

Oregon's Primary Care Transformation Initiative

2021 Progress Report

Primary Care Payment Reform Collaborative

April 2022



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Executive Summary

The Primary Care Payment Reform Collaborative (Collaborative) is charged with developing and sharing best practices in technical assistance and methods of reimbursement that direct greater health care resources and investments toward supporting and facilitating health care innovation and care improvement in primary care. Specifically, Collaborative activities should:

- Increase investment in primary care (without increasing costs to consumers or increasing the total cost of health care);
- Improve reimbursement methods, including by investing in the social determinants of health; and
- Align primary care reimbursement by purchasers of care.

This annual report reviews the Collaborative's work in 2021 and outlines next steps for making progress in 2022.

The disproportionate impact of the COVID-19 pandemic on people of color motivated the Collaborative to focus on how primary care payment reform could positively impact health equity. Members discussed multiple potential strategies, including leveraging the Patient-Centered Primary Care Home (PCPCH) program, supporting data collection, and incentivizing the integration of traditional health workers (THWs).

Collaborative members decided to focus on payment models that sustainably support the integration of THWs into primary care and coordinated with the THW program in OHA's Division of Equity and Inclusion to create Integrating and Paying for Traditional Health Workers in Primary Care, a guidance document recommending improving health equity by incentivizing the integration of THWs into primary care through targeted and sustainable payment strategies, including value-based payment (VBP) models.

The Collaborative also seeks to align with the Oregon VBP Compact and in December presented recommendations for primary care VBP to the VBP Compact Workgroup. Recommendations include alignment to minimize administrative burden, VBPs to address health equity, inclusion of enhanced fee-for-service and per-member-per-month (PMPM) payments and limited number of metrics that address care across the lifespan.

In December, staff interviewed Collaborative members about the focus and role of the Collaborative, reflecting on the legislative charge of the group, its past work and the current environment. Staff identified key themes and elicited further input via a survey to prioritize the Collaborative's work in 2022 and beyond, including continued coordination with the VBP Compact Workgroup.

Introduction

The Primary Care Payment Reform Collaborative (“Collaborative”) is a legislatively mandated multi-stakeholder advisory body to the Oregon Health Authority (OHA). According to Senate Bill 934 (2017), the Collaborative advises and assists OHA in implementing a Primary Care Transformation Initiative (“Initiative”) to:

- Use value-based payment (VBP) methods that are not paid on a per-claim basis to:
 - Increase the investment in primary care
 - Align primary care reimbursement by all purchasers of care
 - Continue to improve reimbursement methods, including by investing in the social determinants of health
- Increase investment in primary care without increasing costs to consumers or increasing the total cost of health care
- Facilitate the integration of primary care behavioral and physical health care

The legislation directs the Collaborative to develop strategies that support the implementation of the Initiative, including the provision of technical assistance; the aggregation of data and alignment of metrics; and evaluation of the Initiative. The Collaborative currently includes 39 members representing a range of providers, payers and other primary care stakeholders.

This annual report reviews the Collaborative’s work in 2021 and outlines its next steps for making progress in 2022.

COVID Impact and Role of Primary Care Payment Reform on Practice Sustainability

The COVID-19 pandemic continued to impact the members and work of the Collaborative in 2021. Primary care providers have expressed being overwhelmed by the pandemic and the toll it has taken on their practices and patients.

The pandemic exposed the vulnerability of a Fee-For-Service (FFS) payment system – long perceived as the “safe” status quo – to providers. Providers and practices that were prepaid via certain VBP models for the populations they serve were better positioned to rapidly transform their practices to meet patient needs and benefited from payment sustainability which allowed them to manage the financial uncertainties of the pandemic. To support providers, some Oregon payers developed prepayment models to accelerate the transition to telehealth for primary care practices in their networks. Other Oregon payers offered relief payments, with particular focus on independent physician practices, to help providers bridge cash-flow shortfalls during the public health emergency.

The expansion of VBPs and evidence of cost savings prior to COVID-19, coupled with increased interest in models such as capitation during the pandemic, creates a window for accelerated transition to VBPs across the system. The Collaborative is taking advantage of this momentum and will develop a payment model in 2022.

Role of Payment Reform Strategies to Increase Health Equity

The COVID-19 pandemic also brought social and racial injustice and inequity to the forefront. A key learning both in Oregon and across the country is how deeply this virus exacerbates existing racial and economic inequities with wide-ranging health, social, and economic implications. For example, long-standing health inequities have caused higher rates of chronic health problems within communities of color compared to white communities. Because people with chronic health conditions are at increased risk for severe COVID-19 illness, people of color face a greater chance of experiencing severe COVID-19 illness.

In light of the pandemic's disproportionate impact and in alignment with OHA's goal to eliminate health inequities in Oregon by 2030, the Collaborative continued the exploration, begun in 2020, of three potential payment mechanisms to target health disparities:

- Implement payment models, such as VBPs or increased payment rates, to sustainably support Traditional Health Workers (THWs)
- Incorporate equity more explicitly into the Patient-Centered Primary Care Home (PCPCH) Program by adding:
 - A distinction or certification to identify providers that offer culturally and linguistically sensitive services and work to reduce health care disparities
 - A standard with specific definitions and measurement criteria for equity-focused trainings, such as anti-racism and culturally responsive care
- Simplify and support the collection of Race, Ethnicity, Language and Disability (REALD) data through:
 - Identification of a central mechanism to collect data
 - Implementation of patient education strategies to introduce the REALD form and the importance of collecting the data
 - Implementation of a payment model to support the full cost of data collection practices incur

Following robust discussion, the Collaborative members decided focusing on payment models that sustainably support the integration of THWs into primary care

is consistent with the Collaborative's charge, leverages their unique expertise and could be completed in a timely fashion to make an impact. The Collaborative recommended improving health equity by incentivizing the integration of THWs into primary care through targeted and sustainable payment strategies, including VBP models. In coordination with the THW program in OHA's Office of Equity and Inclusion, the Collaborative created Integrating and Paying for Traditional Health Workers in Primary Care, a guidance document exploring integration and payment models (see Appendix C).

As laid out in this document, THWs diversify the health care workforce, provide high-quality and culturally competent care to Oregon's increasingly diverse populations and ultimately promote health equity. The evidence of THW impact on cost and quality is robust, as detailed in the studies listed in Appendix C. Given the variations in types of THWs, there is no one-size-fits-all payment model to support THWs. Implementation of THW programs and payment models will vary and should build upon the strengths and respond to the needs of the community.

The resource guidance document has been shared with Collaborative member organizations, coordinated care organizations, the VBP Compact Workgroup, other states and national organizations. The Collaborative will continue to share the document and track implementation of THW payment models.

Alignment and Collaboration with the Value-based Payment Compact Workgroup

As part of Oregon's legislatively mandated initiative to contain growth in health care costs, Health Care Cost Growth Target Implementation Workgroup identified advancing VBPs across Oregon as its first strategy to achieve its the cost-growth target. As a result, payers and providers are working together to advance payment reform and move to value-based payments (VBP). The Oregon VBP Compact is a voluntary commitment by payers and providers to participate in and spread VBPs, meeting specified targets on prescribed timelines over the next four years.

The Collaborative has a keen interest in Oregon's VBP Compact and wants to work in partnership with the VBP Compact Workgroup (Workgroup) to promote the spread of primary care VBPs across the state. Two Collaborative members – Eleanor Escafi from Cambia Health Solutions and Dr. Elizabeth Powers from Winding Waters Community Health Center – also sit on the VBP Compact Workgroup. To initiate a partnership with the VBP Compact Workgroup, the Collaborative drafted and presented a memo (see Appendix D) to the Workgroup outlining overarching recommendations for primary care VBP and recommendations specific to the continuum of VBP models, attribution, complex care, behavioral health integration and care for children and youth.

The memo includes recommendations related to the following:

- Alignment to minimize administrative burden
- VBPs to address health equity
- Inclusion of enhanced fee-for-service and per-member-per-month (PMPM) payments
- Exclusion of high-cost health care such as certain specialist procedures and inpatient stays that are largely outside the control of primary care
- Analysis of quality, access and utilization data by race, ethnicity, language and disability (REALD)
- Limited metrics that address care across the lifespan
- Improvement targets
- Risk and mitigation strategies

The VBP Compact Workgroup requested the Collaborative develop a primary care payment model incorporating these recommendations. In 2022, the Collaborative will build on the contents of the memo and its 2018 recommended payment model.

Collaborative Role Going Forward

At the end of 2021, staff interviewed Collaborative members about the focus and role of the Collaborative, reflecting on the legislative charge of the group, its past work and the current environment. Staff identified key themes and elicited further input via a survey to prioritize the Collaborative's work in 2022 and beyond, including continued coordination with the VBP Compact Workgroup. The Collaborative prioritized the following areas of work for 2022:

- Identify opportunities for alignment across payers, including metrics and risk adjustment, with a focus on accounting for the social determinants of health.
- Develop a payment model or a menu of models building on the Collaborative's 2018 recommendations.
- Support integration through primary care payment reform, including behavioral health, pharmacy and oral health.
- Identify incentives and other options to increase provider and payer adoption of VBP.
- Continue to influence the work of the VBP Workgroup (e.g., the Collaborative should serve as a resource for guidance on primary care payment).

Staff also identified the need for more leadership from Collaborative members in strategic planning and agenda setting. Seven members volunteered to form a steering committee to take the priorities identified and develop a scope of work and

timeline for 2022. The Steering Committee will provide leadership to the Collaborative to maximize its impact in the evolving payment reform environment.

Appendix A: Primary Care Payment Reform Collaborative Members

- Carolyn Anderson, Clinical Quality Director, Mountain View Medical Center
- Gary Ashby, Health Insurance Specialist, U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services
- Beth Black, Employee Benefit Consultant, Hagan Hamilton Insurance Solutions
- Tanveer Bokhari, VP, Quality & Health Equity, Umpqua Health Alliance
- Bill Bouska, Director of Community Solutions and Government Affairs, Samaritan Health Plans, InterCommunity Health Network CCO
- Damian Brayko, Deputy Director, Public Employees' Benefit Board & Oregon Educators Benefit Board
- Vanessa Casillas, Regional Director of Behavioral Health Integration and Specialty Clinics, Providence* Medical Group – Oregon
- Joy Conklin, Vice President of Practice Advocacy, Oregon Medical Association
- Dawn Creach, Health Care Consultant, Creach Consulting, LLC
- Bill Dwyer, Director of Analytics, Moda Health and Eastern Oregon CCO
- Eleanor Escafi, Assistant Director of Strategy and Execution, Network Management/Provider Partnership Innovation, Regence BlueCross BlueShield of Oregon & Cambia Health Solutions
- Amy Hill, VP, Provider and Network Management, Health Net Health Plan of Oregon Inc. and Trillium Community Health Plan
- Scott Fields, Chief Medical Officer/Chief Informatics Officer, OCHIN
- Brian Frank, Physician, Oregon Academy of Family Physicians*
- Maribeth Guarino, High Value Care Associate, OSPIRG
- Ruben Halperin, Medical Director, Providence Health Plans
- Kristan Jeannis, Quality Improvement Coordinator, Tuality Health Alliance
- Jen Johnstun, Chief Quality Officer, Siskiyou Community Health Center (previously at Primary Health)
- Lisa Ladd, Director of Contracting & Provider Network, WVP Health Authority
- Cat Livingston, Medical Director, Health Share of Oregon
- Doug Lincoln, Pediatrician, Metropolitan Pediatrics

- Lynnea Lindsey, Director of Behavioral Health Services, Legacy Health
- Barbara Martin, Director of Primary Care, Central City Concern
- Ben Messner, Chief Executive Officer, Advanced Health
- Angela Mitchell, Vice President, VBP and Contracting, CareOregon
- Justin Montoya, Medical Director of Commercial Programs, PacificSource Health Plans
- Liz Powers, Innovations Officer & Chief Medical Officer, Winding Waters Community Health Center & Wallowa Memorial Hospital
- Colleen Reuland, Director, Oregon Pediatric Improvement Partnership
- Deborah Rumsey, Executive Director, Children's Health Alliance
- Divya Sharma, Medical Director, Central Oregon Independent Practice Association
- Christi Siedlecki, Chief Executive Officer, Grants Pass Clinic
- Martha Snow, Project Manager, Oregon Rural Practice-based Research Network
- Danielle Sobel, Policy Director, Oregon Primary Care Association
- Larry Soderberg, Chief Financial Officer, Yamhill Community Care
- Maria Tafolla, Manager, equity, Diversity and Inclusion, Health Share of Oregon
- Rebecca Tiel, Director of Public Policy, Oregon Association of Hospitals and Health Systems
- Megan Viehmann, Pharmacist, OHSU Family Medicine at Richmond
- C.J. Wilson, General Counsel, ATRIO Health Plans
- Gayle Woods, Senior Policy Advisor, Oregon Department of Consumer and Business Services

Oregon Health Authority staff and consultants

- Diana Bianco, Collaborative Facilitator, Artemis Consulting
- Summer Boslaugh, Transformation Analyst, Oregon Health Authority Transformation Center
- Chris DeMars, Director, Oregon Health Authority Transformation Center and Interim Director, Delivery Systems Innovation Office

- Amy Harris, Manager, Oregon Health Authority Patient-Centered Primary Care Home Program

* New member in 2021

Appendix B: Primary Care Payment Reform Collaborative 2021 Charter

I. Authority

Oregon is required by statute (Chapter 575 Oregon Laws) to convene a Primary Care Payment Reform Collaborative to advise and assist in the implementation of a Primary Care Transformation Initiative. The purpose of the Initiative is to develop and share best practices in technical assistance and methods of reimbursement that direct greater health care resources and investments toward supporting and facilitating health care innovation and care improvement in primary care. Senate Bill 934 (2017) states that the Initiative should:

- Increase investment in primary care (without increasing costs to consumers or increasing the total cost of health care);
- Improve reimbursement methods, including by investing in the social determinants of health; and
- Align primary care reimbursement by purchasers of care.

To achieve the implementation of this Initiative, the Collaborative will support:

- Use of value-based payment methods;
- Incorporation of health equity into primary care payment reform;
- Provision of technical assistance to clinics and payers in implementing the initiative;
- Aggregation of data across payers and providers;
- Alignment of metrics, in concert with work of the Health Plan Quality Metrics Committee established in ORS 413.017; and
- Facilitation of the integration of primary care behavioral and physical health care.

II. Deliverables

Senate Bill 934 (2017) requires the Collaborative to report annually to the Oregon Health Policy Board (OHBP) and the Oregon Legislature on the implementation of the Primary Care Transformation Initiative and progress toward meeting primary care spending targets. The third progress report was delivered by April 1, 2020. The goals of the Initiative will be met by 2027.

The Collaborative has combined the Implementation and Technical Assistance work groups, convened in 2019, into one work group to move the Initiative forward in 2021. This group will meet regularly in between Collaborative meetings to identify:

1. Strategies to support implementation of payment models in the Initiative including attribution, data aggregation and reporting; and
2. Technical assistance (TA) resources to support implementation of the Initiative payment models, including leveraging existing TA resources.

The Collaborative is focused on primary care transformation and reimbursement. Specialty care and inpatient hospital services are not within the scope, except to the extent to which that these topics impact the goals of the Initiative.

The Collaborative is committed to coordinating and aligning with related initiatives including, but not limited to, Comprehensive Primary Care Plus (CPC+), Health Plan Quality Metrics Committee, the Patient-Centered Primary Care Home Program and the Sustainable Health Care Cost Growth Target Program.

III. Dependencies

To the extent directed and supported by OHA, the Committee will coordinate its recommendations to align with national and state health policy initiatives in formal reports submitted to:

- OHA Leadership
- Oregon Health Policy Board
- Oregon Legislature

The ability of the Committee to fulfill its statutory duties as outlined in sections I and III is contingent upon support of and direction by OHA, as well as coordination with other health policy advisory bodies.

IV. Membership

In accordance with Chapter 575 Oregon Law, Collaborative membership includes representatives from the following entities:

- Primary care providers
- Health care consumers
- Experts in primary care contracting and reimbursement
- Independent practice associations
- Behavioral health treatment providers
- Third party administrators
- Employers that offer self-insured health benefit plans
- The Department of Consumer and Business Services
- Carriers
- A statewide organization for mental health professionals who provide primary care
- A statewide organization representing federally qualified health centers
- A statewide organization representing hospitals and health systems
- A statewide professional association for family physicians
- A statewide professional association for physicians
- A statewide professional association for nurses
- The Centers for Medicare and Medicaid Services

Additional members may be invited to participate based on their experience and knowledge of primary care. Collaborative member terms are for a minimum of two years, with up to six meetings per year.

V. Resources

Internal staff resources include the following:

- Executive Sponsors: OHA Health Policy & Analytics Division Director; OHA Chief Medical Officer
- Staff support:

- Health Policy and Analytics Division, Transformation Center (lead)
 - Health Systems Division
- External Relations Division

Appendix C: Integrating and Paying for Traditional Health Workers in Primary Care

The Primary Care Payment Reform Collaborative (PCPRC) developed this document to recommend incentivizing the integration of Traditional Health Workers (THWs) in primary care through payment strategies, including value-based payment (VBP). In addition to payment, successful integration of THWs requires provider and staff education about their role and how to best utilize them to address patient needs. The practice may also require infrastructure and workflow changes, including administrative support and data collection to measure quality and impact. The THW workforce will also need to grow to meet the expanded need with training and development of new THWs. These issues, while important, are out of scope for this document which is focused on payment.

The last section of this document provides background information on THWs and evidence of their impact on the quality and of cost care.

Recommendation: The PCPRC recommends improving health equity by incentivizing the integration of THWs into primary care through targeted and sustainable payment strategies, including VBP models.

The PCPRC recommends improving health equity by incentivizing the integration of THWs into primary care through payment strategies, including VBP models. Given the variations in types of THWs, there is no one-size-fits-all payment model to support THWs. Implementation of THW programs and payment models will vary and should build upon the strengths and respond to the needs of the community.

Principles for Developing and Implementing Payment Strategies for THWs

The Oregon Health Authority (OHA) Traditional Health Worker Commission has outlined the following core principles for payments for THWs:¹

1. Sustainable (i.e., continuous, not time-limited grants or pilots)
 - Funding needs to account for the initial start-up costs of setting up and administering a new program
 - Rates that sustain services including administrative costs, living wage and benefits for THWs, ancillary program costs (e.g., supervision, training & education, data collection & evaluation), and a career ladder/lattice for THWs.
 - THWs are part of members' continuum of care and wellbeing across care settings.
2. Support THWs practicing at the top of their certification
 - THW roles and position descriptions should be based on the THW Commission-approved THW scope of practice.²

¹ <https://www.oregon.gov/oha/OEI/THW%20Documents/FINAL-Payment-Models-Grid-by-Worker-Type-with-Disclaimer-9.25.19.pdf>

² Traditional Health Worker Toolkit <https://www.oregon.gov/oha/OEI/THW%20Documents/Traditional-Health-Worker-Toolkit-2019-Final.pdf>

- Enable and support THWs to enact their full range of core roles, including individual-level (health-related social needs) and upstream community and policy-level (social determinants of health) interventions and activities.
 - Alternative payment methods such as per-member-per-month (PMPM), capitated payments and population-based payments are likely to better support the full THW scope of practice compared to fee-for-service.
3. Community and equity-driven
- Health systems are encouraged to partner with and leverage the expertise of community-based organizations and other health systems that currently employ or contract with THWs.
 - Options for integrating THWs include hiring directly or contracting with community-based organizations.
 - Consult the THW Commission for referrals to appropriate community-based organizations (CBOs), THW-run organizations, and/or THW-recommended best and promising practices for THW integration.
4. Not solely contingent upon short-term outcomes
- THWs are an important component of strategies moving toward health equity and addressing the social determinants of health, not short-term return on investment or particular health outcomes, though those may well be some results of integrating THWs.
 - THWs improve the overall quality and value of healthcare by providing person-centered care and increasing the timeliness, efficiency, equitability, safety and effectiveness of care.
 - It is recommended that THWs and participants of THW programs are involved in planning and implementing qualitative and quantitative THW evaluation.

Building on these principles for payment, the following design principles are recommended for VBP for THWs:³

- Co-design: Any specific approach to VBP, as well as implementation and evaluation, should be co-designed by THWs, providers, and payers, as well as representatives of patients and communities served.
- Equity: Local and regional community needs assessments that identify disparities and gaps in access and utilization should drive VBP that intentionally includes THWs as an evidence-based strategy to reduce those disparities and close those gaps.
- Capacity: VBP should leverage existing availability, experiences, strengths, skills, and network/organizational capacities of local THWs, or intentionally increase such availability and build such capacities.
- Sustainability: Any VBP model should build long-term sustainability, including documentation of outcomes and impacts.

³ Oregon Community Health Worker Association, Community Health Worker Payment Model Guide, 2020, <https://www.orchwa.org/resources/Documents/ORCHWA%20Payment%20Model%20Guide%202020.pdf>

Various payment models can be used to support THWs.⁴

As in all of healthcare, a payment model can impact the type of care that is available. THW payment models must fund the development of programs and sustainably support the unique value THWs provide to patient care. The evidence of THW impact on cost and quality is robust as demonstrated in the studies listed starting on page six. These programs were supported by fee-for-service and / or grants. There is limited evidence of the impact of other payment models.

Payment mechanism	Strengths	Limitations
Fee-for-service	<ul style="list-style-type: none"> Fee Schedule with billing codes for some THW services is available: <ul style="list-style-type: none"> For CHWs: https://www.oregon.gov/oha/HSD/OHP/Tools/CHW_Billing%20Guide.pdf For doulas: https://www.oregon.gov/oha/HSD/OHP/Tools/Billing%20for%20doula%20services.pdf For peer specialists: https://www.oregon.gov/oha/HSD/OHP/Tools/Enrollment%20and%20billing%20for%20peer-delivered%20services.pdf Primary care providers who employ THWs can bill and receive reimbursement for approved services⁵ Extensive tracking/billing for services can be used for calculating ROI of THW services 	<ul style="list-style-type: none"> Requires a diagnosis and adherence to a medical model of care that limits community and population health roles of THWs, many of whom operate outside health care settings⁶ Reimbursement limited to approved service codes only and might discourage holistic services Billing codes not available for all THW types, i.e., patient navigators Reimbursable services can sometimes cover the salary for a CHW, but not other provider types If services are strictly clinical, incentive to “upcode” by using other higher-paid providers Requires billing infrastructure No connection to quality of service or outcomes
Performance-based payment	<ul style="list-style-type: none"> Can be designed for panels of patients and longitudinal care rather than tying payment to individual billed encounters 	<ul style="list-style-type: none"> Payment relies upon meeting performance standards so there is some risk of not meeting standards and

⁴ Ibid.

⁵ Eastern Oregon CCO Community Health Worker Policy. https://www.eocco.com/-/media/EOCCO/PDFs/chw_policy.pdf

⁶ Ibe CA, Hickman D, Cooper LA. To advance health equity during COVID-19 and beyond, elevate and support community health workers. JAMA Health Forum. 2021;2(7):e212724 <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2782746>

Payment mechanism	Strengths	Limitations
	<ul style="list-style-type: none"> ● Primary care clinics could employ THWs as part of clinic costs in a performance-based contract ● Rewards quality, not quantity ● Can be an “on-ramp” to more advanced VBPs and can be coupled with more advanced VBP models. 	<p>therefore, not receiving full payment</p> <ul style="list-style-type: none"> ● Pay for performance models that tie payment to outcomes are generally limited to short-term outcomes that are easily documented versus longer term outcomes addressing social determinants of health and equity
PMPM payments / global payments / case rate payments	<ul style="list-style-type: none"> ● Provides flexibility for the employing entity to use the funds consistent with the needs of their patient population ● Can include foundational payments to pay for HIT and data exchange capabilities to document and increase impact ● Could be structured with partial prospective payments to provide working capital/funding to hire THWs (with reconciliation of payments after a performance period) ● Payments are more stable over time allowing programs to and sustain investments 	<ul style="list-style-type: none"> ● Funds may not be earmarked for THWs and may be used for other purposes. ● Payments may not be sufficient to fund community based THW services ● Payments may exclude THW services provided in the community or with specialist physicians and other providers serving patients with chronic conditions such as diabetes or substance use disorders ● PMPMs may not be sufficient to fully support and sustain the program ● A provider or organization needs a large, assigned population in order to support the overall costs of program development and on-going support ● Few shared savings or downside risk models have included THWs
Grant or contract	<ul style="list-style-type: none"> ● Organization receiving the grants/contracts and hiring THWs has certainty about revenue available and what THW services can be provided ● THWs may be funded by multiple payers and/or braided funding streams 	<ul style="list-style-type: none"> ● Grants will end and contracts may not be renewed ● Grants and contracts often do not cover true overhead/administrative (or constant grant writing/reporting and contracting) expenses ● Commonly tied to a specific program, e.g. diabetes, cancer,

Payment mechanism	Strengths	Limitations
	<ul style="list-style-type: none"> • Can leverage/braid federal and foundation funding for THWs • Builds organizational/community capacity that supports THWs (and THW ownership/control) • Flexibility in program design to meet patient and/or community identified needs 	<p>etc. which may limit scope of THW services available and tailoring to patient and community needs</p> <ul style="list-style-type: none"> • Integration can be a challenge if the primary care provider is not directly hiring or supervising the THWs

There are different models to integrate and sustain the THW workforce.⁷

One successful model of THW implementation is employment by a primary care clinic combined with extensive work in the community. The close connection with the clinic facilitates integration with the primary care team and availability for warm handoffs. Work in the community allows a THW to meet patients in the community where they live and / or work and maintain connections with organizations working in the community.

THWs can also work solely in the community or a clinic. Clinic-based approaches can be easier and more comfortable for health and hospital systems to implement with easy integration into the care team, warm handoffs and increased trust among some patients. With a clinic-based approach, THWs spend their time in a clinical setting and may be unable to fully connect with community members. The strengths of THWs to work in the community is not leveraged when patients must come to the clinic for care and services, including those provided by the THWs; this is additionally pronounced for underserved communities that have faced decades of discrimination and disparate treatment from and often mistrust healthcare and government institutions.

THWs working exclusively out of a CBO can benefit from the relationship CBOs have with target populations. CBOs are often known and trusted, making it easier to connect with the population and be more knowledgeable about the resources available in a community. However, there can be challenges incorporating community based THWs into systems of care, including sharing of health records and the ability to do warm handoffs. There is also often a lack of capacity of CBOs to contract with health systems due to underinvestment in CBOs. Culturally specific CBOs may especially lack the infrastructure to contract with health systems and government entities. Additional investments from healthcare funding dollars would be beneficial to bridge this gap.

Key Definitions, Background and Evidence

THWs are trusted individuals from their local communities who may also share socioeconomic ties and lived life experiences with health plan members. THWs have historically provided person- and community-centered care by bridging communities and the health systems that serve them,

⁷ Oregon Community Health Worker Association, Community Health Worker Payment Model Guide, 2020, <https://www.orchwa.org/resources/Documents/ORCHWA%20Payment%20Model%20Guide%202020.pdf>; Traditional Health Worker Toolkit <https://www.oregon.gov/oha/OEI/THW%20Documents/Traditional-Health-Worker-Toolkit-2019-Final.pdf>

increasing the appropriate use of care by connecting people with health systems, advocating for patients, supporting adherence to care and treatment, and empowering individuals to be agents in improving their own health.

THWs diversify the health care workforce, provide high-quality and culturally competent care to Oregon's increasingly diverse populations and ultimately promote health equity.⁸ OHA defines health equity as "when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistributing of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

There are multiple types of THWs recognized and certified by OHA:

- **Doula** is a birth companion who provides personal, nonmedical support to women and families throughout a woman's pregnancy, childbirth, and post-partum experience.
- **Peer Support Specialist** is any range of individuals who provide supportive services to a current or former consumer of mental health or addiction treatment.
- **Peer Wellness Specialist** is an individual who has lived experience with a psychiatric condition(s) plus intensive training, who works as part of a person-driven, health home team, integrating behavioral health and primary care to assist and advocate for individuals in achieving well-being.
- **Family Support Specialist** is an individual with experience parenting a child or youth who has experience with substance use or mental health treatment who supports other parents with children or youth experiencing substance use or mental health treatment.
- **Youth Support Specialist** is an individual with lived experience with substance use or mental health treatment who also had difficulty accessing education, health or wellness services who wants to strictly provide support services to people under the age of 30.
- **Personal Health Navigator** is an individual who provides information, assistance, tools and support to enable a patient to make the best health care decisions.
- **Community Health Worker** is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served.
- **Tribal Traditional Health Worker** is an individual who has expertise or experience in public health and works in a tribal community or an urban Indian community.

Multiple program evaluations show strong evidence of improved quality and decreased costs resulting from the integration of THWs across provider types.

⁸ <https://www.oregon.gov/oha/OEI/Pages/THW-Become-Certified.aspx>

<p>Doulas – findings from three studies</p>	<p>A randomized control trial of continuous support in labor to low-income women by a lay doula at a women’s ambulatory care center at a tertiary perinatal care hospital in New Jersey found that doula-supported mothers had significantly shorter lengths of labor, more cervical dilation and higher infant Apgar scores at one- and five-minutes post birth.⁹</p> <p>A retrospective program evaluation of a hospital-based doula program in an urban, multicultural setting through the first seven years of the program found that women with doula support had significantly higher rates of breastfeeding initiation and lower rates of cesarean deliveries.¹⁰</p> <p>The YWCA community-based Healthy Beginnings Doula Program launched in 2008 in Greensboro, North Carolina focuses on reducing adverse birth outcomes for women at risk because of racial disparity (particularly African American and Hispanic), homelessness, interpersonal violence, unhealthy housing, poverty or young age. A study of the program found doula-assisted mothers were four times less likely to have a low-birth-weight baby, two times less likely to experience a birth complication involving themselves or their baby and significantly more likely to initiate breastfeeding.¹¹</p> <p>Women who received doula support had lower preterm and cesarean birth rates than Medicaid beneficiaries regionally (4.7% vs. 6.3%, and 20.4% vs. 34.2%). After adjustment for covariates, women with doula care had 22% lower odds of preterm birth (AOR=0.77, 95% CI [0.61–0.96]). Cost-effectiveness analyses indicate potential savings associated with doula support reimbursed at an average of \$986, (ranging from \$929 to \$1,047 across states). [In comparison group, doulas worked at CBO, and were funded by Medicaid managed care plans to provide childbirth-related education, but were not funded to provide support during labor and delivery]¹²</p>
<p>Personal health navigators / patient navigators –</p>	<p>A study of the Cancer Disparity Research Partnership, a community-based program in South Dakota for Native Americans developed by the National Cancer Institute, found that navigated patients undergoing radiotherapy had fewer treatment breaks compared with non-navigated patients. This outcome may result in higher cure rates for some tumor</p>

⁹ Campbell DA, Lake MF, Falk M, Backstrand JR, J Obstet Gynecol Neonatal Nurs. 2006 Jul-Aug; 35(4):456-64.

¹⁰ Mottl-Santiago J, Walker C, Ewan J, Vragovic O, Winder S, Stubblefield P. A hospital-based doula program and childbirth outcomes in an urban, multicultural setting. Matern Child Health J. 2008 May;12(3):372-7. doi: 10.1007/s10995-007-0245-9. Epub 2007 Jul 3. PMID: 17610053. <https://pubmed.ncbi.nlm.nih.gov/17610053/>

¹¹ Gruber J, Cupito S, Dobson C. Impact of Doulas on Healthy Birth Outcomes. J Perinat Educ. 2013 Winter; 22(1): 49-58. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/>

¹² Kozhimannil KB, Hardeman RR, Alarid-Escudero F, Vogelsang CA, Blauer-Peterson C, Howell EA. Modeling the cost-effectiveness of doula care associated with reductions in preterm birth and cesarean delivery. Birth. 2016;43(1):20-27. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5544530/pdf/nihms882297.pdf>

findings from one study	types as a result of this intervention. The success of the program resulted in fewer referrals out for treatment, thereby significantly increasing health care dollars available for cancer treatment. ¹³
Peer support specialist – findings from five studies	<p>In 2006 the Georgia Department of Behavioral Health & Developmental Disabilities compared consumers using certified peer specialists as a part of their treatment verses consumers who received the normal services in day treatment. The study found that consumers using certified peer specialists cost the state \$997 per year on average verses an average cost of \$6,491 in day treatment, providing an average cost savings of \$5,494 per person per year.¹⁴</p> <p>A New York Association of Psychiatric Rehabilitation Services program matches peers who are managing their recovery and completed training with patients just beginning treatment. An evaluation of the program found that 71% of the people the Peer Bridgers worked with were able to stay out of the hospital in 2009 and 54% have not been re-hospitalized.¹⁵</p> <p>A peer support program in Pierce County Washington reduced involuntary hospitalizations by 32% leading to savings of \$1.99M in one year. The Optum Pierce Peer Bridger program used peer coaches to serve 125 people; 100% of participating consumers had been hospitalized prior to having a peer coach, but only 3.4% were hospitalized after getting a coach; there was an estimated \$550,215 in savings due to the 79.2% reduction in hospital admissions year over year.¹⁶</p> <p>A Federally Qualified Health Center in Denver (FQHC) that used peer support had an ROI of \$2.28 for every \$1 spent.</p>
Family support specialist – findings from one study of three programs	Early research studies of three programs suggests that parent peer support offers parents and other caregivers 1) increased sense of collaboration, 2) decreased internalized blame, 3) increased sense of self-efficacy, 4) recognition of the importance of self-care, 5) decreased family isolation, 6) increased empowerment to take action and 7)

¹³ Petereit D, Molloy K, Reiner M, Helbig P, Cina K, Miner R, Spotted Tail C, Rost C, Conroy P, Roberts C. Establishing a Patient Navigator Program to Reduce Cancer Disparities in the American Indian Communities of Western South Dakota: Initial Observations and Results. *Cancer Control*. 2008 Jul; 15(3): 254–259.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2556124/>

¹⁴ Bergeson, S. (2011). Cost Effectiveness of Using Peers as Providers.

<https://mhanational.org/sites/default/files/Evidence%20for%20Peer%20Support%20May%202019.pdf>

¹⁵ Ibid.

¹⁶ Ibid.

	increased acceptance and appreciation of child's challenges and increased ability to work with both formal and informal supports. ¹⁷
Community health workers – findings from five studies of 10 programs	<p>An Asthma CHW project among Medicaid covered children living in disadvantaged Chicago neighborhoods found an ROI of 5.58:1.¹⁸</p> <p>A study in Nevada found a 1.81:1 ROI for a CHW-led program that worked with patients for 30-60 days.¹⁹</p> <p>A Maryland CHW outreach program for African American Medicaid patients with diabetes resulted in a decline of 40% in ED visits, 33% in admissions and 27% in Medicaid reimbursements. These quality improvements resulted in average savings of \$2,245 per patient per year.²⁰</p> <p>Eastern Kentucky's rural health information hub staffed by CHWs targeting low-income residents saved \$11.34 for every \$1 invested in CHW staff and services.²¹</p> <p>A Denver CHW outreach program increased primary and specialty care visits and decreased urgent care, inpatient, and outpatient behavioral health care utilization, resulting in a ROI of 2.28:1.²²</p> <p>The Individualized Management for Patient-Centered Targets (IMPACT), a Medicaid standardized community health worker intervention implemented across the country that addresses unmet social needs for disadvantaged people, resulted in a ROI of 2.47:1.²³</p> <p>A study of multisector interventions conducted by the Oregon Health Authority Health Evidence Review Commission found that the</p>

¹⁷ Family, Parent and Caregiver Peer Support in Behavioral Health. Bringing Recovery Supports to Scale, Technical Assistance Center Strategy. SAMHSA. https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tac/family-parent-caregiver-support-behavioral-health-2017.pdf

¹⁸ Margellos-Anast H, Gutierrez MA, Whitman S. Improving asthma management among African-American children via a community health worker model: findings from a Chicago-based pilot intervention. J Asthma. 2012 May;49(4):380-9. doi: 10.3109/02770903.2012.660295. Epub 2012 Feb 21. PMID: 22348448. <https://pubmed.ncbi.nlm.nih.gov/22348448/>

¹⁹ Christiansen E and Morning K. 2017 May 31. Community Health Worker Return on Investment Study Final Report. <https://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Programs/CHW/dta/Publications/CHW%20ROI%20Report%209-26-17.pdf>

²⁰ Fedder DO, Chang RJ, Curry S, Nichols G. The effectiveness of a community health worker outreach program on healthcare utilization of west Baltimore City Medicaid patients with diabetes, with or without hypertension. Ethn Dis. 2003 Winter;13(1):22-7. PMID: 12723008. <https://pubmed.ncbi.nlm.nih.gov/12723008/>

²¹ Kentucky Homeplace. <https://www.ruralhealthinfo.org/project-examples/785>

²² Whitley EM, Everhart RM, Wright RA. Measuring return on investment of outreach by community health workers. J Health Care Poor Underserved. 2006 Feb;17(1 Suppl):6-15. doi: 10.1353/hpu.2006.0015. PMID: 16520499. <https://pubmed.ncbi.nlm.nih.gov/16520499/>

²³ Kangovi S, et al. Evidence-Based Community Health Worker Program Addresses Unmet Social Needs And Generates Positive Return On Investment. Health Affairs, Feb 2020 VOL. 39, NO. 2. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00981>

preponderance of evidence supports that CHWs serving as a part of an integrated care team appear to improve outcomes in:

- Children with asthma with preventable emergency department visits
- Adults with uncontrolled diabetes or uncontrolled hypertension

This evidence includes an emphasis on minority and low-income populations.²⁴

Beginning in 2005, a New Mexico Medicaid managed care plan contracted to pay University of New Mexico Department of Family and Community Medicine \$256 per member per month for CHW services (increased to \$306 in 2007, and to \$321 in 2009); 5 CHWs were employed by the UNM, and one by a partner federally qualified health center; ROI of 3:1.²⁵

The Buckeye Health Plan in Ohio partnered with a community hub to provide CHW services, documenting an ROI of 2.36:1 from over 3,700 deliveries from 2013-2017, with greatest per member per month cost savings for newborns born to mothers with high risk (\$403 PMPM).²⁶

Pooled data (n=1,340) from three randomized clinical trials from 2011-2016, with CHWs employed by health systems, academic medical centers, Veterans Affairs medical centers, and Federally Qualified Health Centers, providing tailored social support, health behavior coaching, connection with resources, and health system navigation showed total number of hospital days per patient in the intervention group was 66% of the total in the control group, with fewer hospitalizations per patient and shorter mean length of stay.²⁷

A randomized clinical trial of CHW intervention at an academic medical center among patients with ACO insurance showed reduced hospital

²⁴ Oregon Health Authority Health Evidence Review Commission, Multisector Intervention Report: Community Health Workers for Patients with Chronic Disease, 2019. <https://www.oregon.gov/oha/OEI/THWMTgDocs/CHW-Multisector-Report-Final.pdf>

²⁵ Johnson D, Saavedra P, Sun E, Stageman A, Grovet D, Alfero C, Maynes C, Skipper B, Powell W, Kaufman A. Community health workers and Medicaid managed care in New Mexico. *J Community Health*. 2012;37(3):563-571. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3343233/pdf/10900_2011_Article_9484.pdf

²⁶ Lucas B, Detty A. Lower first year of life costs for health plan and community hub partnerships, Buckeye Health Plan, 2018 http://www.hcgc.org/uploads/1/0/2/7/102711164/buckeye_hcno_pathways_success--cost_savings.pdf

²⁷ Vasan A, Morgan JW, Mitra N, Xu C, Long JA, Asch DA, Kangovi S. Effects of a standardized community health worker intervention on hospitalization among disadvantaged patients with multiple chronic conditions: A pooled analysis of three clinical trials. *Health Serv Res*. 2020;55(Suppl 2):894-901 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7518822/pdf/HESR-55-894.pdf>

readmissions, reduced missed clinic appointments, and reduced readmissions to rehabilitation for patients discharged to rehabilitation.²⁸

²⁸ Carter J, Hassan S, Walton A, Yu L, Donelan K, Thorndike AN. Effect of community health workers on 30-day hospital readmissions in an accountable care organization population: A randomized clinical trial. *JAMA Netw Open*. 2021;4(5):e2110936
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8138690/?report=printable>

Appendix D: Memorandum

To: Oregon Value-based Payment Compact Workgroup

From: Primary Care Payment Reform Collaborative

Date: December 6, 2021

Subject: Value-based Payment and Primary Care

The Primary Care Payment Reform Collaborative (“Collaborative”) is a legislatively mandated multi-stakeholder advisory body to the Oregon Health Authority (OHA). The Collaborative advises and assists OHA on increasing investment in primary care and using value-based payment (VBP) to align primary care reimbursement and improve reimbursement methods, including by investing in the social determinants of health. The Collaborative also seeks to facilitate the integration of behavioral and physical health in primary care through VBPs.

The legislation that created the Collaborative also directs it to develop strategies that support the use of VBPs in primary care, including the provision of technical assistance, the aggregation of data and alignment of metrics, and evaluation. The Collaborative includes thirty-nine members with expertise in primary care payment representing a range of providers, payers and other primary care stakeholders. Two Collaborative members -- Eleanor Escafi from Cambia Health Solutions and Dr. Elizabeth Powers from Winding Waters Community Health Center -- also sit on the VBP Compact Workgroup.

The Collaborative has a keen interest in Oregon’s VBP Compact and wants to work in partnership with the VBP Compact Workgroup to promote the spread of VBPs across the state. The purpose of this memo is to share recommendations for your consideration regarding primary care and VBPs.

Before presenting the recommendations, it is important to acknowledge the continued impact of the coronavirus on the healthcare system—including primary care. Early in the pandemic, primary care practices experienced an abrupt decrease in patient visits, which led many to struggle financially to keep the doors open. VBP arrangements, particularly population-based payments, allowed some practices the flexibility to meet the changing demands of the pandemic while minimizing the stress of a decreasing cashflow. Even as patient volume has stabilized, the workforce is still impacted by trauma, stress and burnout.

Overarching recommendations

The 2018 Collaborative recommendations called for an aligned VBP structure to support primary care practices to improve quality and reduce health care costs. The Collaborative is pleased with the creation of the VBP Compact Workgroup and strongly urges the following be adopted by the Workgroup:

1. Create alignment of VBP models and metrics across lines of business to eliminate fragmentation, duplication and administrative burden and costs.
2. Design VBPs to address health equity by setting care delivery expectations for provision of person-centered, culturally appropriate care (e.g., community health workers [CHWs] and translation services); and pay incentives to reduce health disparities in quality of care, outcomes, and patient experience.
3. Implement, at a minimum, a blended model of enhanced fee-for-service and per-member-per-month (PMPM) payments to support Patient-Centered Primary Care Homes (PCPCHs) and providers delivering high-quality care.
4. Exclude expensive health care costs for children and adults such as certain specialist procedures and inpatient stays that are largely outside the control of primary care.
5. Collect and analyze quality, access and utilization data by race, ethnicity, language and disability (REALD) to understand health disparities and develop outreach and other mitigation strategies to improve health equity.
6. Incorporate a limited number of metrics from the Health Plan Quality Metrics Committee Aligned Measure Menu Set²⁹ that measure both short- and long-term outcomes, such as primary care engagement of patients who have not previously established with a PCP, and address care across the lifespan.
7. Set improvement targets for metrics when there is a significant gap in performance from established benchmarks. For example, a clinic with a tobacco use rate of 65% could reasonably reduce the rate to 62% while achieving a benchmark of 25% would be very difficult.
8. If using a total cost of care VBP model, outline risks and mitigation strategies in contract such as stop-loss insurance, exclusion of high-cost patients, available networks, and associated rates and pharmacy costs.
9. Recommend primary care practices participating in VBP models be an OHA recognized PCPCH.

Below are additional recommendations specific to the following topics: the continuum of VBP models, attribution, complex care, behavioral health integration and care for children and youth.

Considerations	Recommendations
<p>Continuum of VBP models There is a continuum of VBP models and many primary care practices are not equipped to take on</p>	<ul style="list-style-type: none"> • Implement aligned shared savings models that are more attractive for clinics to participate in and could provide a steppingstone toward more advanced VBP arrangements. • When developing shared risk agreements, ensure they will not negatively impact clinics that are working with the highest risk clients by including representatives from some of these clinics in the development of the agreements.

²⁹Health Plan Quality Metrics Committee Aligned Measure Menu Set Reflecting HPQMC decisions through May 25, 2021 <https://www.oregon.gov/oha/HPA/ANALYTICS/Quality%20Metrics%20Committee%20Docs/Aligned-Measures-Menu.pdf>

Considerations	Recommendations
full financial risk for patients.	<ul style="list-style-type: none"> Implement appropriate risk adjustment for addressing high-cost patients. Leverage the experience of Massachusetts. Risk-adjust for youth separately from adults to adequately address the complexities of children’s health conditions and risk factors.
<p>Attribution Better attribution alignment and transparency will improve practice understanding of and success in VBP models.</p>	<ul style="list-style-type: none"> Payers, providers and patients need to work collaboratively to ensure accuracy and agreement about patient attribution. Clearly communicate at the beginning of the VBP performance period—in advance of care delivery—which providers can take on accountability for patients, prioritizing primary care providers. Regularly communicate member assignment to primary care providers with opportunities for providers to make corrections. Allow and facilitate member selection of a primary care provider within the applicable network at time of enrollment across lines of business. If patient input cannot be obtained, attribute patients to providers based on claims evaluation and management visits for a minimum of 24 months, prioritizing primary care and preventive care visits.
<p>Complex care Providers who deliver care to patients with complex health and social needs require support to maintain services.</p>	<ul style="list-style-type: none"> Implement appropriate risk adjustment for addressing high-cost patients. Risk-adjust for youth separately from adults to adequately address the complexities of children’s health conditions and risk factors. Work towards development and adoption of a risk adjustment model that incorporates the impact of social determinants of health and health related social needs on outcomes for any VBP model. Leverage the experience of Massachusetts. Implement an enhanced PMPM based on comprehensive risk stratification for health and social needs that fully captures the cost of providing complex care.
<p>Behavioral health integration VBPs can sustainably support integrated team-based behavioral health care in primary care.</p>	<ul style="list-style-type: none"> Pay primary care providers and behavioral health clinicians working in a clinic with integrated health care for an agreed-upon set of FFS codes with no pre-authorization requirements. Include population-based payments, based on meeting standards of integration or quality benchmarks, that sustainably support key elements of behavioral health integration in primary care that are not typically paid for under FFS mechanisms, such as same-day brief consultations; preventive behavioral health; warm hand-offs between the primary care provider and the behavioral

Considerations	Recommendations
	<p>health clinician; behavioral health clinician participation in pre-visit planning and team huddles; consultations between primary care and behavioral health clinicians; and care coordination and communication, especially outside the primary care clinic, including with specialists, schools, teachers, community services, etc. Payment models include risk adjusted PMPM based on meeting standards of integration or benchmarks.</p> <ul style="list-style-type: none"> • For VBPs use both child and adult measures such as behavioral health screening and intervention, population reach, access to care, patient experience or other outcomes and physical health measures that are impacted by behavioral health integration such as HbA1c, blood pressure, and nicotine use, asthma medication adherence and ADHD medication adherence. • Contract with integrated clinics for all services delivered at the clinic in a single contract that does not require prior authorization for behavioral health services and double co-payments for patients who see a primary care provider and behavioral health clinician on the same day. • Remove policies that reject two payments for services provided on the same day by a primary care provider and behavioral health clinician.
<p>Children and youth VBPs are appropriate for health care for children and youth if they take into account the unique aspects of pediatric care.</p>	<ul style="list-style-type: none"> • Risk-adjust for youth separately from adults to adequately address the complexities of children’s health conditions and risk factors. • Structure VBP models to incentivize increased screening, preventive care and effective management of chronic health conditions, recognizing that investment in children’s health and well-being may support lifelong wellness and result in a long-term return on investment for society. • Recognize that there are limited opportunities for short-term, direct health care cost savings among pediatric populations compared to adult populations. VBP models that incentivize short-term cost savings may not optimally serve most pediatric patients.

Next steps

Thank you for the opportunity to share these recommendations for consideration. The Collaborative requests a response describing how the recommendations will be integrated into the Workgroup activities. The Collaborative looks forward to further engagement with the Workgroup and is available to speak to the Workgroup on specific topics and answer questions.

The following members of the Collaborative endorsed these recommendations

Advanced Health	Oregon Rural Practice-based Research Network
Atrio Health Plans	OSPIRG
CareOregon	PacificSource Health Plans
Central City Concern	Providence Health Plans
Central Oregon Independent Practice Association	Providence Medical Group – Oregon
Children's Health Alliance	Public Employees' Benefit Board
Columbia Pacific CCO	Regence & Cambia Health Solutions
Creach Consulting, LLC	Samaritan Health Plans
Grants Pass Clinic, LLP	Trillium Community Health Plan
Hagan Hamilton Insurance Solutions	Tuality Health Alliance
Health Net Health Plan of Oregon, Inc.	Umpqua Health Alliance
Health Share of Oregon	Willamette Family, Inc.
InterCommunity Health Network CCO	Winding Waters Clinic
Legacy Health	WVP Health Authority
Metropolitan Pediatrics	Yamhill Community Care Organization
Mountain View Medical Center	
OCHIN	
OHSU Family Medicine at Richmond	
Oregon Academy of Family Physicians	
Oregon Association of Hospitals & Health Systems	
Oregon Department of Consumer and Business Services	
Oregon Educator's Benefit Board	
Oregon Medical Association	
Oregon Pediatric Improvement Partnership	
Oregon Primary Care Association	