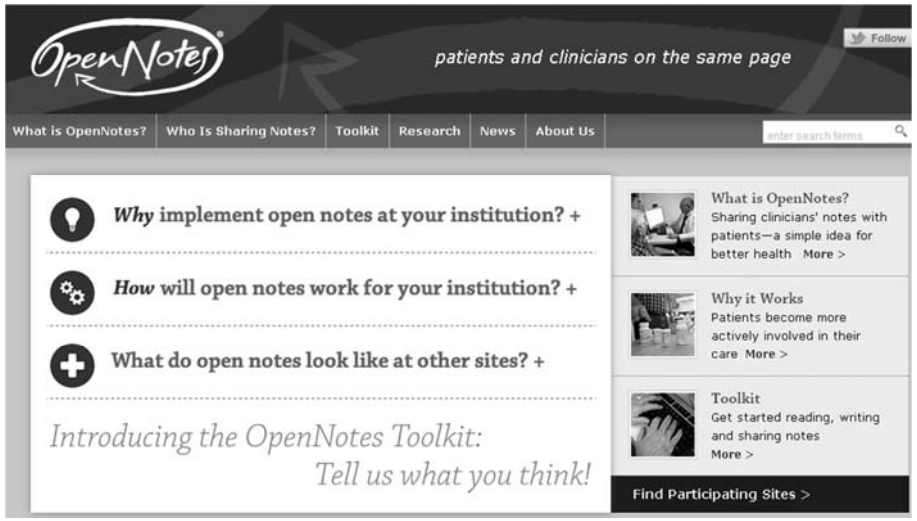
3 Overall Study Findings

- Patients are more engaged in their care:
  - 80% opened at least one note.
  - 70 – 80% reported taking better care, better understanding, better prepared for visits, felt more in control, better at taking meds.
  - 1- 8 % caused confusion, worry, or offense
- Providers not adversely affected
- After one year, 99% of patients wanted to continue, no provider asked to have OpenNotes turned off.

Initial NW Consortium Clinical Participants

Health System	Pilot	Full Scale	Comments
Adventist Health			
Kaiser Permanente		Apr 2014	500 K Members
Legacy		Aug 2015	Primary Care and Medical Specialties; 2600 providers
OCHIN	May 2014		19 states
OHSU		May 2014	Primary Care
PeaceHealth		Oct 2014	3 regions; ~800 MDs
The Portland Clinic		Jul 2014	105 MDs
Providence	Jun 2015		Oregon region
Salem Health	?		
Samaritan Health	?		
St. Alphonsus	Jun 2015		Cerner EHR
Tuality			Cerner EHR
Vancouver Clinic		Jul 2014	220 Providers
VA		Jan 2013	"Blue Button"

National Toolkit: www.myopennotes.org



Summary

- OpenNotes: A national initiative working to give patients access to the visit notes written by their providers
- Good evidence for significant benefits in patient engagement
- Impact to physician well-being may actually be positive
  - MD email traffic flat
  - ?? Shorter visits ??
- Physician leadership is critical ! ! Change management is the hardest part.
- Technical piece is smaller; need vendor functionality.
- "Co-opetition" helps to drive pace of change
  - Supporting and pushing/challenging each other
- EHR is an enabler for this; one of the tangible benefits of widespread EHR adoption.
- NW OpenNotes Consortium
  - First to embrace OpenNotes as a community
  - Co-opetition as a driver for adoption
- Consumer/patient advocacy??
- Contacts:
  - Homer.L.Chin@kp.org , or
  - Amy Fellows: amy@wecandobetter.org

Approach

- Work with your EHR and Patient Portal vendor on functionality:
  - Access to the provider note after it is "signed"
  - Turn on/off by location, department, provider
  - Tickler email to patient that note is available for reading
  - Provider ability to hide specific note if necessary
- When EHR / Patient Portal functionality in place:
  - *Use www.MyOpenNotes.org as resource
  - Communication / Change management plan
  - Organizational leadership
  - Providers
  - Patients
  - Decide on roll-out plan: locations, departments, adult/adolescent issues, etc.
- Prior to go-live communication
  - Provider education and preparation
  - Patient notification
- Go-live
  - Monitoring and trouble-shooting
  - Tracking
- Post go-live assessment
- Assistance and/or questions:
  - Homer.L.Chin@kp.org Amy Fellows: amy@wecandobetter.org

Cafe Discussion Session 2
Traditional Health Workers

Clackamas County Peer Services

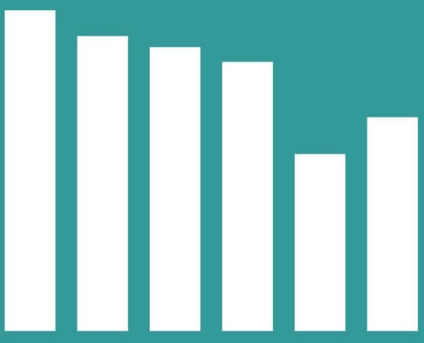
People Served: 3118

1:1 Peer Support: 1687
Drop-ins: 1431
Support Groups/Workshops: 1602
Outreach Activities to Community and System Partners: 496
Staff Training Activities: 78

2009:BHD Redesign

Recognition of peer support as a critical component to sustained recovery for MH and Addiction

Creation of the Peer Services Coordinator



Experience of Services

87% Engagement Rate
80% Improved Overall Wellness
77% Improved Quality of Life
73% Increase in Natural Supports
48% Feel accepted in their community
58% Reported they would have returned to a higher level of care if not of PDS

Children and Families

84% Engagement Rate
82% Improved Quality of Life
82% Increase in Natural Supports
30% Feel Accepted in their Community
84% Increase in Overall Wellness

Families Served: 438

Family Reunifications: 45
16 children originally had a permanency plan of adoption

Child Welfare: 257
JJ or OYA: 20

Adult Addiction Tx: 48
Adult Court: 143

Cost Savings

Corrections: $1,288,710

Warm Line: $283,003

Child Welfare: $720,400

Length of stay in foster care for children whose parents worked with a Family Partner was reduced by almost half (11 months)

Source:

Ally Linfoot
Peer Services Coordinator
Clackamas County Behavioral Health Division
alinfoot@clackamas.us
(503) 742-5951

Project Goal

The project aims to build a model through which healthcare systems can partner with community health worker (CHW) programs to improve health and decrease health disparities among communities of color in the Portland metro area.

Expected Outcomes

- Improved chronic disease prevention and management
- Increased health knowledge among participants
- Increased empowerment among participants
- Reduced health disparities (over the long term)
- A replicable model for community-based CHW integration with CCOs and health systems

Key Characteristics of the Model

- CHWs are employed by community-based organizations.
- CHWs are meaningfully involved along with the funder and the health care organization in program planning.
- CHWs work across the socio-ecological model and play a full range of roles.
- Popular education methodology is used for planning, in CHW training and on the Steering Committee.
- Supervision structure includes administrative and clinical supervision by Licensed Clinical Social Workers (LCSWs).
- CHW interventions are specific to each community and responsive to community needs.

To find out more about

WARRIORS of WELLNESS

WOW

A Multicultural Community Health Workers Collaborative

contact Celia Higueras:
celia@orchwa.org

Warriors of Wellness is a program of

ORCHWA
Oregon Community Health Workers Association

The **Oregon Community Health Workers Association (ORCHWA)** is the statewide professional association for Community Health Workers (CHWs). ORCHWA's mission is to serve as a unified voice to empower and advocate for community health workers and our communities. ORCHWA is a membership organization and is led and directed by CHWs.

www.orchwa.org
503-227-5502 ext. 232
310 SW 4th Ave, Suite 900, Portland, OR 97204

WARRIORS of WELLNESS

WOW

A Model for Integration of Culturally-Centered Community Health Worker Services

Community Health Workers affiliated with the Warriors of Wellness project

Project Partners

- ORCHWA
- Kaiser Permanente
- Health Share of Oregon
- Multnomah County Community Capacitation Center
- Urban League of Portland
- El Programa Hispano
- Immigrant & Refugee Community Organization (IRCO)
- Native American Youth and Family Center (NAYA)
- Northwest Family Services

WOW Steering Committee, which includes all project partners

How Does Our Community Health Worker Collaborative Work?

In an effort to better serve members, **Health Care Providers** reach out to **ORCHWA** for help.

Community Partners step forward to fund the program.

KAISER PERMANENTE®

health share
Health Share of Oregon

ORCHWA
Oregon Community Health Workers Association

The Multnomah County **Community Capacitation Center** works with ORCHWA to provide specialized CHW training and evaluation support.

WARRIORS of WELLNESS
WOW

Community Health Workers are recruited and employed by **Community Based Organizations** providing culturally-specific services to communities of color.

- NW Family Services
- IRCO
- NAYA
- El Programa Hispano
- Urban League

Community Health Workers work with individuals, families and communities in collaboration with **Health Care Providers**.

Direct Referral and Linkage/Support Available:

After completing the assessment the Community Health Worker will discuss options that are available to the student to meet his/her health needs. Together they will create a plan that includes calling the referral agency and questions that need to be asked before attending the appointment. Once appointments are set for the referrals given the Community Health Worker will follow up with both the agency referred and the student to confirm the student followed through on the appointment and offer support for any follow up appointments that are needed.

- Health Insurance Enrollment
- Dental Assistance
- Nutrition Education
- Access to Healthy Foods
- Housing
- Child Care Assistance
- Parenting Education
- Family Planning Services
- Medical Equipment
- Vision Testing & Glasses
- Mental Health Services
- Behavioral Health Services
- Transportation
- Counseling (drugs, alcohol, family, & personal)

Program Funding & Malheur CAC

The AHA! Project was funded by a competitive grant process awarded to the Malheur CAC by the EOCCO Transformation Fund. Lifeways, Inc. is the fiscal agent for the project, and the agency's Projects Manager, Megan Gomeza, MSW along with the LCAC Vice Chair, Joni Delgado, RN serve as the direct link to report to the Malheur LCAC.

Development and implementation of the Adolescent Health Access pilot was done through multiple committees' that provided guidance and support to the Community Health Worker. Each committee was comprised of representatives from the Malheur County Health Department, Ontario High School, Oregon Child Development Coalition, Valley Family Health Care, Wettstein Dental, Advantage Dental, Treasure Valley Pediatrics, Department of Human Services, Malheur Co. Juvenile Dept., and other community members.

If you have any questions or would like more information please contact us.

Crystal Clifford, B.S.
Community Health Worker
Phone: (208) 991-8494
Email: cclifford@lifeways.org

Megan Gomeza, MSW
Project Manager
Phone: (208) 772-4051
Email: mgomeza@lifeways.org

AHA!

Adolescent Health Access

What is Adolescent Health Access?

The Adolescent Health Access project, AHA!, was piloted with the intention of increasing pregnant and parenting school aged youth member access to health care and social services in the community with direct referral and linkage/support activities. Accessing health services as young adults is key to normalizing lifelong health seeking behaviors, which reduce the likelihood of developing chronic conditions and improves adult health outcomes.

Promotion: Education of community partners, presentations at community meetings, and presentation at the local high schools (Ontario, Nyssa, and Vale).

Referral Sources: Teachers and counselors at the high school, community partners such as Community in Action and the Health Department, and student self referrals resulting from classroom presentations.

Success: The community health worker was able to serve and support 9 students in the teen pregnant and parenting program at Ontario High School, 7 traditional students, and 3 parents of students attending the pregnant and parenting program.

Replication: With the success of the AHA! pilot the Malheur CAC and local school districts are working together to replicate the project in Nyssa and Vale. This will add 2 high schools and 2 alternative schools to the programs service area. The program will be expanded by increasing the age range and modifying the diagnosis requirement. Students 14 –20 with a minimum of 2 diagnosis's.

Outreach and Health Promotion Events

Classroom Presentations: The community health worker was able to complete nine (9) classroom presentations reaching a total of 132 students. Additionally, other community providers were brought into the classroom to discuss the services they offered and to help educate the students on how to access those services. As a result of these classroom presentations seven (7) students felt comfortable enough to go to the community health worker and ask for assistance in accessing health insurance, dental services, and food assistance.

"Spring into Wellness" Event: With the support of local community partners the Community Health Worker organized a wellness event to be hosted at Ontario High School. Over the course of the three hour event 25 community providers served over 230 community members. The event offered dental, vision, and hearing screenings as well as education about available resources, such as; housing, food, transportation, mental health, behavioral health, emergency services, employment, child care, and early intervention services and how to connect with those resources.

Incentive Funds: In addition to the AHA! project funding grant the Malheur CAC received incentive funds that were used for community outreach and health promotion. With these funds we were able to develop and implement four (4) "Spring into Wellness" events throughout Malheur County. The four events took place in Harper, Nyssa, Jordan Valley, and Vale. Over 350 community members attended these events and a minimum of 15 community vendors participated at each location.

Health Checklist & Assessment

Once the COMMUNITY HEALTH WORKER has spent time getting to know a student and building a relationship based on trust, an intake appointment will be scheduled. The intake appointment consists of gathering demographic information in the form of an application then, through the use of motivational interviewing, a comprehensive assessment will be completed. The assessment covers a wide variety of health needs and social determinants of health is completed.

- Are you homeless?
- Do you need heat at home?
- Are you pregnant?
- Are you planning to become pregnant in the next year?
- Do you experience regular pain in your body or teeth?
- Do you have a hard time reading the class white board?
- Do you have difficulty hearing?
- Do you feel down or sad?
- Do you feel unsafe?
- Do you have any current medical issues?
- Do you have a regular medical doctor?
- Do you require medical equipment?
- Do you need help with transportation to appointments?
- Do you struggle with drugs or alcohol?
- Are you using tobacco products?
- Are there any safety concerns at home, work, or school?

As a local organization based in Grants Pass, AllCare CCO wants to see our friends and neighbors healthy and happy. That's why, since 1995, Mid Rogue Independent Physician Association has been offering Medicaid enrollees in Southern Oregon quality health care. From the very beginning, our goal has been to provide high quality care in our community that's truly accessible. Today, we have more than 51,000 AllCare CCO members throughout Jackson, Josephine, Curry Counties and Southern Douglas County, served by a network of over 1,300 health care providers, clinics and hospitals. Quality care is never far.

In November 2014, AllCare created a Health and Education Integration Coordinator position to serve as a bridge between the essential work taking place within the health care transformation and that of both the early learning and youth development sectors. This position is embedded within an Integration Team that includes AllCare's Community Liaison to its three Community Advisory Councils, an Oral Health Integration Coordinator, and a Behavioral Health Integration Manager.

About Our Project Partner

Southern Oregon Head Start prepares children and their families for success in school and throughout life. Southern Oregon Child and Family Council, Inc. (SOCFC) has provided services to low-income families in Jackson and Josephine counties for 48 years; in Jackson County since 1967 and in Josephine County since 1989. SOCFC currently serves 1,107 children and their families in the Southern Oregon Head Start (SOHS) program, and 148 infants, toddlers and pregnant women in the Early Head Start program. Currently there are 19 Head Start and 4 Early Head Start centers ranging from Ashland to Merlin, and from Cave Junction to Eagle Point. The agency is one of the largest in the state, and our Early Head Start program was the first funded in Oregon in 1995. The agency employs 414 staff members and has an annual operating budget of over $14 million.

As two of the agencies making up the Southern Oregon Early Learning Services (SOELS) HUB, SOCFC and AllCare support the innovative changes in progress to transform the early childhood system to support improved outcomes for young children and their families. The AllCare Health and Education Integration Coordinator and the Head Start Director sits on the SOELS HUB Executive Council, and the EHS Director and Head Start Deputy Director sit on the Agency Advisory Council.

SOCFC's Coordination with CCOs

The EHS Director has served on the AllCare and Jackson Care Connect Community Advisory Councils since fall 2013, and has helped facilitate enthusiastic participation of Head Start and Early Head Start parents in focus groups in the development of the Community Health Assessment. She keeps our parent Policy council up-to-date on the integration activities of the CCOs, the CHIP, and innovative programs coming out of the creative process that the CCOs have spear-headed during this exciting new phase of health care transformation. Several Head Start and Early Head Start families have directly benefitted from this as well, as we are linking families with special needs to the CCOs to improve access to services and reduce barriers to improved health outcomes. SOCFC has been enriched as well with participation of AllCare, Jackson Care Connect and Primary Health on our Health Services Advisory Committee and annual self-assessment process. Last summer, we were delighted to have AllCare provide both volunteers and financial support to our Head Start Health Roundups, making this new project a great success. In addition, our Head Start Health Director serves on the Trauma Informed Care Strategic Planning Committee with CCO representatives.

A Common Service Population

Both AllCare and SOCFC serve a very high need population with many families affected by a variety of social determinants that negatively impact the health and well-being of pregnant women, infants, toddlers and pre-school children. These include compromised oral health, trauma, sub-standard housing, domestic violence, parental substance abuse, parents with mental health diagnoses, high rates of maternal depression, food insecurity and incarcerated family members. Although SOCFC has a strong program with Family Advocates (in Head Start) and Specialists (in Early Head Start) supporting families, they are increasingly faced with many families at the top tier of the high need pyramid, who need a much more intensive model of support to reduce risk factors and improve health and well-being.

It is this need that has compelled us to propose a creative new collaboration between AllCare CCO and SOCFC to improve our effectiveness in reaching out to our highest risk families, improving health outcomes to the most vulnerable children and ramping up our health education outreach and training to many more families. Through the placement of two Community Health Workers through AllCare's support, SOCFC will have the capacity to move forward in supporting joint goals toward improving health and well-being in young children and their families.

Project's Purpose

AllCare and SOCFC sees this opportunity as a pilot program to explore and understand the positive impacts we believe that CHWs will have in the Head Start and Early Head Start programs. Through initial targeted focuses for the CHWs, we will capture both quantitative and qualitative data regarding the impacts of CHWs in improving the health, well-being and health literacy of families. We intend to meet quarterly to share this rich data and realign CHW activities as we go in order to achieve the highest level of effectiveness in working with families and achieving desired outcomes.

CHWs will be an integral part of the Head Start Health Services Department and will specifically focus on high needs families and provision of effective parent education. Some of these families have barriers unknown to Health Services which renders them unable to fully participate in the program, often resulting in their children's high absence rate in Head Start. CHWs will provide a bridge between high needs families and other Health Services staff to allow a more focused approach on investigating and understanding barriers unique to each family. CHWs will build trusting relationships with families and work in partnership with them to problem-solve barriers, identify resources, and facilitate creative solutions to resolve issues and enhance family health and well-being. This approach will ultimately result in better outcomes for enrolled children and their families.

CHWs will also provide effective evidence-based parent health education training to families. We know many families misuse, overuse, or underuse health care systems as a result of low health literacy levels and a lack of understanding of their children's health, dental and nutritional needs. Others struggle with food insecurity, and a lack of skills, equipment or time to prepare healthy low-cost meals. Others need education on the impacts of diet on their children's oral health and ways to change family eating habits to help prevent dental caries and maintain a healthy weight.

Program Activities

- Provide intensive support to identified high-need families to resolve issues related to health and lifestyle practices that are negatively impacting health and wellbeing.
- Work alongside families to provide education regarding health literacy using the "What to Do When Your Child is Sick" and "What to Do When Your Child is Heavy" curriculum provided by Head Start.
- Provide a bridge to help families access appropriate medical, dental, and mental health services when a family is identified as needing that support.
- Provide outreach to pregnant women with enrolled Head Start children to support their health care needs, encourage a dental exam, and provide screening for maternal depression and referrals as needed.
- Work with families whose children are experiencing chronic poor attendance due to health concerns to discover what barriers may be impacting each situation.
- Assist in assessing home safety concerns to prevent potential injuries to children using the Home Safety Curriculum provided by Head Start.
- Assist in determining issues of food insecurity and access to healthy foods in the home for families in need.
- Assist in provision of UCLA-Neutrogena Sun Safety Training for Early Head Start families.
- Provide and facilitate nutrition education training and low-cost meal planning directly and through collaborations with partners such as OSU Extension Service.
- Participate in additional trainings and events provided by or through the agency and as appropriate such as First Tooth training, Health Round Ups, and other health related training.
- Maintain qualitative data related to their experiences working with high-need families.

Program Outcomes

1. High-need families will show an improvement in the resolution of identified health and lifestyle issues as measured by qualitative data gathered by CHWs.
2. Parents will demonstrate increased skills and knowledge in health literacy including common childhood illnesses, home safety, oral health, sun safety, general physical health, and nutrition as measured by pre and post-test assessments.
3. Children identified as having chronic poor attendance due to health barriers will have improved attendance in school as measured by attendance data in Head Start and Early Head Start.
4. Pregnant women with Head Start enrolled children will be screened for maternal depression and referred for services as measured by depression screening results and program data on services received.
5. Families will show improved access and attendance to needed health, dental, and mental health services through the identification and resolution of barriers, as measured by both quantitative and qualitative data.
6. Children identified as having health concerns will receive needed health care and have their health needs met as measured by program data.
7. Families served by the CHWs will report a satisfactory experience as measured by a parent satisfaction survey.

For more information contact: Susan Fischer, M.Ed
Health & Education Integration Coordinator
sfischer@mripa.org

Cafe Discussion Session 3

Cafe Discussion Session 3
Behavioral Health Integration

Behavioral Health Integration in SW Oregon

Heather Hartman, Behavioral Health Integration Manager
AllCare CCO
(541)471-4106 hhartman@mripa.org

Background:

AllCare CCO service Curry, Jackson, Josephine and part of Douglas Counties in Southwest Oregon. The majority of the area we serve is rural, although there are population centers as well as a metropolitan area in Jackson County. We are in an area where there is need of providers from all disciplines, including primary care, psychiatry, and oral health. As a result we have a range of providers from independent practitioners, larger clinics, and FQHCs.

In each of our 4 county areas, there is one other CCO. Many of our stakeholders and providers are shared between the CCOs, which makes collaboration and coordination necessary between CCOs.

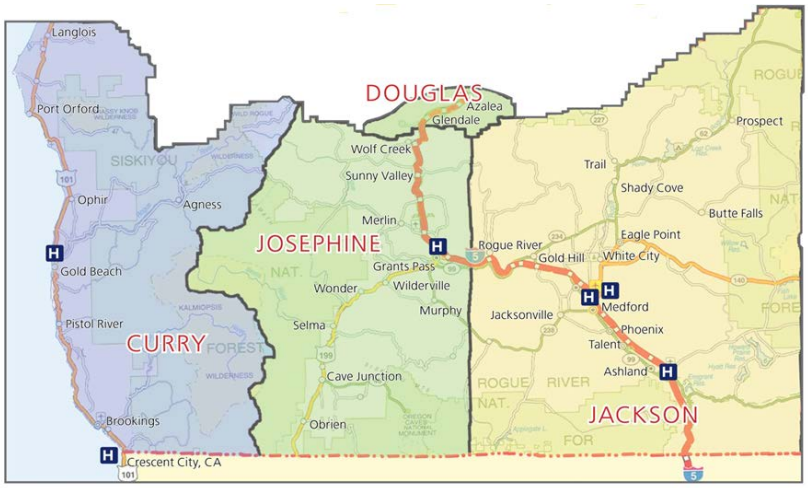


Figure 1: AllCare CCO Service Area

Behavioral Health Integration Goals:

1. Increase opportunities for integrated care throughout service area.
2. Work with existing primary care and behavioral health providers to integrate.
3. Ensure that all members have access to this level of care, regardless of where they receive their primary care (FQHC, Multi-provider Practice, and Independent Physician).

Current Integration efforts underway include:

1. Curry Community Health Brookings Clinic has mental health, addictions, and public health (with some primary care mixed in).
2. Options has a Tier 3 PCPCH located within one of their clinics that serves adults with mental health
3. Jackson County Mental Health, ARC, OnTrack, and La Clinica have the Birch Grove clinic that is operating at Jackson County's new Health and Human Services building. This clinic serves individuals with SUD and SPMI individuals.
4. AllCare contracts with other integrated sites that serve our members include Asante Physicians Partners and Providence Medical Group, both of whom have licensed mental health practitioners as part of their clinics. All 3 of our FQHCs have integrated care teams. La Clinica and Siskiyou Community Health both have dental integrated as well.
5. For our Independent Providers we provide care coordination and integrated support utilizing our Care Coordination team embedded within AllCare CCO.

Yakima Valley Farm Workers Clinic
somos familia

Primary Care Behavioral Health in Eastern Oregon: Successes, Challenges, and Lessons Learned

What was the goal of the project?

In July 2014, Yakima Valley Farm Workers Clinic (YVFWC) was awarded a grant by the Eastern Oregon Coordinated Care Organization (EOOCO) to integrate behavioral health services at Mirasol Family Health Center in Hermiston. During the one-year grant period, YVFWC was responsible for recruiting and hiring a Behavioral Health Consultant (BHC), creating workflows to ensure "real-time" access for patients, and measuring tangible outcomes associated with our Primary Care Behavioral Health program. The overall goal of the project was to expand "whole person care" at Mirasol Family Health Center and rural Umatilla County, which is comprised of a high percentage of Medicaid and uninsured patients.

Why did we pursue this project?

The Affordable Care Act has led to an exponential increase in the number of insured patients in Oregon, many of whom are at high risk for comorbid physical and behavioral health conditions. When compared to national and Oregon state benchmarks, Umatilla County residents have higher rates of chronic disease, depression, alcohol use disorders, inadequate social support, and violent crime. Particularly in underserved rural areas such as Umatilla County, the demand for mental health care is significantly greater than the availability of services to consumers. Investing resources solely in specialty care settings will not solve the problem. Research shows that at least half of mental health consumers receive care exclusively in a primary care clinic and that more than 70% of primary care visits are influenced by a psychosocial component. Our project aimed to address mental health shortages in Umatilla County by implementing a brief, population-based model in the setting where individuals present most frequently: primary care.

What did we expect?

The literature shows that Primary Care Behavioral Health programs provide increased access to care and have a positive impact on outcomes for depression and anxiety. Research also suggests that many patients actually prefer to receive behavioral health services in primary care due to the reduced stigma in this setting. We expected that our Hermiston-based Primary Care Behavioral Health program would replicate these findings by reaching a large number of unique patients and demonstrating notable penetration of the entire clinic population. We hypothesized that patients who met with our Behavioral Health Consultant would have improved outcomes on the PHQ-9 (for depression) and the GAD-7 (for anxiety). It was also predicted that patients would be comfortable discussing their concerns with the Behavioral Health Consultant and would report satisfaction with the service in general.

What did we find?

1) Primary Care Behavioral Health addresses a large population need for mental health services.

Total Unique Patients Served in 6 Months = 930

Patient Visit Data – Q4 2014

Month / Year	Total Face-to-Face Encounters	Total Alternative Touches	Total Monthly Contacts	Unique Patients*
Oct 2014	128	65	193	120
Nov 2014	159	67	226	138
Dec 2014	190	87	277	170
TOTALS	**477**	**219**	**696**	**428**

Patient Visit Data – Q1 2015

Month / Year	Total Face-to-Face Encounters	Total Alternative Touches	Total Monthly Contacts	Unique Patients*
Jan 2015	178	73	251	157
Feb 2015	157	92	249	154
Mar 2015	234	84	318	191
TOTALS	**569**	**249**	**818**	**502**

Clinic Population Penetration by Quarter

Study Period	Total Unique BHC Patients*	Total Unique Medical Patients*	Population Penetration
Q4 2014	428	3318	**12.9%**
Q1 2015	502	3588	**14.0%**

***Unique patient data only takes into account patients seen for face-to-face encounters**

2) Primary Care Behavioral Health provides enhanced access to care for patients who screen positive for depression or anxiety. Patients who receive services from a Behavioral Health Consultant experience symptomatic improvement.

Measure	Total Patients Screened	Patients w/ Positive Screens	% seen by BHC	% positive outcomes	% significant improvement*
PHQ-9	637	332	77%	76%	47%
GAD-7	589	274	80%	82%	70%

*Significant improvement is ≥ 5 points on PHQ-9 and ≥ 3 points on GAD-7 (Kroenke et al., 2001; Spitzer et al., 2006)

3) Patients are satisfied with the Primary Care Behavioral Health service and feel comfortable discussing concerns.

Patient Satisfaction Results **(n = 26 patients)**

How satisfied are you with the service you received today from your behavioral health consultant?

Very Satisfied	Satisfied	Somewhat Satisfied	Unsatisfied
84%	16%	0%	0%

How comfortable were you in discussing your concerns with the behavioral health consultant?

Very Comfortable	Comfortable	Somewhat Comfortable	Uncomfortable
85%	12%	3%	0%

Were the behavioral health consultant's recommendations useful?

Yes, Very Useful	Yes, Useful	Somewhat Useful	Not very useful
54%	46%	0%	0%

Would you recommend this behavioral health service to a friend?

Yes	Probably	Probably Not	No
96%	4%	0%	0%

Challenges and Lessons Learned

Recruitment and Hiring

Eastern Oregon is a difficult place to recruit mental health professionals, especially to work in a non-traditional model of care delivery. To address this challenge, we decided to open up the application process to postdoc psychologist residents (along with independently licensed clinicians). We also found it beneficial to recruit in rural areas both stateside and abroad. We were successful in finding a bilingual postdoc candidate from Puerto Rico who has been fantastic in her role. Although YVFWC has been unable to bill for her services during the postdoc year, we learned that hiring the right "fit" for a Primary Care Behavioral Health program is paramount to its success. We were fortunate to receive the EOCCO Transformation grant funding to help offset the upfront costs for our program in Hermiston.

Training

Training individuals in a new model of care can be challenging, especially in a rural setting. We have learned that extensive, onsite preceptorship training is time-consuming but worth the investment. Our standard onboarding program lasts 4 weeks, with new hires shadowing at a well-established site first and then receiving close mentorship at their own clinics. Periodic onsite visits are also necessary for model fidelity and shared workflows across sites. Additionally, videoconferences and online platforms foster team support and promote the sharing of clinical resources.

Technology

YVFWC is currently in the process of transitioning to a new EMR, which limited our ability to create relevant reports for this project and our program as a whole. To overcome this barrier we chose to pull large, raw data sets at quarterly intervals to analyze our findings. We expect that our new EMR will allow for improved real-time reporting capabilities to better evaluate our Primary Care Behavioral Health program. We learned that managing data manually results in considerable time commitments and limits the ability to measure rapid PDSA cycles.

Contact for additional information about the project:

Brian E. Sandoval, Psy.D.
Primary Care Behavioral Health Manager
(503) 982-0635 Ext. 6429
BrianSa@yvfwc.org

Behavioral Health Home Learning Collaborative

(Funding from the CMS Adult Medicaid Quality Grant Program)

Project Goal

Improve the health of persons with Severe and Persistent Mental Illness and Substance Use Disorders.

Background

Persons with Severe and Persistent Mental Illnesses (SPMI) or are recovering from Substance Abuse Disorders (SUD) have a high incidence of chronic medical problems. They have specialized care needs that are difficult to address in general primary care practices. The Behavioral Health Home Learning Collaborative is supporting organizations serving SPMI and SUD populations with integrating primary care services into their programs.

Oregon's Patient Centered Primary Care Home (PCPCH) model is composed of evidence-based practices in managing chronic health conditions. The BHH Learning Collaborative will apply elements of the PCPCH model into behavioral health settings. SAMHSA and AHRQ have identified those BHH components that are core for serving persons with SPMI and SUD.

Strategies

- Improve screening for unmet physical or behavioral health needs.
- Create registries of clients in need of integrated care.
- Promote team-based care across physical health, mental health and addictions treatment.
- Use care management protocols and tools.

Learning Methods

- On-site ORPRN Practice Enhancement Research Coordinators (PERCs).
- Learning collaborative face-to-face meetings.
- Care Management Plus training.
- Webinars

Project Sites (years 1 & 2)

Mid-Columbia Center for Living	Hood River	Community Health Alliance	Roseburg
Bridgeway Recovery Services	Salem	Old Town Recovery Center	Portland
Cascadia Behavior Health	Portland	Options for Souther Oregon	Grants Pass
Eastern Oregon Alcoholism FND.	Pendleton	La Clinica	Medford
Lane County Behavioreal Health	Eugene	Center for Family Development	Eugene
Lifeworks NW	Portland/Hillsboro	Willamette Family Inc.	Eugene

Contact: Rita Moore, Oregon Health Authority, 971-673-3365, RITA.MOORE@dhsoha.state.or.us

Cafe Discussion Session 3
Complex Care

Mission

Trauma Informed Oregon (TIO) is a statewide collaborative aimed at preventing and ameliorating the impact of adverse experiences on children, adults and families. TIO works in partnership with providers, individuals with lived experience, and families to promote and sustain trauma informed policies and practices across physical, mental, and behavioral health systems and to disseminate promising strategies to support wellness and resilience.

Purpose

In June of 2014, the Oregon Health Authority, Addictions and Mental Health Division (AMH), contracted with Portland State University, in partnership with Oregon Health Sciences University (OHSU), to initiate a statewide collaboration to promote and sustain trauma informed care across child- and family-serving systems. Trauma Informed Oregon (TIO) was created in recognition of the impact of adverse experiences in childhood on long-term health outcomes. TIO is the result of commitment at the state level to promote prevention and to bring policies and practices into better alignment with the principles of trauma informed care. TIO will serve as a centralized source of information and resources and will coordinate and provide training for healthcare and related systems. TIO works with state agencies, state and local providers, communities, family and youth organizations, and diverse constituents to bring many voices and perspectives to the table to learn from one another and to advocate for informed policies and practices to promote healing and support wellbeing for all of Oregon's children and families.

Background

A complex and prolonged trauma can have profound effects on physical, mental and behavioral health outcomes across the lifespan. The publication of ACE research beginning in 1998 brought the impact of early childhood trauma into public awareness and resulted in greater national attention to supportive services needed by young children who have experienced adverse and traumatic events. More recently, promising practices have begun to emerge that promise to buffer children and families from the effects of adverse experiences and to prevent their most negative consequences.

In Oregon, efforts to recognize and respond to the impact of trauma have emerged across multiple service systems. In 2006, the Addiction and Mental Health Division (then a part of the Department of Human Services) wrote the first state policy on trauma.

In 2012, the Children's System Advisory Committee (CSAC, advisory to Addiction and Mental Health, AMH) identified the impact of trauma on children and youth with mental health challenges as a priority in its annual work plan. The resulting workgroup, composed of state leaders, providers, family members of children with emotional disorders and youth with lived experience in the mental health system, prepared and circulated a white paper on trauma informed care followed by a proposed state policy. The white paper and its recommendations were AMH trauma informed care policy.

The advent of healthcare transformation and the integration of physical, mental, and behavioral health in Oregon provides a unique opportunity to change the way trauma and adverse childhood events are perceived and responded to by service providers and the public in general. To this end, Trauma Informed Oregon was initiated through the child mental health leadership of AMH and CSAC, and made possible by the vision of state legislators.

What You Can Expect from Trauma Informed Oregon

- A centralized repository of information and resources for providers, youth, family members, stakeholders.
- Coordination of training and systems-change efforts across systems and around the state.
- Workforce development through education and training of professionals in healthcare, social work, education, and other fields that influence children and families.
- Support for community-based healthcare and related systems to incorporate the principles of trauma informed care into policies, practices, and procedures.
- Opportunities to share experiences, ideas, concerns and have input into state policy and local priorities

Collaborative

To support and strengthen the work of Trauma Informed Oregon, a broad group of stakeholders is being convened to represents the needs and interests of our constituents, including individuals with lived experience, youth and families, public and private partner systems, and providers across multiple service systems. For more information, contact info@traumainformedoregon.org.

For More Information

- Visit online at traumainformedoregon.org
- Email info@traumainformedoregon.org
- Call 503-725-9618

Portland State UNIVERSITY

Oregon Health Authority

OPS Oregon Pediatric Society

OHSU

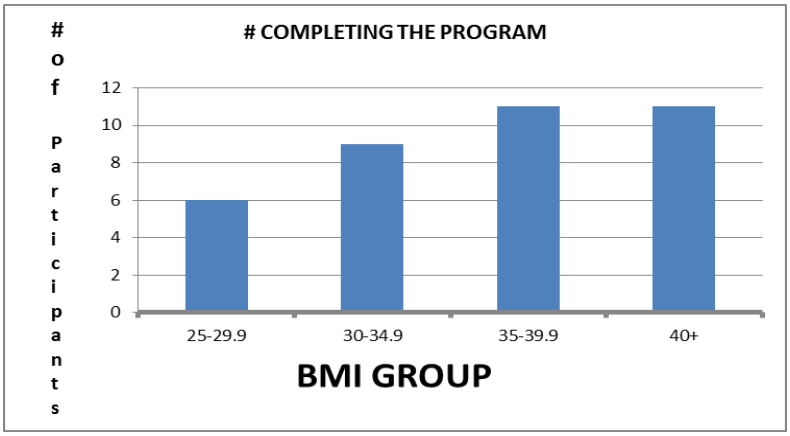
WHEELER COUNTY - Community Advisory Council (CAC) - April 2015

Report on Eastern Oregon Coordinated Care Organization Transformation Grant
BMI REDUCTION IN A RURAL COMMUNITY

PI: Dr. James Carlson, (jcarlson7@asherhealth.net), Director of Quality Assurance & Planning

OVERVIEW

1. Purpose of the project: Reduce BMI in targeted groups by the use of a tablet to track daily exercise and diet and monthly checking-in to measure BMI: Group1—Overweight adults (BMI 25-29.9); Group 2—Obese adults (BMI 30+). Each group will run for 6 months, sequentially. The target for each group is 50 participants.
2. **There will be two outcomes for the BMI reduction program:**
   - **i.** Compliance in recording diet and exercise as measured by summary of tablet recordings
   - **ii.** BMI reduction
3. Community meetings were held in each of Wheeler County's 3 communities; 29 attended from Fossil (population 460); 15 attended from Spray (population 160); 5 attended from Mitchell (population 130).
4. 50 adults signed up for Group 1 in September 2014. The six month session ended in March 2015; 37 people completed the session (74%). All but 3 of the 13 who dropped out did so immediately after the first of the monthly counseling sessions when they could determine whether the program was a fit for them.
5. It was not possible to run the first group at BMI 25-29.9 and the second group beginning April 2015 as BMI 30+. Multiple BMI groups enrolled in session 1.
6. As a general rule it was harder for those in the higher BMI groups to lose weight than those in the lower groups



BMI GROUP	Average LOSS (LBS)
25-29.9	-7.8
30-34.9	-5.3
35-39.9	-5.3
40+	-3.3
Grand Total	-5.1

THE PARTICIPANTS

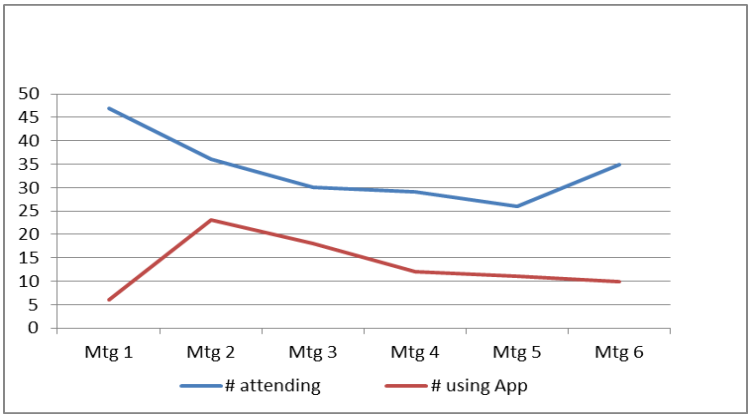
- Two of the 37 completers were male; the remainder were female.

Age of Completers	
18-40	4
41-64	21
65+	12
Grand Total	37

THE PROCESS

Participants were to meet monthly with a nutrition counselor. Goals were set at the first meeting. Barriers were discussed and problem solved. The novel part of the program was to record diet and exercise on a tablet provided by the program using an app: http://www.myfitnesspal.com/

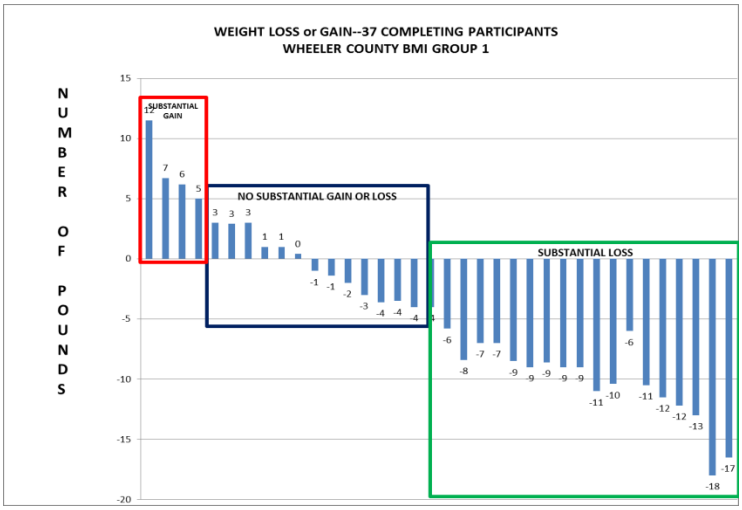
- 35 of the 37 completers came to the last counseling session but only 10 were still using the app to record their diet and exercise.

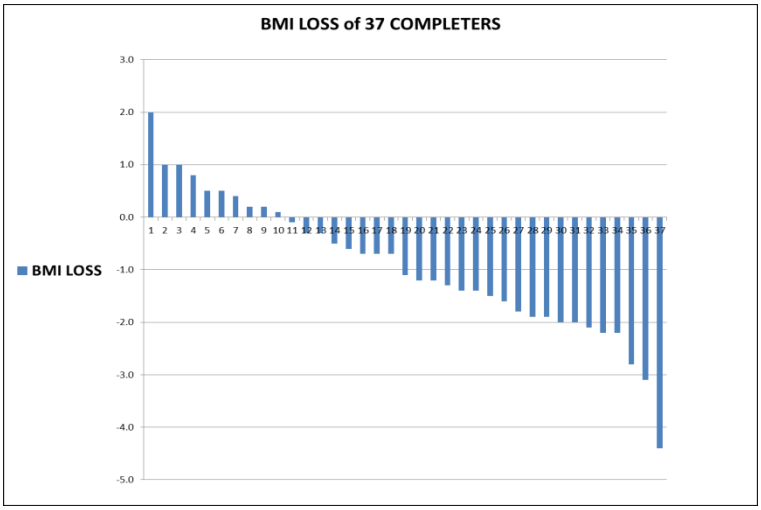


WHEELER COUNTY - Community Advisory Council (CAC) - April 2015

THE RESULTS

- There is a very even distribution of results across the partcipants.
- If a BMI gain or loss of 1 or more is counted as a change, 3 of 37 gained BMI; 19 lost.





WHAT FACTORS WERE IMPORTANT?

OVERALL WEIGHT LOSS RESULTS

Weight Loss Group	# of Participants	% of completers	% of enrolled
Lost 5-10	10	27%	20%
Lost >10	9	24%	18%
Stayed same (+ or - 4lbs)	14	38%	28%
gained	4	11%	8%
SUBTOTAL	**37**	**100%**	**74%**
Dropped at Mtg 1	11		22%
Dropped after Mtg 1	2		4%
TOTAL	**50**		**100%**

- Once you get them past meeting 1, retention is good.

WEIGHT GAIN OR LOSS BY AGE GROUP

Age Group	Number of Participants	Lost >10	Lost 5-10	+ or - 4lbs	gained
18-40	4	0%	25%	25%	50%
41-64	21	29%	24%	38%	10%
65+	12	25%	33%	42%	0%
Grand Total	37	24%	27%	38%	11%

- Age does not appear to be a factor.
- It appears to be harder for those with a greater initial BMI to lose weight, though 45% (18% + 27%) lost 5 pounds or more. Only the 40+ BMI group had individuals (4) who gained weight.

WEIGHT GAIN OR LOSS BY BMI GROUP

BMI GROUP	Number of Participants	Lost >10	Lost 5-10	+ or - 4lbs	gained	Grand Total
25-29.9	6	50%	17%	33%	0%	100%
30-34.9	9	22%	33%	44%	0%	100%
35-39.9	11	18%	27%	55%	0%	100%
40+	11	18%	27%	18%	36%	100%
Grand Total	37	24%	27%	38%	11%	100%

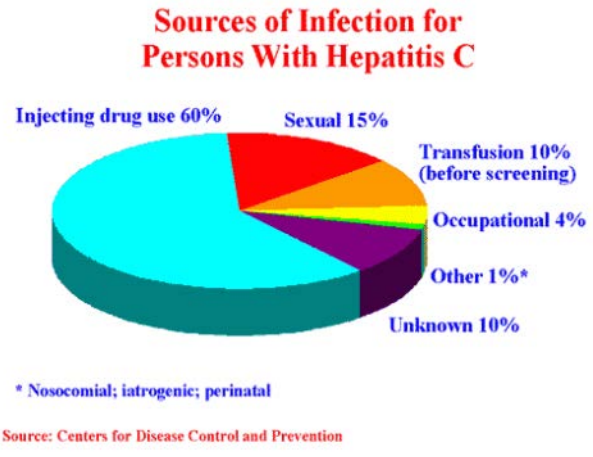
HCV Care Coordination

HIV Alliance Hep C program:

- Goals:
    1. Increase access to education and care for people with Hep C
        - Activities: educate Hep C positive individuals of their disease and facilitate access to medical care
        - Impact: Hep C positive individuals will understand their disease and will know more about how to prevent infecting others
    2. Find new HCV infections
        - Activities: reach and recruit at-risk populations to increase the number of focus population members who know their HCV status
        - Impact: at-risk groups will know their HCV status
- As of April 23rd,we have 52 active clients, 35 of which have HCV confirmations
- In the last quarter, 19 out 83 HCV screenings were reactive (22.9%); 42 out of 260 in the current fiscal year thus far (16.2%)
- Oregon sees over 5,000 new reports of HCV each year, yet the Oregon Health Authority suspects that 50% of people living with HCV in Oregon are not aware of their infection.

Facts about HCV generally:

- a contagious liver disease that takes two forms—acute and chronic. The former refers to the first six months of living with HCV, the latter is life long and can scar the liver
- 80% of patients develop liver cancer: $280,000 for liver transplant, and the cost of living with HCV without the transplant is estimated at $100,000
- Most prevalent among: people who inject drugs, baby boomers, and people living with HIV
    - Baby boomers are included because blood bank screenings were not implemented until 1990s
    - Syringe exchange targets PWID, open testing in Eugene May 17 and 31st for all at-risk populations
    - Scott County, Indiana: 11 HIV infections in January, and that number reached 150 in early April. CDC saw 84% HCV co-infection rate
- In 2013, people whose age was between 55-64 accounted for 51% of HCV-related deaths



Cafe Discussion Session 3
Health Information Technology and Telehealth

CHILDREN'S HEALTH *alliance* CHILDREN'S HEALTH *foundation*

Pediatric Care Management Approaches, Measures and PHM Solution

Abstract/Overview:

The Children's Health Alliance (CHA) sought HIT solutions for their private practice pediatricians to combine data for a 360-degree view of the child/family to support effective office-based pediatric care management and population health analytics. But they discovered that PHM solutions targeted adult populations and lacked robust protocols and measures meaningful for pediatric workflow. So, with a history of success implementing pediatrician-led quality improvement programs, the CHA determined to create the tools and requirements needed for pediatric PHM. The CHA implemented a web-based solution in 2014 offering actionable care alerts, care gap alerts, meaningful reporting, and shared community care plan functionality. The CHA continues to enhance the pediatric protocol-based content and workflow supports that make this a viable care management and population analytics tool supporting the triple aim goals as well as claims-based analytics for pediatricians and other primary and specialty care providers and organizations.

More About Us:

The **Children's Health Alliance** is a pediatric IPA in the greater Portland/Salem/SW Washington area with over 100 pediatrician members across twenty practice sites and using eight different EMR systems. These pediatricians and other pediatrician members of the **Children's Health Foundation** work together on clinical quality improvement programs to raise the standard of care for children in our community.

The Identified Need:

Through their quality improvement work in areas including Developmental Screening, Immunizations, and Asthma Care Management, these pediatric practices identified the need for a tool beyond the EMR to facilitate proactive patient needs-assessments and targeted care management for both chronic care and preventative care of children and their families. Homegrown registries and disparate EHRs provided limitations, and there was critical need for **aggregation of clinical and claims-based data** both at the population level for operational planning and risk management, but also at the patient level to offer a **360 degree view of the patient** and enable **actionable clinical care alerts and reporting**. With industry movement toward new payment models and increased focus on HIE from the many systems including ACO's, CCO's and Provider groups, the CHA/CHF foresaw providers needing to exchange data with many different entities. To avoid some of this redundancy, CHA/CHF envisioned a provider-based tool that would not only allow multiple practices to funnel data through one HIE , but that also had analytics to **transform the data exchange into meaningful and actionable information for provider practices to improve care and affect the triple aim**. *(See Figure A on page 2)*

Pediatricians Pioneer a Care Management HIT Solution:

No PHM solution offered robust pediatric protocols nor workflow supports, so the CHA/CHF has teamed up with Wellcentive, a leading PHM vendor, to develop a web-based tool for the practice that links to data from their EMRs, registries, hospitals (via EDIE), payer claims and eventually other community data sources. This Care Management, Analytics and Reporting (CMART) tool enables pediatricians to assess risk/needs of their patients/families and pair that with a broader view of care utilization information so they can monitor achievement of care protocols and be alerted of upcoming gaps toward their care goals.

For example, if a patient admits to the ED, data is pushed to the CMART tool prompting the primary care team to complete a follow-up call to determine need for a visit and/or education. These patients appear to clinical staff on an actionable list with a goal of contact within 3 days. When clinical staff drill into each patient, their ED visit history, primary care visit history, medication refill history, care goals, upcoming appointments and any care actions due are displayed on one screen (based on interfaces with the EMR, PMS, EDIE, Payer Claims, etc.).

This solution offers providers and their care teams meaningful and actionable data to proactively manage the preventative and chronic care needs of their pediatric patients, largely driven by evidence-based care protocols and associated CHA level care goals. *(See Figure B on page 2)*

Contacts: **Deborah Rumsey**, Executive Director (drumsey@ch-alliance.org), **Julie Harris**, Director, Quality Programs (jharris@ch-alliance.org)

CHILDREN'S HEALTH *alliance* CHILDREN'S HEALTH *foundation*

Pediatric Care Management Approaches, Measures and PHM Solution

Figure A:

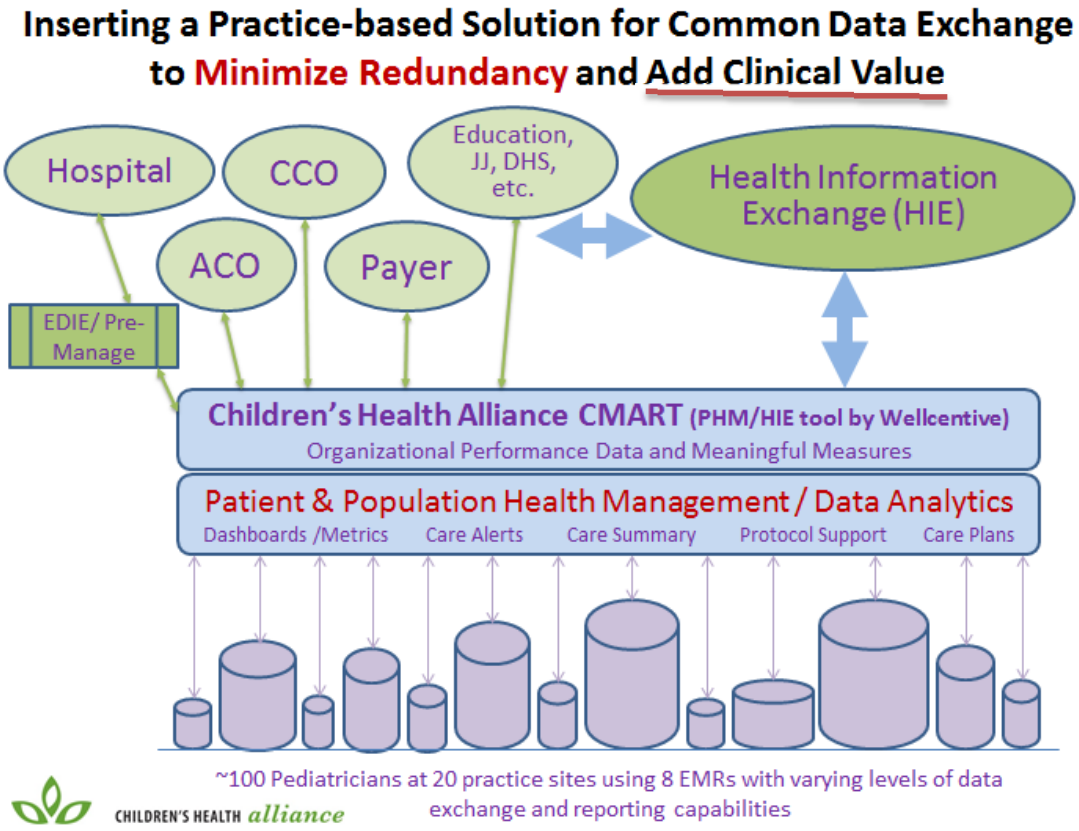
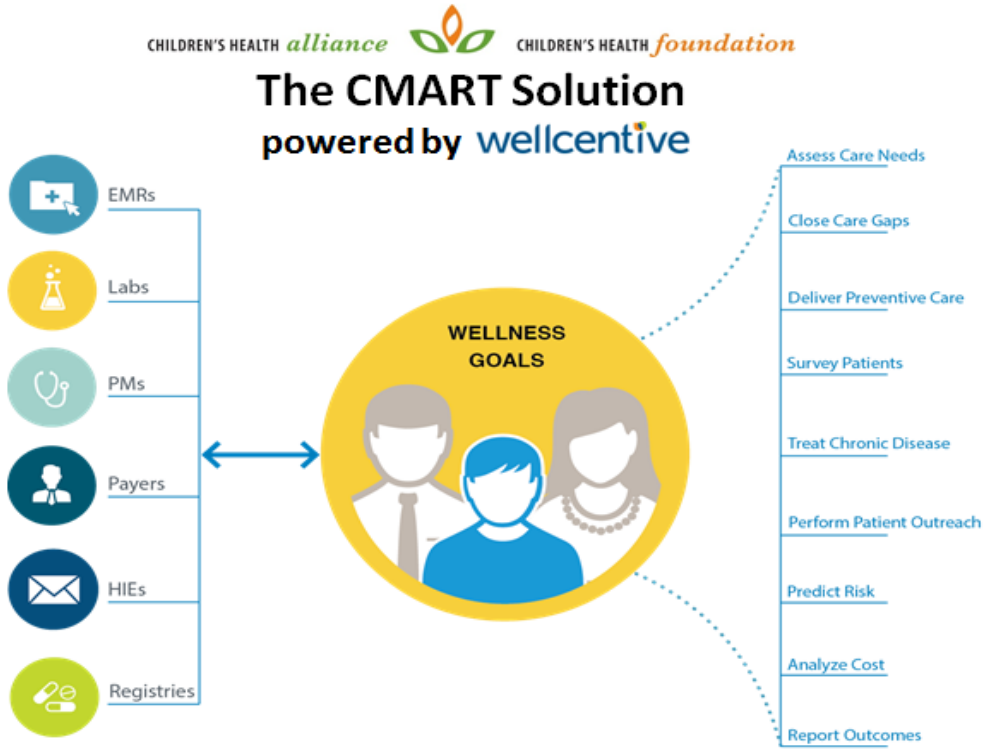


Figure B:



Oregon Health System Innovation Café

Emergency Department Information Exchange (EDIE) Utility & PreManage Projects

The Oregon statewide EDIE Utility & PreManage projects came about as a direct result of the Oregon Health Leadership Council (OHLC)'s Evidence Based Best Practice committee's recommendation to focus on emergency department (ED) utilization as a priority in the state's efforts to reduce waste in the Oregon health system. In 2013, OHLC formed a unique coalition of major stakeholders, including hospitals, health plans, ED physicians, the Oregon Health Authority (OHA) and the Oregon Association of Hospitals and Health Systems (OAHHS), who were all committed to addressing the issue of appropriate utilization of ED services via the voluntary implementation of the EDIE Utility. All 59 Oregon hospitals attested to implementing the EDIE technology developed by Collective Medical Systems (CMT) in 2014.

EDIE

EDIE is a real-time information exchange which proactively notifies ED providers and care coordinators when high utilizing and complex needs patients present in their EDs. This is the first real-time information exchange that pushes data to providers across all WA and OR hospitals. Receiving proactive, concise, actionable data at the point of care helps to improve communication and care coordination. **95% of all OR hospital are fully operational on EDIE, sending real time data and receiving real time alerts.**

Hospitals set their criteria for notification (baseline criteria are: 5 or more ED visits in the last 12 months and/or 3 visits to different EDs in the past 6 months) and can receive notifications in a variety of ways such as EMR integration to stay within the provider's workflow, fax, phone, email, etc. When a patient is registered in the hospital or ED, their registration data is automatically uploaded to CMT. CMT runs patient matching algorithms to identify patients and automatically pushes notifications based on the hospital's pre-defined criteria.

Care guidelines manually entered into EDIE follows the patient and provides concise, actionable information that authoring provider wants all care givers to know about this patient. There is work being done in Oregon to define best practices around care guideline data and format to allow for a consistent approach statewide. Interface development work is being done to pull pertinent data from a hospital entered EMR Care Plan to populate and share via the EDIE care guidelines.

EDIE Utility

The EDIE Utility added inpatient hospital event data (Admissions, Discharges & Transfers (ADT)) to the exchange and created a mechanism for financial sustainability of EDIE. The Utility allows all hospital event data to easily flow across the healthcare continuum and increases visibility of patient activity to improve care and care coordination. At-risk patients can be identified and managed to reduce medically avoidable (re)admissions and stay durations**. 83% of all OR hospitals are currently sending inpatient ADT data to the exchange with a goal of all hospitals contributing by the end of 2Q15.**

The goals of the EDIE Utility in Oregon are:

- Continue trend of decline in ED utilization by 1% by end of 2015 (reduction of 12,547 visits). Projected savings of $12,158,000.

- Match State of Washington ED utilization rates per 1000 population by the end of 2016. Represents a 6.3% improvement or 79,046 fewer ED visits. Projected savings of $79,596,574.
- Meet the Oregon Health System Transformation ED visit benchmark by the end of 2016 for the Oregon Health Plan patient population. This represents a 12% decrease in ED utilization from 2013

PreManage

PreManage is a companion offering from CMT which expands EDIE notifications to health plans, clinics, CCO's, HIE's, group practices, care managers, social worker, etc. The purpose of this product is to close communication gaps across the health care ecosystem and provide the ability to focus on and manage high risk patients. The system allows health plans, medical groups, CCO's to receive real time notifications for their members or patient panels. PreManage is an optional product which is currently operational in multiple Oregon health plans and a significant number of OR medical groups and clinics. OHA plans to purchase a basic subscription of PreManage for Oregon CCOs and other Medicaid care coordinators who wish to participate. OHA is also piloting the use of PreManage with ACT (Assertive Community Treatment) teams to close communication gaps and improve the ACT team's ability to provide the best care for their patient population—individuals with complex behavioral health needs.

PrimaryHealth of Josephine County
Using CCOMetricsManager Towards Improved CCO Incentive Measures

What are you trying to accomplish?

All CCOs are working towards improved outcomes on the Quality Pool targets. Data from OHA is useful, but has limitations. Inteligenz assists PrimaryHealth in the development of a clear strategy for improvement.

- Inteligenz allows PrimaryHealth to drill down to member, provider or clinic level data to help refine QI efforts towards CCO Incentive Measures. It is more timely than OHA data and updated weekly.
- Data is sorted to distinguish clinics that are high performers on specific measures. This helps PrimaryHealth focus improvement efforts where they are needed most.
- Actionable data ("Gap Lists") from Inteligenz give providers a clear pathway to improvement, at the member level.

How will we know that a change is an improvement?

- CCO, Clinic or provider specific rates can be reviewed over time to evaluate improvements.
- Data can be presented in multiple ways, depending on the audience.

What changes can we make that will result in an improvement?

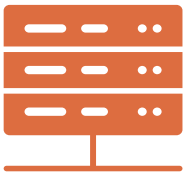
- PrimaryHealth, like many CCOs, has multifaceted strategic plans to help achieve improvement on the incentive measures. Inteligenz allows the CCO to evaluate these strategies as pilots that are carried out.

PrimaryHealth of Josephine County
Your Community Health Plan

CCOMetricsManager
Key Benefits of Using CCOMetricsManager

Web Based Solution

- Data is accessbile in a single, cloud-based location. Easy to distribute to stakeholders.
- Saves lag time from accessing across mulitiple locations and sources.

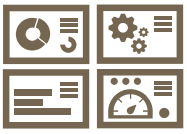


Data Integration

- Captures Claims, RX, 7/11, Eligibility, Premium and Clinical data.
- As real time data as possible.
- Fresh data stored in single repository.

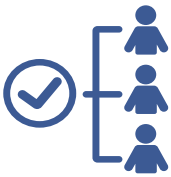
OHA Specific/Focused

- Up to date with OHA unique and changing specifications as opposed to tools with generic metric measures.



PH Tech Provider Portal

- Solution is distributed through healthcare community using the self serve Provider Portal that is widely used.



Workflow Oriented

- Not just data analytics.
- Promotes working together to close gaps in care for community.

Incentive Focused

- Increased performance in metrics management means increased revenue returning to the community.

inteligenz

phtech performance health technology

Oregon Health Authority
OFFICE OF HEALTH INFORMATION TECHNOLOGY

Statewide Direct Secure Messaging EHR/HISP Integration Pilot

careaccord™ Oregon's Health Information Exchange

Administered by the Oregon Health Authority (OHA), CareAccord is a nationally accredited Health Information Service Provider (HISP) offering Direct secure messaging services via a web-portal. Direct secure messaging is used through a web-portal or a Direct-enabled Electronic Health Record (EHR). Direct secure messaging is a HIPAA-compliant way to electronically exchange patient information between organizations and care teams for improved care coordination. CareAccord users are interoperable with other users of Direct, including hospitals, providers, and health information exchanges (HIEs) like Jefferson HIE.

CareAccord's goals are to 1) improve communication among Oregon's health care providers and organizations for better individual and family care coordination through electronic health information exchange (HIE), 2) improve access to HIE by providing support to providers facing barriers to implementing Direct securing messaging, and 3) improve interoperability through statewide Direct secure messaging.

Seeking participants to pilot Direct secure messaging from an EHR

In addition to providing Direct secure messaging services, CareAccord manages a Flat File Directory, which is Oregon's combined address book for Direct secure messaging. This tool enables participants throughout Oregon to "discover" Direct addresses outside their own organizations.

EHR/HISP Integration Pilot Overview

CareAccord is seeking to pilot with healthcare organizations in the state of Oregon to enable trusted exchange of Direct secure messaging from a 2014-certified EHR. EHRs that are Direct-enabled are interoperable across organizational and geographical boundaries, improving care coordination among care teams and helping simplify workflows (reduce paper processes, integrate messaging). Many Oregon providers need to use Direct secure messaging from their EHR to electronically send patient care summaries for transitions of care, a requirement for one of the Meaningful Use (MU) Stage 2 measures.

This pilot will expand CareAccord's Direct secure messaging services (beyond web-portal) and provide pilot participants the opportunity to begin health information exchange with other users of Direct secure messaging.

The pilot will begin summer 2015, and conclude September 30, 2016.

Participation

During the pilot, CareAccord will provide at no cost to each participant:

- HISP services necessary for becoming Direct enabled from a 2014-certified Electronic Health Record (EHR)
  - ✓ Connectivity for Direct secure messaging
  - ✓ Direct addresses
  - ✓ Digital organizational certificates
- Access to the Flat File Directory for monthly upload into the each participant's EHR

Direct Secure Messaging Benefits

- *Required for MU Stage 2 transitions of care objective*
- *Improves care coordination across team members*
- *Reduces paper processing*
- *Easy, secure, integrated messaging between providers*

Participation Requirements

CareAccord is looking to integrate its HISP services across a broad sample of health care organizations and clinics – focusing on organizations that face barriers to health information exchange and Direct secure messaging. Organizations do not have to be seeking to attest to Meaningful Use to participate in the EHR/HISP integration pilot. Minimum eligibility criteria include:

- Fully implemented 2014-certified EHR
- An Oregon-based organization
- Flexibility to begin piloting between July 1, 2015 and conclude by September 30, 2016
- Does not currently have a HISP service integrated into their EHR
- Signs CareAccord's participation agreements
- Meets technical requirements outlined in pilot application

Contact Us | careaccord.info@state.or.us | 503-378-6575 | 500 Summer Street E-52 Salem, OR 97301

Cafe Discussion Session 3
Traditional Health Workers

The Role of Community Health Workers in Preventing Heart Disease and Stroke

North by Northeast Community Health Center reduces the risk of cardiovascular disease and advances health equity by offering primary care services focused on chronic health conditions affecting the local African American population.

We launched our Community Health Worker program in 2011 as a response to seeing patients with severe high blood pressure every week and hearing tragic stories of early heart attack and stroke in the community we serve. It is well known that one of the best ways to prevent heart disease and stroke is to adequately control high blood pressure. Therefore, we established more rigorous treatment and follow-up protocols inside our clinic to improve our blood pressure control outcomes (now over 75%, compared with 30% nationally for African Americans). By incorporating CHWs into this work we were able to better engage our patients and extend our efforts into the community.

Our state-certified CHW works with all of our patients with high blood pressure. Patients with complex care coordination needs (e.g. new cancer diagnosis) are also referred to our CHW for assistance with health system navigation. In weekly supervisory meetings with our Medical Director, our CHW reviews her caseload, prepares for upcoming visits, reports on patients' progress with their health goals and discusses clinical concerns or questions. Our CHW also provides blood pressure screening at local health fairs and churches and staffs our barbershop blood pressure program, Cuts and Checks, which is a partnership with three neighborhood barbershops and Legacy Emanuel Medical Center.

In 2012 we helped launch an 80-hour Afro-centric state-certified CHW training in partnership with the Urban League of Portland and the Community Capacitation Center. To help prepare CHWs for successful employment in clinical settings we developed a 24-hour "Clinical Topics for CHWs" training in 2013 and have offered it twice a year. This training has been certified by the OHA for Continuing Education Units.

For more information contact:
Suzy Jeffreys
Executive Director
North by Northeast Community Health Center
sjeffreys@nxneclinic.org
(503) 946-6380

- **Barriers to managing chronic disease**
  - Providers not following evidence-based guidelines
  - Patients lack access to care
  - Patients lack understanding of disease and need for treatment
  - Poor medication adherence
  - History of relationship with medical system defined by disconnection, disappointment and distrust

- **Why Community Health Workers?**
  - Trusted community members
  - Many already be serving in this role
  - Understand barriers and patient perspective
  - Knowledge of community resources
  - Serve as a "bridge" to health care team

- **Roles of CHWs in CVD prevention**
  - Health screening
    - Visit health fairs, faith communities, barber shops and other gathering places to screen for high blood pressure and other risk factors
    - Identify individuals in need of further education and services
  - Connect community members with health insurance and traditional health services
    - Be knowledgeable about eligibility and community resources
    - Assist with applications
    - Ensure appropriate connections and follow-up
  - Education
    - Using culturally appropriate information, educate individuals and groups about CVD risk factors
    - Support adherence to medications and self-management goals
    - Support health behavior changes such as smoking cessation
    - Educate other CHWs in areas of expertise
  - Assist with navigation through the health care system
    - Assist with appointment scheduling
    - Provide appointment reminders
    - Connect patients to transportation support
    - Accompany patients to health care visits when needed
    - Provide home visits
  - Participate in the health care team
    - Bridging and cultural mediation
    - Education of health care providers about patient perspective and barriers patients may face
    - Education of community members to be successful health care consumers

- **Lessons Learned**
  - Know your population and tailor your program to be successful (don't plan to do things you know won't work)
  - Assess frequently and modify as needed (don't keep doing things that don't work)
  - CHWs are not miracle workers; keep your expectations reasonable
  - State health departments and legislators should take the lead from CHWs and community organizations when developing policy to integrate CHWs into the healthcare workforce

OREGON COMMUNITY HEALTH WORKER CONSORTIUM

What is ORCHWC?

The Oregon Community Health Worker Consortium (ORCHWC) is a collaborative effort based at the School of Community Health at Portland State University. It is funded by a grant from the Cambia Health Foundation.

The goal of ORCHWC is to enable CHWs to make an optimum contribution to improving community health and reducing health inequities by bringing the field together around best and promising practices. We seek to achieve our goal through the coordinated actions of three teams: Education, Research, and Policy.

Who are CHWs? (Community Health Workers)

CHWs are trusted members of their communities who participate in training so that they can promote health in their own communities.

CHWs play a variety of roles including:

- **Bridging** between health and social service systems and communities
- **Facilitating** access to high quality and culturally competent services
- **Advocating** for individual and community needs
- **Building** individual and community capacity through education and social support

What are the goals of the Education Team?

- **Continue to assess stakeholders' knowledge and develop high-quality materials and presentations** to educate various stakeholders
- Correct myths about CHWs and **articulate the complementary role of CHWs with health care professions**
- **Share information** around the region and nationally to achieve alignment about:

essential characteristics and attributes;	recruitment, training, and retention;
roles and competencies;	appropriate remuneration;
program models;	support and supervision
professional development;	

How will the Education Team achieve its goals?

- **Facilitate** 6-10 strategic presentations/conversations
- **Develop** materials/toolkit about the CHW model and facilitate 2-3 train-the-trainer workshops to enable others to use it in various settings
- **Strengthen** local and national partnerships

How can I get involved?

- Educate Coordinated Care Organizations (CCOs) and other stakeholders about CHWs
- Invite CHWs to do presentations about their work for your group or organization
- Provide feedback about the training materials and toolkit

For more information

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One Key Question®

Integrating Preventive Reproductive Health into Primary Care

OFRH is dedicated to improving access to reproductive health care, including preventing unintended pregnancy and planning healthy families.

We are committed to advancing reproductive rights and advocating for reproductive health equity in all Oregon communities.

Oregon Foundation for Reproductive Health

Contact us for more information!

info@onekeyquestion.org

Follow us on Twitter and Facebook: **OregonRH**

THE ACA REQUIRES INSURANCE COVERAGE OF:

ALL FDA-APPROVED BIRTH CONTROL METHODS & PRECONCEPTION CARE INCLUDING FOLIC ACID

2015 INCENTIVIZED HEALTH METRIC FOR CCO'S:

EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY

ONE KEY QUESTION®: Are You Asking It?

THE PROBLEM

The unintended pregnancy rate remain at almost half of all pregnancies in Oregon. Unintended pregnancies are known to have worse health outcomes both for mother and infants and women living in poverty are five times more likely to experience an unplanned birth. The extensive social ramifications such as increasing family stressors, increasing financial instability of families and increasing the risk for family violence make reducing unintended pregnancy a public health concern.

Lack of Contraception Care

Unintended pregnancy occurs among women who are not using contraception at all (52%) and women who are inconsistent in their birth control use (42%). Too many women lack comprehensive contraception advice on how to avoid pregnancy from their clinician. There are advances in birth control methods, such as long-acting reversible contraceptives, and improvements in reducing out-of-pocket costs for many women, making it extremely important for providers to check in with women about their method.

Lack of Preconception Care

A preconception visit can optimize a woman's chance for a healthy pregnancy; the factors that affect fetal development and the health of the pregnancy can only be modified before a pregnancy begins. More women who are choosing pregnancy are older, struggling with chronic medical conditions and taking medications regularly. Also, only about 1/3 of women take folic acid daily before birth to prevent major birth defects of the brain and spinal cord. Too many women do not routinely receive preventive reproductive health services and enter prenatal care *after* the critical first weeks of fetal development.

OUR SOLUTION

The **One Key Question®** initiative encourages all primary care health teams to routinely ask women of reproductive-age "Would you like to become pregnant in the next year?" Women are then offered essential preventive reproductive health services depending on their needs and goals: preconception counseling with folic acid and/or contraceptive services. Including OKQ as a pregnancy intention screening in comprehensive care promises to decrease unintended pregnancy and improve the health of wanted pregnancies.

One Key Question® can help traditional health workers (THW) start a conversation with their patients about preventive reproductive health care needs. THW's often establish a connection with patients outside of the clinic and have the time and relationship to explore health concerns or issues that cannot be completely addressed in a 10 minute primary care or family planning appointment. OFRH has conducted patient focus groups with Latina women and AAPI women, and heard a common theme that their sexual/reproductive health was not an easy topic to discuss with a doctor in a clinical setting. By incorporating OKQ into their work with patients, THW's can help bridge the gap between women accessing proactive, preventive reproductive health care in a clinical setting and meeting their own goals for if and when to become pregnant. Ensuring that THW's are conducting pregnancy intention screening and follow up care/referrals based on her response, we can better serve women with preconception and contraception care.

Our **CONNEXIONS** Program partnership was created in response to Transformation Grant funding received by three organizations in Umatilla County: Good Shepherd Health Care System, Lifeways, and Umatilla County Human Services. Care coordination is a fundamental part of the ConneXions Program: the client is at the center of all care and coordination activities with support, services and collaboration from all resources available to them.

At the hub of our ConneXions Program is a centralized referral process: uniform referral and communication forms, a single referral phone & fax number, and email to scan and forward referrals or other communications. In addition to widely distributed brochures, postcards and business cards, forms and information about ConneXions is located on the Healthy Communities Coalition website (www.healthycommunitiescoalition.com) which is accessible to everyone. Phone or walk-in referrals are also welcomed. Referrals can be generated by anyone in the community: providers, community service agencies, self referrals, EMS, Law Enforcement, community outreach activities (health fairs, health coverage "fairs" etc) as well as internal processes (Emergency Department referrals, hospital & Case Management referrals, and provider/clinic referrals).

Community Health Workers (CHW's) work collaboratively with other CHW's as well as any/all providers, services and agencies that will help our clients with health issues, basic needs, mental or behavior health concerns, healthcare coverage or financial needs. Communication and referrals flow back and forth between everyone involved with the client with the goal of keeping the client at the center of their care coordination.

Using health education, screenings, and partnerships between our clients, their healthcare provider and the CHW, our goal is to encourage healthier behaviors in our community members along with decreasing unnecessary healthcare service utilization.

GOOD SHEPHERD HEALTH CARE SYSTEM

UCO HEALTH Building a Healthy Community

LIFEWAYS Helping People