

OREGON HEALTH AUTHORITY

# State Innovation Model Operational Plan Update

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State of Oregon

August 1, 2014



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## **Oregon State Innovation Model Operational Plan Update Foreword**

As we complete Year 1, we want to thank CCMI for the contributions the State Innovation Model (SIM) resources have made this past year and look forward to a continued partnership as we move into Years 2 and 3 to fuel Oregon's efforts towards the triple aim. The CMMI investment in Oregon through the SIM award to date supports the acceleration of health transformation in our state. The SIM grant fuels the spread of the coordinated care model from the Medicaid population to other payers and populations more quickly and effectively than if the SIM resources were not available to support our leading-edge work.

As detailed in Oregon's October 2013 Operational Plan, the SIM grant supports the Oregon Health Authority (OHA) and its Transformation Center in coordinating implementation, spreading health care innovations and lessons learned, and evaluating the coordinated care model. This update highlights some of Oregon's accomplishments supported or enhanced by SIM funding and outlines any variations from our original operational plan.

### **Coordinated care model elements – this is what we're doing and what we're testing**

Elements of the coordinated care model include:

- Disseminating best practices to manage and coordinate care
- Sharing responsibility for health
- Measuring performance
- Paying for outcomes and health
- Providing information
- Managing a sustainable rate of growth

SIM funding has allowed the work to go further and faster and is critical for us to touch more Oregonians and move beyond Medicaid, which our CMS waiver initiated as the first application of the coordinated care model. SIM also provides funding for a comprehensive evaluation to help other states learn what key steps and tools work to transform the delivery system and achieve the triple aim: better health, better care and lower costs.

- If SIM funds were not available, Oregon would not have been able to develop a robust Transformation Center and its activities, such as learning collaboratives that are now available to CCO staff, community advisory councils, and other payers and providers across the state. The center's efforts provide rapid sharing of evidence-based and emerging best practices, information and lessons learned through innovation. It is key support that enables good ideas to travel faster.
- SIM funds allow Oregon to provide a rich offering of additional tools and resources to support innovation and develop a culture of innovation that helps the state's Innovator Agents and OHA, in partnership with our stakeholders, support transformation of Oregon's delivery system.
- SIM funding allows the coordinated model to spread more quickly and with more success beyond Medicaid to state employees, Oregon's educators, Medicare and other additional payers and employers across the state.

- With SIM funding in Year 1, we have already achieved our SIM Year 2 target to certify 500 clinics as patient-centered primary care home certified, and are now engaging approximately 43,000 primary care providers in the coordinated care model.
- SIM funding allows Oregon to continue to assist primary care clinicians across the state by providing support to the Oregon Patient-Centered Primary Care Institute (PCPCI), which works in collaboration with the Transformation Center to spread best practices and adopt the primary care home model, a core element of Oregon's model.
- Since payment drives change, SIM has made it possible to bring all of the commercial and public payers to the table to achieve consensus on Oregon's multi-payer strategy to support primary care and continue conversations with these key stakeholders for additional alignment of payment towards outcomes.

The funding also allows for a thorough assessment of the model as a whole, and of its key elements. This will allow us to understand innovations that are making a true difference in improving health while lowering costs – and then to further spread these innovations across the health system and share with other states.

*The focus of our innovation and spreading the coordinated care model*

Oregon's SIM grant focuses on innovation in three areas: innovation and rapid learning, delivery models and payment models. Work includes:

- Integrating and coordinating care among primary, specialty, mental and behavioral, and oral health providers;
- Engaging patients and consumers in their own care for better outcomes;
- Engaging providers in health system transformation;
- Improving community health through local partnerships that support promotion and prevention activities, including funding pilot projects in local health departments to promote integration of public health and health care, innovation and healthy communities;
- Implementing more effective health care payment models that incentivize better health;
- Encouraging consensus building to support primary care payment and other payment reform, which now includes more than 25 payers, provider organizations and other key partners;
- Implementing and sharing across Oregon's health care sector those innovations and best practices that reduce health disparities;
- Supporting health information technology and exchange – building on other funding in Oregon with SIM investments and technical assistance to ensure innovation and successful implementation;
- Improving quality and health outcomes for those eligible for both Medicaid and Medicare; and
- Integrating long-term services and supports – reviewing options for shared accountability between long-term care and CCOs.

Key activities that support transformation beyond Medicaid:

- Learning collaboratives;
- Council of Clinical Innovators;

- Bringing payers and providers together for alternative payment efforts initially in primary care and now exploring spreading to broader payment approaches;
- Bringing together the hospitals across the state to coordinate care and align payments with the transforming health care delivery system;
- Technical assistance in the areas of promoting health;
- Technical assistance in the areas of promoting health equity, consumer engagement and provider engagement;
- Improving the state's analytic infrastructure and tools to allow for more integrated, linked and accessible data in a secure environment to support data analytics needs at multiple levels and improve transparency of health and health care data;
- Implementation and evaluation support for the housing with services program – a new model moving forward to incorporate housing and social services to improve health outcomes for low income, single adults and people with disabilities; and
- Coordination with early learning councils and hubs, focusing specifically on kindergarten readiness to integrate education efforts with health reform.

SIM funding allows assessment of:

- Success of the overall model in Medicaid, where it was first implemented, which will guide efforts to spread the model to other markets;
- Individual key payment, delivery system and support elements to determine how much each contribute to the overall success;
- The degree and pace of spread of the coordinated care model to other payers and populations, specifically public employees, educators and Medicare; and
- Best practices and learning for other states.

#### *Willingness to spread Oregon's model*

Oregon is in the unique position of being a national leader in health care reform efforts. Governor Kitzhaber continues to invite collaboration with CMS, CMMI and other state governors to develop multi-payer strategies and move forward to aid other states around a common set of core principles that focus on fiscal sustainability and changing the way care is organized. Oregon is in a positive position to share our accomplishments and experience in health reform and support the efforts at the national, state and local levels to transform the health care delivery system to produce better health and better care at lower cost.

## Overview

Oregon's health system transformation continues to enjoy broad support from Oregon's Governor, Legislature, state agencies, community leaders and the private sector. The State Innovation Model (SIM) project leverages and supports progressive implementation steps for Oregon to successfully transform its delivery system to achieve the three-part aim:

- Improve the lifelong health of all Oregonians;
- Increase the quality, reliability and availability of care for all Oregonians; and
- Lower or contain the cost of care so it is affordable for everyone.

Oregon's commitment to the coordinated care model is demonstrated through an intentional coordinated and strategic multi-year planning and implementation process that included extensive public discussion across the state and active engagement by the Governor, Legislature and Oregon Health Authority (OHA), and in partnership with the Oregon Insurance Division and Oregon's health insurance exchange, Cover Oregon. This high level of coordination in planning and implementation continues today, now fueled by the SIM grant, to extend the coordinated care model across the delivery system in Oregon. Oregon has achieved many significant mileposts during the first demonstration period and anticipates continued forward momentum in Years 2 and 3.

Oregon's October 2013 Operational Plan has extensive details of our planned activities that are now underway and moving forward. Over the course of the first demonstration year, leadership across Oregon at all levels exemplified the engagement, innovation and commitment necessary to make health care transformation in Oregon a success.

## Year 1 accomplishments

### Governor's engagement in oversight and implementation

Governor John Kitzhaber continues to actively and directly lead development of Oregon's framework for delivery system redesign and implementation of the coordinated care model. His level of commitment is reflected not only in his hands-on executive leadership, but also in numerous interviews and articles (see Appendix 1). The Governor's Office meets weekly with leadership from the Oregon Health Authority, the Department of Human Services, the Oregon Insurance Division and Cover Oregon (Oregon's health insurance exchange) to continue strategic policy development that will ensure that both public and private health care purchasing are increasingly aligned around the coordinated care model.

Governor Kitzhaber participated as co-chair of the National Governors Association Health Care Sustainability Task Force during this past year to identify legislative and regulatory actions the federal government can pursue to reduce barriers to innovation and further support state health initiatives. Recommendations were approved in February 2014 and mirror many of the key elements of Oregon's coordinated care model, including 1) financial sustainability in Medicaid

and reducing the growth rate of spending; 2) flexibility to pursue delivery system changes that achieve desired outcomes; 3) federal investment with states who demonstrate a return on that investment in Medicaid and can leverage those efforts with multiple payers; 4) payment for performance outcomes instead of volume; 5) accountability and transparency with common metrics across payers, including Medicare; and 6) multi-payer strategy that partners with Medicare and the private sector to pursue health care reform efforts beyond Medicaid. These recommendations have helped to shape a new Innovators program for states in partnership with CMS, CMMI, the NGA and other national experts, which is launching this summer.

## **Oregon Health Policy Board**

The Oregon Health Policy Board is the nine-member, citizen-led policy-making and oversight body for the Oregon Health Authority. Formed by the same legislation that created the health authority, the health policy board has a broad mandate for health care transformation and its membership includes key leaders from the provider community, labor, large and small businesses, and insurance.

### *Governor's direction to the Oregon Health Policy Board*

Oregon's SIM goals and activities take place in the context of the Governor's vision and direction for overall health system transformation. In June 2013, Governor Kitzhaber directed the Oregon Health Policy Board to develop recommendations to align Oregon's implementation of the Affordable Care Act with Oregon's health system reform efforts and spread the triple aim goals across all markets.

In response, the health policy board convened on five occasions over five months during 2013 to develop a process, review policy options and recommend actions that met the Governor's charge. Manatt Health Solutions and Georgetown University's Health Policy Institute, supported by the Robert Wood Johnson Foundation, provided technical and policy guidance. In December 2013, the health policy board responded with a number of recommended strategies and actions.

### *Recommendation 1: Measure the effects of ACA and health system transformation implementation.*

- OHA and Oregon Insurance Division use All-Payer All-Claims Database and other data sources to create a measurement framework which includes multiple tiers of data and a public-facing dashboard with measures of utilization, cost, coverage, quality and health equity.
- Action steps:
  - Multi-payer dashboards released in March and June 2014; updates expected quarterly
  - All-Payer All-Claims Technical Advisory Group is in beginning stages of formation (July 2014)

*Recommendation 2: Establish a predictable and sustainable rate of growth.*

- Action steps:
  - A sustainable health expenditure work group is in the early stages of development as of July 2014. This work group will be responsible for determining a sustainable rate of growth methodology by December 31, 2014.

*Recommendation 3: Focus on primary, preventive and chronic care.*

- Improve quality and contain costs by expanding an innovative and outcome-focused primary preventive and chronic care infrastructure and by supporting metrics alignment at the provider level.
- Action steps:
  - Thanks to the availability of SIM technical assistance, the Center for Health Care Strategies and the State Health Access Data Assistance Center produced an informal research paper defining policy options to stimulate multi-payer investment and strategies to track and assess investments in primary care.

*Recommendation 4: Move the foundation of Oregon's health system transformation – the coordinated care model – forward by spreading the model to the broader marketplace.*

- Embed elements of the coordinated care model in Public Employees' Benefit Board and Oregon Educators' Benefit Board purchasing strategies.
- Action steps:
  - The Public Employees' Benefit Board contract negotiations are complete (June 2014) and successfully incorporated many of the coordinated care model principles. Open enrollment is scheduled to begin October 1, 2014, for the 2015 benefit year.
  - Additionally the coordinated care model principles are being operationalized in the metrics alignment work group that was convened to identify common metrics for Public Employees' Benefit Board, Oregon Educators' Benefit Board and qualified health plans offered on the exchange.

The Coordinated Care Model Alignment Work Group (consisting of representatives from Public Employees' Benefit Board, Oregon Educators' Benefit Board and Cover Oregon) was initially established in September 2013 to guide the Oregon Health Policy Board in spreading the coordinated care model beyond Medicaid. See Appendix 2 for the work group's progress report to the health policy board as of December 2013.

On the recommendation of the health policy board after that progress report, a similar work group has been created to continue this effort. The new work group will be responsible for sharing best practices and ensuring coordinated care model alignment across organizations and their respective health plan contracts over the course of the next few years. By December 31, 2016, coordinated care model principles will be embedded in Public Employees' Benefit Board and Oregon Educators' Benefit Board purchasing strategies and incorporated in individual and small group commercial plans sold in Oregon. See Appendix 3 for the charter of the newly established continuation work group.

*Recommendation 5: Enhance and improve rate review.*

- A small set of cost and quality metrics, many similar to our Medicaid CCO metrics, have been selected for informal inclusion in rate review filings for 2015 (See Appendix 4 for a crosswalk of different metric sets in use in Oregon.)
- Rates will be approved and finalized by August 1, 2014.
- Rules were adopted to update filing standards to reduce the amount of correspondence with insurers during rate review, integrate ACA-related rate requirements and eliminate redundant requirements.

*Oregon Health Policy Board partnership with the Early Learning Council*

The health policy board established a joint subcommittee with the state's Early Learning Council to make recommendations for aligning early learning and health system transformation in 2013. The Early Learning Council adopted a statewide kindergarten readiness assessment, which is a shared goal with the health policy board that launched in the fall of 2013. The subcommittee is also working on establishing shared incentives, a shared measurement strategy, and adopting and implementing a statewide system of screening across the early learning system and health system. Additionally, the Early Learning Council has moved forward on the creation of early learning "hubs," which are self-organized community-based coordinating bodies created to provide a system approach to early childhood education that works to improve efficiency and outcomes for our youngest children. By July 1 of 2014, Oregon will have 14 of these regional collaboratives coordinating services for the state. These hubs will be responsible for coordinating services across sectors, moving away from the isolated impact of a programs approach and moving toward the collective impact of a systems approach, including the health system. Hubs were selected, in part, for how well they demonstrated coordination with their local coordinated care organizations.

**The Transformation Center**

The Oregon Health Authority's Transformation Center, supported by SIM funding, serves as the internal and external transformation hub around which public and private efforts to test key model elements are coordinated. The Transformation Center focuses on spreading best practices by both improving OHA internal processes and coordinating support for innovation in health care delivery systems. SIM supports leadership positions responsible for guiding the work of the center, including the Transformation Center executive director, director of systems innovation, director of clinical innovation and the director of operations.

**Oregon Health Leadership Council**

The Oregon Health Leadership Council is a collaborative organization composed of public, private and nonprofit sector leaders working together to develop approaches to reduce the rate of increase in health care cost and premiums so health care and insurance are more affordable. Thanks to SIM support and collaboration with the health leadership council, transformative work took place in two critical arenas.

With the support of the SIM grant, the Oregon Health & Science University's Center for Evidence-based Practice convened and facilitated the Multi-Payer Primary Care Payment Strategy Work Group, which includes all the major commercial insurers in the state, representatives of the new Medicaid CCOs, primary care provider organizations and the state. Through a consensus process, they produced recommendations for strategies for public and private payers to support primary care homes in Oregon. The end result is that nearly all commercial and public payers in Oregon (excluding Medicare fee for service) will offer structured payments using Oregon's patient-centered primary care home recognition standards to support patient-centered primary care homes. Payers will establish the amount, the type of payment and timeline for implementation with the providers in their networks. As purchasers, the Public Employees' Benefit Board, Oregon Educators' Benefit Board and Medicaid are also aligning with this agreement through their contracting processes. Ongoing work on next steps for multi-payer alternative payment collaboration is continuing in partnership with the health leadership council, with focused interviews with health plan, health care delivery system and provider stakeholders.

Additionally, our partnership with the Oregon Health Leadership Council has supported the development and implementation of the Emergency Department Information Exchange (EDIE), a web-based communication technology that enables intra- and inter-emergency department communication. EDIE has been supported by SIM funds and continues to progress further in its implementation, aiming for 100 percent hospital participation by November 1, 2014. As of May 1, 76 percent of Oregon hospitals have begun the IT integration progress, and 32 percent have live feeds. The EDIE Governance and Operations Committee meets frequently and recently gained approval from the health leadership council and coordinated care organizations for a proposed financing strategy that would support ongoing costs and expansion of EDIE through a shared utility model.

### **Health information technology leadership**

The Health Information Technology Advisory Group guides the development and implementation of critical health information technology infrastructure to support health care transformation and CCO efforts. Thanks to SIM support, the Provider Directory Subject Matter Experts Work Group provides guidance on scope, functions and parameters of a state-level provider directory. Accomplishments this year include the launch of the Emergency Department Information Exchange described above and the Provider Directory. See Section E for details on health information exchange and technology progress and planning for next periods.

### **Mechanisms to coordinate public and private efforts**

As mentioned above, ongoing work in partnership with the Oregon Health Leadership Council includes continued dialogue and engagement towards multi-payer strategies for payment reform beyond the primary care consensus work. The Oregon Health Authority has again contracted with the Center for Evidence-based Practice to prepare materials to assist CCOs with implementing alternative payment methods. The center has completed three stages of a five-stage process by analyzing the published literature on alternative payment models, conducting interviews with 18 Oregon thought leaders, and presenting preliminary results from this work at

six stakeholder meanings. This summer, the center will interview individuals with experience implementing alternative payment models and begin developing tools and strategies for CCOs to use in their alternative payment model development. The work will be completed in the fall with a written report including analysis of findings and tools and strategies for implementation. Please see Appendix 5 for an overview of this work and Appendix 6 for a presentation on preliminary findings.

An approved state plan amendment submitted to CMS for alternative payments for a pilot group of federally qualified health centers in Oregon has been operational since January 2014. Four Oregon clinics are being paid on a per-member, per-month basis for their wraparound payments prospectively instead of being paid retrospectively based on fee-for-service units. This allows more predictable funding expectations for the health centers to implement new and innovative ways to engage and manage patients as well as enhance efforts to recruit and retain doctors. New efforts will bring in Oregon's most populated county's federally qualified health centers, (Multnomah, in the Portland area) starting in August this year. We anticipate continued interest from other federally qualified health centers in the state. Data is being collected for the initial four sites to help the state and the clinics to understand the impact of this new payment structure.

Another integrative effort undertaken in Oregon was the study group on integrating long-term services and supports into the global budgets of CCOs. A final report was sent to CMS on December 20, 2013 (see Appendix 7). The work group made recommendations to better integrate and coordinate long-term services and supports with health systems and provide a road map for the future. The framework includes:

- Developing shared accountability and shared savings through flexible and outcome-focused metrics, incentives and penalties, financial mechanisms to address inappropriate cost shifting, risk adjustments, alternative payment methods and other financial mechanisms – yearly milestones, metrics development, baseline and financial mechanisms will be phased in over a four-year period with full implementation before 2018;
- Emphasizing the importance and need for better coordination across systems using a team-based approach, as well as reducing duplication and inefficiency through clearly defined interdisciplinary team roles and responsibilities;
- Selecting the appropriate lead entity for care coordination on the basis of its risk bearing responsibility, its capacity, and its links to Patient-Centered Primary Care Homes, as well as knowledge of an individual's needs; and
- Supporting and encouraging local control through data-driven innovation, contract flexibility and innovative pilots; barriers to contracting are identified and removed as appropriate.

Ultimately, the study group did not recommend that long-term services and supports be included in CCO global budgets. Shared strategies to follow up on the recommendations for alignment and coordination without budgetary integration are under development and progress will be reported in subsequent SIM reports.

In addition, OHA is working with the Oregon Association of Hospitals and Health Systems Small and Rural Hospital Committee, which has established the Rural Health Reform Initiative

to prepare Oregon's 32 type A/B<sup>1</sup> hospitals for transitioning to alternative payment methods consistent with coordinated care. The goal of this work was to examine alternative payment and delivery models and to coordinate with both federal and state leaders to develop solutions not only in support of the financial sustainability of small rural hospitals, but also of the coordinated care model. Working with three independent consultants and an independent actuarial firm, the advisory work group developed a method to evaluate a hospital's readiness to transition to the new payment methods. Using this tool, the advisory work group recommended that of the 32 rural hospitals in Oregon, 18 should transition to an alternative payment model aligned with coordinated care, and 14 should maintain cost-based reimbursement. This process will be revisited every two years to reevaluate which hospitals should continue with an alternative payment model. Please see Appendix 8 for additional details.

### **Outreach to stakeholders**

The state has been working with stakeholders on reforming health and health care since 2007, when the Oregon Health Fund Board first began its work. Regular communication with stakeholders, public feedback and testimony has been an essential component throughout Oregon's health care transformation. With funding through SIM, Oregon intends to maintain a high level of public and stakeholder engagement throughout the grant period, as the coordinated care model is spread.

#### *CCO tours*

In May and June of 2013, OHA leadership conducted listening sessions with each of the CCOs. OHA members included: the chief medical officer and SIM principal investigator, the director of the Transformation Center, and the administrators for health analytics and health information technology. CCO participants included chief executive officers, chief operating officers and information technology staff. The purpose of the listening tour was to understand the priorities and needs of the CCOs so OHA could design effective and relevant technical assistance and supports. A second tour focused on enhancing communications, especially around operations, just concluded in the spring of 2014. The new OHA chief of policy, the Medicaid director and the director of Addictions and Mental Health all participated in the second tour. These efforts have been invaluable to understanding the work underway across the regions served by the CCOs and to build relationships.

A major component of the coordinated care model is integrating physical and behavioral health systems. In May and June 2014, Dr. Pamela Martin, director of the Addictions and Mental Health Division, and Leslie Clement, chief of health policy and programs, hosted six town hall meetings across the state to discuss the state's behavioral health system. The goal was to develop a comprehensive strategic plan that would create an integrated, coordinated and culturally competent behavioral health system that provides better health, better care and lower costs for all Oregonians. The feedback from the meetings is being used to develop a two to five-year strategic plan, which will then be presented to stakeholders for additional input. Please see Appendix 9 for the announcement of the meetings.

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<sup>1</sup> Type A and B hospitals are small, rural hospitals that receive cost-based reimbursement by Medicaid in Oregon. Many are also designated as critical access hospitals by Medicare.

In September, Oregon's Public Employees' Benefit Board will be communicating to more than 130,000 individuals across the state. The board will be holding a series of statewide meetings where employees and their families can learn more about new plans offered for 2015, all of which have coordinated care model elements. It will also be an opportunity to learn more about how these plans are bringing better health, better care and lower costs to public employees through the coordinated care model.

## Legislation

Since the original state innovation plan and SIM application were provided to CMMI, additional work has been under way during the 2013 legislative session that concluded in July. Updates to the legislation are as follows:

[HB 2279](#) allows local government entities to join the Public Employees' Benefit Board or Oregon Educators' Benefit Board, potentially expanding the reach of Oregon's SIM activities.

- Public Employees' Benefit Board: The 2015 plan rates were released in June 2014, and the plan expects more activity and interest in this opportunity as a result. Staff recently met with a large county in southern Oregon and provided them with information regarding plan participation.
- Oregon Educators' Benefit Board: The following local governments have joined: Josephine County (1/1/2014), Klamath County (7/1/2014) and Coquille Valley Hospital (Special District, joined 7/1/2014). Several other local governments have also inquired and are considering joining.

[HB 2118](#) established the Health Plan Quality Metrics Work Group to recommend a core set of health outcomes and quality measures for use by Cover Oregon, OHA, Oregon Educators' Benefit Board and Public Employees' Benefit Board. The work group's final report (see Appendix 10) identified a small number of measures that have been defined by expert organizations and are relevant for Oregonians enrolled in Medicaid CCOs, qualified health plans available through Cover Oregon, and Oregon Educators' Benefit Board and Public Employees' Benefit Board contracted health plans. The recommended measures include 13 Phase I measures that can be reported immediately and 15 proposed Phase II measures that can be reported when needed data are more easily accessible and specifications for all measures are fully developed.

[HB 2216](#) directs OHA to establish a hospital performance metrics committee with representation from hospitals, CCOs and performance measurement experts. The group will recommend three to five quality measures and related benchmarks to be used to reward hospitals for their performance and distribute funds from the hospital 1 percent quality incentive pool (see Sections G and I for more information).

- This work group has met five times from February to July 2014. Additional information can be found at: <http://www.oregon.gov/oha/Pages/http.aspx>

[HB 2013](#) specifies that OHA and Oregon's Early Learning Council shall work collaboratively with CCOs to develop performance metrics for prenatal care, delivery and infant care that align with early learning outcomes. As described earlier in this section, the Early Learning Council

and Oregon Health Policy Board joint subcommittee is in the process of defining shared incentives, shared metrics and a shared measurement strategy.

[HB 2859](#) establishes a work group to identify strategies to meaningfully engage Oregon Medicaid patients in their health care and to set parameters for a grant program that would support CCO pilot projects focused on patient engagement and responsibility. The work group developed a set of recommendations. Please see Appendix 11 for the full report. Several of the recommendations were tasked to the Transformation Center for follow-up action.

[SB 604](#) directs OHA to create a statewide database for health care provider credentialing. Related bills direct OHA to establish credentialing standards for telemedicine and to update credentialing review of mental health providers. Reducing administrative burdens for providers and removing waste in the system – as these bills aim to do – is part of Oregon’s transformation strategy. The common credentialing work is closely related to ongoing work for a provider directory in Oregon’s health information exchange efforts. More details are available in Section E.

- Stakeholders have been meeting monthly to assist OHA in implementing this program and have helped to finalize rules and develop a Request for Proposal to be released by July 2014. OHA’s goal is to ensure an efficient and effective solution that will be optional by January 2016 as mandated. More information can be found at: <http://www.oregon.gov/oha/OHPR/Pages/ccag.aspx>

## **Years 2 and 3**

### **Changes in leadership**

The Oregon Health Authority (OHA) has experienced transitions in leadership during this past year. Suzanne Hoffman currently serves as the interim director of OHA, replacing Dr. Bruce Goldberg. Tina Edlund (who is currently the Governor’s lead for the Cover Oregon technology transition project) has had Leslie Clement assume her duties as the chief of health policy and programs. Linda Hammond is the chief of operations. Dr. Jeanene Smith, as the OHA chief medical officer, has been tasked to develop the Clinical Services Improvement Office to coordinate clinical and quality innovation efforts across the system. Dr. Smith also continues to serve as the administrator of the Office of Health Policy and Research and as the SIM principal investigator. The SIM Steering Committee is composed of Dr. Smith, Ms. Clement, Cathy Kaufmann (director of the Transformation Center) and Lisa Angus (policy development director of the Office of Health Policy & Research and the SIM evaluation leader). In addition to this executive level oversight, the SIM project director, Beth Crane, convenes a monthly SIM operations team meeting to coordinate activities and actively problem solve as necessary to maintain progress on SIM milestones. See Appendix 12 for a revised SIM organizational structure diagram.

The changes in leadership have occurred smoothly, thanks to a great deal of guidance and support coming from current leaders, previous leaders and staff. Suzanne Hoffman, the interim director, stated in her first weekly Director’s Message that she will focus on the mission to:

“Keep moving forward. Keep moving forward on health system transformation. Keep moving forward on improving community mental health services. Keep moving forward on the improvements that are happening in Public Health, Oregon State Hospital and across the agency. We have a depth of experience and knowledge at OHA. I know we have what it takes to pick up the batons that have been handed to us.”

In their first few months in new positions, Suzanne Hoffman, Leslie Clement and Linda Hammond also conducted multiple face-to-face meetings with staff to introduce themselves, discuss priorities and increase communication and transparency (see notes under Stakeholder Engagement above and Appendix 13).

As expected, some of the Oregon Health Policy Board’s membership has shifted over the past year due to terms expiring and job changes. The new members, listed below, were carefully selected to give the board broad insight into a variety of sectors that are impacted by health care transformation.

- *Zeke Smith* – Zeke Smith is currently the chief impact officer of the United Way of the Columbia Willamette, where he leads the community impact strategy through grant making, volunteerism, community convening and policy work. Previously, Zeke served in a variety of leadership roles within the Portland Public Schools, the Portland Schools Foundation, the Boys & Girls Club and the Youth Employment Institute.
- *Lisa Watson* – Lisa Watson is the owner and founder of Cupcake Jones, a Portland-based bakery that opened in 2007 and today employs ten people. As a small business owner, Lisa is committed to providing majority employer-paid health insurance to her staff. Currently, Lisa serves as a board member for Travel Portland, a committee member for Our House of Portland, and is a member of Entrepreneur Organization’s Accelerator Program. In the past, Lisa has served as a business leadership council member for Basic Rights Oregon and volunteered with the Oregon Food Bank, the Portland Classical Chinese Garden, Cascade AIDS Project and Planned Parenthood of the Columbia Willamette. Lisa is a native Oregonian and a tribal member of the Confederated Tribes of Grande Ronde.

## Section B

## Coordination with Other CMS, HHS, and Federal or Local Initiatives

### Overview

In Oregon, many CMS, HHS, CMMI and other federal initiatives have been operating as transformation has been underway. Tying these initiatives into the work being done through SIM provides vital alignment that supports a more efficient, sustainable and unified health care system. Coordination occurs through direction and guidance from advisory committees, public-private partnerships, the Governor’s Office and the Oregon Legislature, all supported by the Oregon Health Authority. Below is an update and status report on many of these previously outlined in our 2013 Operational Plan. Also see Appendix 14 for a visual representation of connections between key stakeholders for health system transformation in Oregon.

## Year 1 accomplishments

### Medicaid demonstration and ACA expansion into the Oregon Health Plan

The implementation of the Affordable Care Act and Oregon Medicaid expansion has resulted in 349,468 additional Oregonians enrolled in the Oregon Health Plan (Medicaid) since December 2013, for a total of 963,851 enrollees, (25 percent of the population of Oregon) with the majority joining CCOs for their care. Oregon has been successful in offering the coordinated care model to the dually eligible with 55 percent of dually eligible persons enrolled in a CCO. Since 74 percent of Oregon providers see Medicaid and Children's Health Insurance Program enrollees, efforts to fulfill our waiver obligations through the CCOs will echo throughout the delivery system and further support extension of the model across all payers.

### Cycle 3 CCHIO grant

OHA is collaborating with the Oregon Insurance Division on a Cycle III rate review grant from the Center for Consumer Information & Insurance Oversight. Partnering also with the Oregon's Aligning Forces for Quality entity, the Oregon Health Care Quality Corporation (Q Corp), the agencies are working to improve the quality, timeliness and usefulness of the All-Payer, All-Claims database for rate review and health care price transparency to identify and appropriately address privacy, antitrust and trade secret risks associated with price transparency; adopt analytical tools such as groupers, provider or facility identifiers, or risk adjusters; and to otherwise improve technical and organizational infrastructure to collect, manage, validate, analyze, distribute and communicate data. The activities under this grant respond directly to the Governor's charge to increase transparency and accountability and to enhance the rate review process.

### Federal primary care initiatives: Health homes and comprehensive primary care

#### *Multi-payer Consensus on Primary Care*

While payments available through Oregon's [Medicaid Health Home ACA Section 2703 program](#) ended just at the start of Year 1, OHA and the state are committed to sustaining resources towards primary care transformation. Thanks to SIM funding, OHA and the Oregon Health Leadership Council brought together the majority of payers in the state with representation from the providers and hospitals in November 2013, which resulted in a commitment to support primary care. This consensus, signed by those participating, agreed to use Oregon's Patient-Centered Primary Care Home recognition as a common definition of "medical homeness" as well as provide financial support based on that recognition. The agency is currently working with payers and other stakeholders to assess implementation progress. The Oregon Health Policy Board is also considering other strategies to strengthen Oregon's primary care infrastructure that could be used in conjunction with the multi-payer agreement.

#### *Comprehensive Primary Care (CPC) Initiative*

In Oregon, 552 providers in 67 clinics (with 52,172 Medicare beneficiaries) are participating in the Comprehensive Primary Care Initiative. Participating payers include CareOregon, Oregon Health Authority, Providence Health Plans, Regence BlueCross/BlueShield, Teamsters Multi-

Employer Taft-Hartley Funds and Tuality Health Alliance. While per-patient, per-month expenditures and emergency department visits for participating Medicare beneficiaries have risen during the first year of the initiative, hospital admissions and 30-day unplanned hospital readmissions have declined. These findings are aligned with outcomes seen in all seven participating comprehensive primary care regions combined. Clinics are also evaluated across six dimensions of primary care. In Oregon, clinics were rated highest on access and continuity and lowest risk-stratified care management. Again, this was consistent with findings across all seven regions.

Participation in the initiative has allowed OHA to better coordinate multi-payer discussions around sustainability of primary care transformation more broadly through support of the state's Patient-Centered Primary Care Home Program. Recognition by the program is one of the milestones that each clinic must meet to continue participation in the comprehensive primary care initiative. There is currently discussion of how best to align sustainability conversations with the multi-payer consensus group that was convened as a part of SIM activities. Both payers and providers are working to ensure those discussions are coordinated and not carried out exclusive of each other. This will be the focus of the participating payers' work over the course of the next year.

#### *CMS Health Commons Grant Initiative with HealthShare*

The initiative is nearing the two-year mark on the three-year Health Commons Grant which was awarded through Providence Health System to our largest coordinated care organization, HealthShare. Through an amazing collaboration across the multiple health care organizations of the largest urban center of Oregon that make up HealthShare, a complex set of initiatives were launched with a focus on Medicaid "high utilizers." This has stimulated many innovative care coordination efforts across the HealthShare network of care. A comprehensive evaluation framework is now in place and work has reached the point where program data can be analyzed to determine intervention effectiveness; where outcomes are being achieved as hoped for; where efforts need to be refocused; and how to sustain successful work when the grant funding ends in June 2015. This work has been integral to the spread of the coordinated care model across several health systems and provider networks and is setting the new base for further innovations as we enter into Demo Year 2.

### **Other federal initiatives**

Our 2013 Operational Plan outlines many other federal initiatives that Oregon is participating in and that are complementary to our spread of the coordinated care model activities under SIM. A few updates include:

#### *CDC initiatives*

The Public Health Division has submitted numerous federal grant applications in the last year which align with and support Oregon's SIM Operations Plan. Two of these include CDC's Asthma and State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke cooperative agreements, both of which emphasize the role of public health in supporting clinical innovation and linking clinics with community resources. These cooperative agreements, along with the State Public Health Actions to Prevent and Control Diabetes, Heart

Disease, Obesity and Associated Risk Factors and Promote School Health cooperative agreement for which Oregon received both basic and enhanced funding in 2013, require monitoring and reporting on a number of performance measures, some of which align with those included in the SIM Year 2 Operational Plan Update guidance. Over the next year, Oregon will work to align these various population health measure sets with its existing measurement framework and will incorporate these measures as appropriate in the forthcoming State Health Improvement Plan work, which will fuel our SIM-required population health roadmap.

#### *CMS Medicaid Adult Quality Grant*

OHA received an Adult Medicaid Quality Grant in December 2012 that is supporting: collection and analysis of data on the CMS Adult Core Measures (17 to date and more by January 2015); two quality improvement projects; and staff training for data analysis and reporting. Both of the performance improvement projects focus on integrating primary care and behavioral health, a key component of the coordinated care model. The first is a statewide collaborative among all CCOs on “Diabetes Monitoring for People with Diabetes and Schizophrenia or Bipolar Disorder.” The second is a project to increase access to patient-centered medical homes in two ways: 1) nine primary care practices will provide practice-level facilitation and technical assistance and will field the CAHPS Clinician and Group Survey with the Patient-Centered Medical Home Item Set to inform individual rapid-cycle improvement projects intended to advance each clinic’s own transformation goals; 2) eleven mental health and chemical dependency treatment programs from across the state will receive assistance with “reverse” integration, bringing primary care into behavioral health settings. Participating agencies are now planning their improvement projects with the assistance of practice coaches who will provide intensive technical assistance for the duration of the grant period.

#### *Safety net alternative payment models*

An approved state plan amendment submitted to CMS for alternative payments for a pilot group of federally qualified health centers in Oregon has been operational since January 2014. Four Oregon clinics are being paid on a per-member, per-month basis for their wraparound payments prospectively instead of being paid retrospectively based on fee-for-service units. This allows more predictable funding expectations for the health center to implement new and innovative ways to engage and manage patients as well as enhance efforts to recruit and retain doctors. New efforts will bring in Oregon’s most populated county’s federally qualified health centers (Multnomah, in the Portland area) starting in August this year. We anticipate continued interest from other federally qualified health centers in the state. Data is being collected from the initial four sites to help the state and the clinics understand the impact of this new payment structure.

#### **State and local non-federally funded initiatives**

Our 2013 Operational Plan outlined several areas of collaboration. One update to highlight is further progress on our Emergency Department Information Exchange project with our partners in the Oregon Health Leadership Council. This is a solution to exchange information among emergency departments to identify frequent users and create care plans to help determine if there is a more appropriate care setting. The update is described in Section E and also noted in Section A.

## Years 2 and 3

### ACA implementation – Cover Oregon

Cover Oregon, the state health insurance exchange, was responsible for assisting hundreds of thousands of Oregonians choose and receive health insurance. However, significant technological issues meant that the planned user-friendly online enrollment process was not fully realized. As a result, the Cover Oregon Transition Team is building a plan to support transitioning OHP eligibility determination to the federal exchange effective October 1, 2014, for the 2015 benefit year. The OHP/Medicaid eligibility process will revert back to OHA's control. See Appendix 15 for slides from a presentation to the House Interim Committee on Health Care: Cover Oregon and Transition Project Update, May 28, 2014. A major portion of the transition planning includes efforts to assist Oregonians with a smooth transition into the next benefit year for commercial members enrolled through the exchange, and transitioning OHP enrollment efforts back to the Oregon Health Authority.

No other significant changes from the originally approved operational plan are expected for project strategies or timelines in this section.

#### Section C

### Outreach and Recruitment

#### Overview

Oregon has continued to operate transformation activities related to outreach and recruitment at multiple levels: outreach to systems and providers to encourage them to adopt policies and practices associated with the coordinated care model; outreach to consumers and potential enrollees of plans who are transitioning to coordinated care, in alignment with ACA implementation; and tools for clinicians and practices to help patients engage more actively in their own care. Those efforts are described in detail in the October 2013 Operational Plan and activities are proceeding. Key highlights and revisions are noted below.

#### Year 1 accomplishments

##### Systems-level outreach

Oregon's strategies to leverage public purchasing capabilities and influence health care market offerings toward the coordinated care model have been successful in the current SIM demonstration period. Much of our success to date is due to the SIM-funded Transformation Center, which has become a hub of outreach and recruitment as planned, working through Innovator Agents, health systems, health plans and providers to spread best practices and engage the delivery system in transformation. See Section G of this update for details of its activities during Year 1. Supported by the SIM investment in analytics, the Oregon Health Authority has begun publishing regular information about system-level performance, particularly related to the Medicaid CCOs but also an initial dashboard across all markets featuring All-Payer, All-Claims

data. The Transformation Center and analytical work will proceed as previously described in our October 2013 Operational Plan.

Communications have been ongoing and extensive both through the Transformation Center and across OHA in coordination with local efforts. See Section Q, Communications Plan, for details. As Oregon moves into Year 2, these efforts will continue with increased efforts to inform state employees about their new choices for the 2015 plan year that include more coordinated care model elements across the plans available, and intensive efforts to assist enrollees in both Medicaid and Public Employees' Benefit Board to better understand their benefits and available services.

#### *Medicaid CCOs*

In Medicaid, the CCOs have worked closely with OHA's Office of Equity and Inclusion to enhance outreach and recruitment efforts to focus on non-English speaking and other underserved populations as directed by their transformation plans.

As outlined in Section G, the Transformation Center has held learning collaboratives for the CCOs' community advisory councils. These advisory bodies, composed of 51 percent consumer members, assist the CCOs provide culturally competent services relevant to local communities and act as connectors to community-based leaders and stakeholders. In the current period, the Transformation Center developed a learning collaborative for the community advisory councils and convened two in-person meetings to provide access to the technical assistance needed to develop these community-based organizations and to support the community health assessments and health improvement plans the councils are responsible for developing. The community health improvement plans have been submitted to OHA and are currently being analyzed. Additional ongoing technical assistance and support will be provided to community advisory councils and CCOs to achieve the community-identified health outcomes described in the improvement plans.

Additional communication and learning activities to share best practices are outlined and are operational as described in our October 2013 Operational Plan. Efforts have increased with Oregon's large Medicaid expansion of over 300,000 new enrollees. Of note, thanks to SIM support, the Transformation Center sponsored three-day training on improvement science attended by all but one CCO. It is valuable to spread the learnings of quality improvement as the CCOs pursue innovative changes to their delivery systems.

#### *Public Employees' Benefit Board*

As noted above and extensively in our October 2013 Operational Plan, efforts are starting to prepare for open enrollment for state employees now that the new RFP and negotiations are completed and contracts that include elements of the coordinated care model have been signed. Planning is underway for fall 2014 meetings across the state, ahead of the new plan year starting in January 2015 in Year 2, to educate members on how the new contracts hold the health plans accountable to provide care, offer more ways to improve members' health and achieve better health outcomes at lower costs.

### *Qualified health plans*

As of May 15, 2014, 83,852 Oregonians were enrolled in qualified health plans offered through Cover Oregon. The Cover Oregon Transition Team is building a plan to support transitioning qualified health plan eligibility determination to the federal exchange by October 1, 2014, for the 2015 benefit year. See Appendix 15 for slides from a presentation to the House Interim Committee on Health Care: Cover Oregon and Transition Project Update, May 28, 2014.

### *Individual Responsibility and Health Engagement Task Force*

HB 2859 (2013) established the Task Force on Individual Responsibility and Health Engagement. Under the direction of the Governor, the Task Force was responsible for developing recommendations to the Legislature to establish mechanisms to meaningfully engage Oregon Health Plan members in their own health, disease prevention and wellness activities. The Transformation Center's director of systems innovation, Chris DeMars, staffed the task force. The work built on the prior work of Oregon's Medicaid Advisory Committee, which had just completed an extensive review of strategies and best practices for engaging individuals and their families enrolled in the Oregon Health Plan. The group's recommendations, submitted to the Legislative Assembly in November 2013, include:

- OHA should seek federal approval to expand options for member cost-sharing within the Oregon Health Plan, following a value-based benefit design.
- The Transformation Center should work with CCOs to support their planning and execution of member engagement strategies. This could include: developing a resource guide on evidence-based member engagement practices and asking CCOs to articulate their planned approaches in Transformation Plan updates; creating a list of standardized and validated health appraisal tools; or helping to promote the use of tools like Choosing Wisely and key personnel such as traditional health workers to support engagement.
- The Transformation Center should work with professional health licensing boards to incorporate patient engagement training as part of their licensing or continuing education requirements and should ensure that health engagement strategies are integrated within other OHA initiatives, such as health information technology.

Please see Appendix 11 for the full task force report.

## **Years 2 and 3**

As noted above, Oregon continues to pursue the established SIM strategies including focusing on open enrollment for Public Employees' Benefit Board members in new plans featuring elements of the coordinated care model and developing the needed outreach and education to spread the model to the Oregon Educators' Benefit Board via a request for proposals and contract negotiations in Year 2. In addition, at the Governor's direction, we will also pursue increasing business access to the coordinated care model while also working with the federal exchange and plans to offer qualified health plans for benefit years 2015 and 2016. Through the Oregon Health Policy Board, a work group is starting up to develop a template request for proposals and contract that builds on the learning to date of the CCO request for applications and Public Employees' Benefit Board request for proposals processes and folds together the key elements of the coordinated care model into a useful tool for other employers in the state. See Sections A and G for more details related to the board's efforts to continue the spread of the model.

OHA is convening stakeholders into a local health information exchange panel that includes local health information exchanges and other organizations with health information technology and exchange efforts such as health systems, CCOs and other organizations in Oregon. The purpose of convening these stakeholders is to understand what is happening for critical partners and what the Health Information Technology Oversight Council and OHA can do to help move health information technology and exchange forward, including guidance, policy, alignment, sharing best practices and monitoring the environment. OHA plans to have the first meeting with stakeholders before end of 2014.

## Section D

## Information Systems and Data Collection Setup

### Overview

Oregon continues to progress on planning and designing efforts for data integration, data collection and data intake, thanks to SIM funding. We have outlined this extensively in our October 2013 Operational Plan. We have made progress, as outlined in our quarterly reports, over this past year and continue to work to achieve our objectives that support the spread of the coordinated care model.

### Year 1 accomplishments

#### Measurement reporting mechanisms

Oregon continues to demonstrate commitment to accountability and transparency. Oregon has begun publishing regular dashboard reports – both a statewide multi-payer performance report with quality measures, utilization statistics and expenditure trends by major payer category, and a CCO performance dashboard, including quality measures and cost and utilization trends for Medicaid. OHA published the multi-payer dashboard in March and June 2014, and the CCO dashboard in November 2013, February 2014 and June 2014. These reports are viewable at: <http://www.oregon.gov/oha/Metrics/Pages/index.aspx>. The June 2014 CCO report included final CCO performance on all quality measures for calendar year 2013, as well and aligned with the first payout from the quality pool (see Appendix 16).

Oregon intends to continue producing both of these dashboard reports on a regular basis throughout demonstration years two and three, integrating additional measures and more clinical data over time as technology allows. Oregon also intends to leverage both in-state and national work towards aligned measure sets. This will not only reduce the provider and health plan reporting burden but it will also increase cross-market consistency for quality improvement and help Oregon monitor the impact of SIM activities throughout the grant period.

#### *Clinical quality metrics registry*

OHA continued progress this year towards the implementation of a state-level clinical quality metrics registry. The foundational component for the registry is the creation of a new process for

data collection, including a transition from claims-based reporting methods to using data captured within an electronic health record. To support a successful transition, OHA is undertaking a phased approach with an initial focus on three of the 17 CCO incentive measures. The CCOs have completed technology plans outlining how they will develop the ability to do electronic reporting of clinical quality data for three CCO incentive measures: depression screening, diabetes control and hypertension control. These technology plans are a first step towards ensuring that CCOs can leverage certified electronic health record technology to access individual-level electronic clinical quality measure data on their beneficiaries from providers. Year 1 saw the first milestone, with all 16 CCOs submitting sample data to OHA for all three measures. Data collected will support quality reporting and the development of pay-for-performance methods while building additional capacity for electronic reporting of clinical quality measure data.

#### *Common credentialing*

In 2013, Oregon's Legislature mandated OHA to establish a program and database for providing credentialing organizations (health plans, CCOs, hospitals, etc.) access to information necessary to credential all health care practitioners in the state. Under SB 604 (see also description in Section A), health care practitioners or their designees will submit necessary credentialing information into a common credentialing database one time and credentialing organizations will be required to use the database to obtain that information. Stakeholders have been engaged to assist OHA in implementing this program and have helped to finalize rules and develop a request for proposals to be released in August 2014. OHA's goal is to ensure an efficient and effective solution that will be operational by January 2016 as mandated. Please see Section E for additional information on common credentialing.

#### *Data systems*

Timely, consistent data are essential for monitoring transformation at all levels. Two Year 1 accomplishments to note in this area are: 1) Oregon met the January 2014 timeline to use the Transformed-Medicaid Statistical Information System for reporting; and 2) Oregon has required CCOs to submit encounter data within 60 days of adjudication date to improve timeliness of reporting.

Please see Section I, subsection "population health measurement," for an update on Oregon's work related to the Behavioral Risk Factor Surveillance System survey and the Oregon Public Health Analytical Tool.

Note: Previously, many health information technology items were discussed in Section D, Information Systems. For those items and others, please see Section E, Alignment with State HIT Plans for an update and next steps.

### **Years 2 and 3**

No significant changes from the originally approved operational plan are expected for project strategies or timelines in this section. Oregon will continue to develop the data collection infrastructure through:

- Acquisition of Medicare fee-for-service data, which will be included in the All-Payers, All-Claims database to develop a full picture of the health care delivery system. Oregon has been working with CMMI and the Research Data Assistance Center to finalize release of the data; we have submitted payment for the data and our request for assistance has been satisfied.
- Oregon is convening an All-Payers, All-Claims technical advisory group (also noted in Section A) that will assist with further development of this important data source by making recommendations related to new data fields, validation practices and analytic tools such as groupers or risk adjusters.
- The next round of the Oregon Health Insurance Survey will be fielded in 2015, likely a month or so after the 2015 open enrollment period ends. The survey is Oregon's primary method for monitoring health care coverage, and the 2015 survey will provide important information about the impact of ACA coverage expansions in the context of the coordinated care model.
- Development of an internal analytic training program to improve analyst capacity as well as sustainability of the analytic model. The purpose is to provide a customized training program and materials to teach Health Analytics staff how to optimize and integrate SAP Business Objects tools with other software and online products to produce high-quality, accurate statistical and analytical reports for the web. The training program will deliver information and modules on both the basic features and advanced uses of the software package, and specifically focus on the users' ability to work across platforms and software packages that the Oregon Health Authority already uses and/or owns.
- Development of dynamic web tools to provide an efficient, centralized location for the data elements, metrics and measures that are currently reported through segmented channels. More significantly, it will allow the viewer to filter data elements to create automated custom reports using aggregate data. A strategy is currently being developed for how to organize this effectively and present the information of the most interest to stakeholders.

## Section E

## Alignment with State HIT Plans and Existing HIT Infrastructure

### Overview

Oregon's coordinated care model and its spread requires essential tools that can improve care coordination and quality while reducing the cost of care. Health information technology and the electronic exchange of information are some of those key tools. Oregon's efforts, as planned and described in our October 2013 Operational Plan, have proceeded to support and accelerate statewide health information technology initiatives.

### Year 1 accomplishments

#### Strategic work

##### *State HIT business plan framework*

In June 2014, the Oregon Health Authority finalized a roadmap to advance health information technology and health information exchange in the state. These services will support the

transformation of Oregon's health system and help improve health outcomes and quality of care and reduce costs. Please see Appendix 17.

Oregon's health system transformation effort is premised on a model of coordinated care that includes new methods for care coordination, accountability for performance and new models of payment based on outcomes and health. To succeed, the coordinated care model relies on new systems for capturing, analyzing and sharing information about patient care, outcomes and quality of care and new modes of sharing care information between all care team members. OHA has worked closely with a wide range of stakeholders to identify health information technology and exchange needs, and specifically identify how the state, and statewide services, could address some of those needs. In fall 2013, OHA convened a Health Information Technology Task Force to synthesize stakeholder input and develop a business plan framework to chart a path for statewide efforts over the next several years.

This stakeholder process led to a vision for Oregon of a transformed health system where health information technology and exchange efforts ensure the care Oregonians receive is optimized by health information technology. "HIT-optimized" health care is more than the replacement of paper with electronic or mobile technology. It includes changes in workflow to assure providers fully benefit from timely access to clinical and other data that will allow them to provide individual- and family-centric care.

#### *OHA Deeper Dive "Listening Tour" – meetings with CCOs*

OHA will conduct in-person meetings with each CCO during summer 2014 to gain a deeper understanding of each CCO's health information technology project and coordinate around Phase 1.5 HIT/HIE statewide services in development at the state level. The aim is to ensure the state's health information technology services support CCO investments, CCO and state efforts remain aligned, and CCOs have a clear understanding and expectations for what state-level services will include.

### **Phase 1.5 of the State Health Information Technology Plan**

This year, OHA developed consensus on HIT/HIE Phase 1.5 services and, in March 2014, received CMS approval on all I-APD-U funding for technical assistance to eligible professionals and eligible hospitals, described below. OHA also informally submitted an HIT I-APD-U in June to request funding for technology and implementation for an expanded provider directory, Clinical Quality Measures Registry and Systems Integrator (see below). Pending approval, this funding is anticipated to be in place October 1, 2014.

#### *Emergency Department Information Exchange*

This year also saw the implementation of the Emergency Department Information Exchange (EDIE) in partnership with the Oregon Health Leadership Council and Oregon hospitals and health systems. The exchange alerts emergency department clinicians in real time when a patient who has been a high utilizer of emergency department services registers in their emergency department. These real-time alerts reduce duplicative services and assist clinicians in directing high utilizers to the right care setting. All of Oregon's hospitals have engaged with this project. Oregon expects 37 of 59 hospitals to go live by the end of summer. The remaining hospitals are

expected to go live by the end of the year. (References to the exchange are made in several other sections of this update.)

Once fully implemented, the next phase of the exchange will include adding inpatient data and discharge notes to “EDIE Plus” (see below), as well as a subscription-based product called PreManage that would allow regional health information exchanges, providers, health plans and CCOs to access this data as real-time notifications when their member or patient has a hospital event. The EDIE Governance and Operations Committee and OHA have collaborated closely to develop the business plan for EDIE Plus/PreManage and will present this to the Oregon Health Leadership Council and CCO leadership in July 2014. The business plan establishes EDIE Plus as a statewide utility, which would be supported by OHA, all hospitals, the Oregon Health Leadership Council and its member health plans, and CCOs in Oregon. The plan details the performance goals and metrics for the utility, the finance model, governance structure and implementation plan.

#### *Statewide Direct secure messaging*

CareAccord, Oregon’s statewide health information exchange operated by OHA, will expand capabilities to better serve and expand interoperability with the Oregon health information exchange community. Expanded services include templates and formats for electronic health record submission, technical assistance, outreach and support for users and integration into electronic health records.

OHA continued progress with the expansion of CareAccord capabilities with Direct secure messaging by developing a pilot program for a statewide Flat File health information exchange provider directory. This Flat File directory will allow Oregon organizations participating in DirectTrust access to addresses of other Direct secure messaging users. OHA is in the process of finalizing participation agreements between external pilot participants. The directory is scheduled to go live July 2014.

#### *State-level clinical quality metrics registry*

OHA continued progress this year towards implementing a state-level clinical quality metrics registry, as described in Section D. Through this process, OHA encountered an unexpected issue. To streamline requirements, in Year 1 OHA planned to leverage functionality available through 2014 certified electronic health records (such as reporting clinical quality measures in standard formats). A slower than anticipated upgrade to 2014 certified systems prevented stakeholders from using this technology and resulted in a manual data submission process. OHA anticipates similar data challenges for calendar year 2014 reporting (to be submitted to OHA in spring 2015) due to the recent ruling by HHS allowing eligible professionals to attest in 2014 using 2011 technology. However, this challenge should dissipate as upgrades occur and is not anticipated to have a long-term effect on strategy.

#### *Provider directory*

OHA has also conducted meetings with the Provider Directory Subject Matter Experts Work Group to provide guidance on scope, functions and parameters of a state-level provider directory. OHA held the last work group meeting in May 2014, and the members provided feedback on the Provider Directory services framework, opportunities from emerging national and state efforts

and the key uses of the provider directory. This feedback will inform the scope of work in the request for proposals for the state-level provider directory. A future work group will be formed in late 2014 or early 2015 to focus on the governance structure to develop policies.

As described in Section D, Oregon's Legislature in 2013 mandated OHA to establish a program and database for providing credentialing organizations (health plans, CCOs, hospitals, etc.) access to information necessary to credential all health care practitioners in the state. The information needed for a state-level provider directory overlaps with the information needed for credentialing in terms of general practitioner information, affiliations to clinics and provider "addresses" for the electronic exchange of information. Because practitioners are required to regularly attest to their credentialing information, a provider directory that leverages the common credentialing solution can use real-time practitioner data to create further efficiencies and support care coordination, data aggregation and analytics, performance improvement efforts and health information exchange needs. OHA is aligning these bodies of work to ensure the two efforts can work together when implemented.

#### *Systems integrator*

To ensure the multiple Medicaid health information technology efforts (provider directory, common credentialing, clinical quality metrics registry, etc.) are designed, implemented and managed as an integrated, interoperable system of systems, OHA will contract with a systems integrator. OHA has determined that using a systems integrator agent to manage the procurement, design, development, implementation and operations of the projects is the best strategy to ensure successful implementation and ongoing processes while meeting proposed timelines and budgets. OHA's efforts to engage a systems integrator have begun in Year 1 and will continue through Year 2.

OHA anticipates that the systems integrator or other service may include the single sign-on or other potential solutions to barriers related to programs, such as ease of access by prescribers. For example, the Prescription Drug Monitoring Program is a state-mandated database of all Schedules II, III and IV controlled substances which are dispensed to Oregon residents. This database has valuable information for care coordination and population management. However, to access that information, state law specifies only Oregon-licensed health care providers and pharmacists and their staff may access the information. This constrains users to logging into a separate web portal from all other health information, such as the health information exchange.

#### *Technical assistance*

As mentioned earlier, OHA received CMS approval in March for 90/10 funding to support technical assistance to Medicaid eligible professionals and hospitals on electronic health record adoption and meeting Meaningful Use. OHA expects to release a request for proposals in summer 2014 and begin offering technical assistance before the end of calendar year 2014.

OHA is also coordinating with the Transformation Center to align technical assistance for Oregon providers across programs like the Patient-Centered Primary Care Homes, Patient-Centered Primary Care Institute, Comprehensive Primary Care Initiative, Oregon's Regional Health Information Technology Extension Center and others.

### *Telehealth efforts*

OHA is seeking a partnership with the Office of Rural Health at Oregon Health & Sciences University to administer our SIM-funded telehealth pilots, leveraging the university's experience in rural health. This agreement is anticipated to be completed in summer 2014.

This pilot program would provide grant funds to three to five telehealth projects. Focus areas for pilots may include:

- Support for community paramedics with tools such as tablets and triage software;
- Use of HIPAA-compliant videoconferencing services; or
- Use of mobile devices for text messages on topics such as diabetes management, prenatal care, etc.

## **Year 2**

Year 2 will see significant activity around Phase 1.5 health information exchange and related work.

### **Strategic work**

#### *Phase 1.5 work*

By end of 2014, the Emergency Department Information Exchange will be implemented in all 59 hospitals. In January 2015, the EDIE Plus Utility will begin operating, and OHA anticipates the PreManage program will be available to CCOs, plans and providers beginning in 2015. OHA will continue work to implement the provider directory, common credentialing system and clinical quality metrics registry. OHA technical assistance support to providers is expected to be operational by end of 2014. CareAccord and the Flat File Directory will continue, and the CareAccord enhancements and outreach are expected to be implemented in Year 2.

#### *Legislative ask*

In 2015, OHA expects to have a legislative ask to enable continuation and expansion of Phase 1.5 services and statewide hospital notifications. The primary goals of the legislation are to: 1) expand OHA's legislative authority to operate statewide health information exchange services beyond Medicaid to include private partners and the general public – this would include the authority to set and collect fees necessary to operate these services; 2) establish OHA's authority to participate in partnerships or collaboratives for providing health information technology and exchange services necessary to health system transformation in Oregon; and 3) modify existing Health Information Technology Oversight Council legislation to more accurately reflect the council's ongoing work and anticipated role in the future.

#### *Other activities*

OHA is convening stakeholders into a local health information exchange panel that includes local exchanges and other organizations with health information technology and exchange efforts such as health systems, CCOs and other organizations in Oregon. The purpose of convening these stakeholders is to understand what is happening for critical partners and what the Health Information Technology Oversight Council and OHA can do to help move health information technology and exchange forward, including guidance, policy, alignment, sharing best practices

and monitoring the environment. OHA plans to have the first meeting with stakeholders before the end of 2014.

### **Year 3**

OHA expects Year 2 efforts to continue, as described in the above section.

#### **Strategy**

OHA anticipates the evolution of health information exchange governance in Year 3 depending on the 2015 legislation. This could lead to additional formal collaboration or partnerships. OHA will continue to plan for Phase 2.0 expansion of state health information technology services to support query functionality.

#### **Phase 1.5**

OHA expects the provider directory, common credentialing and the clinical quality metrics registry to be fully operational by January 2016. OHA also expects PreManage to be universally adopted by the end of 2016. CareAccord efforts will be ongoing, and OHA technical assistance will continue through at least June 2017.

#### **Telehealth pilots**

By end of Year 3, OHA expects the telehealth pilots to conclude and the evaluation period to end. The pilot sites will report on their efforts and present findings and lessons learned.

<b>Section F</b>	<b>Enrollment and Disenrollment Processes</b>
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Not applicable.

<b>Section G</b>	<b>Model Intervention, Implementation and Delivery</b>
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### **Overview**

#### **Model intervention**

As outlined in our October 2013 Operational Plan, the model being tested under Oregon’s SIM project is the coordinated care model, which focuses on delivery system redesign and payment reform to improve quality, value and outcomes. The interventions supported by SIM include a wide range of policies and activities designed to drive: 1) improved care coordination at all points, emphasizing patient-centered primary care; 2) adoption of value-based payment methods; 3) integration of care across silos, including bridging medical care with population health; and 4) accountability for safe and effective care. Testing and accelerating the spread of effective

innovations in each of those areas is the fifth and unifying aspect of Oregon's SIM project. (See Appendix 18, Oregon SIM Driver Diagram.)

The coordinated care model is at the heart of Oregon's health system transformation efforts, which are driven by the vision and leadership of Governor Kitzhaber and the Oregon Health Policy Board. As updated in Section A, in June 2013, Governor Kitzhaber asked the health policy board to move to the next stage of transformation by: aligning coordinated care model attributes in Public Employees' Benefit Board and Oregon Educators' Benefit Board contracts, marketplace qualified health plans and with other employers; identifying opportunities to enhance the Oregon Insurance Division's rate review process; and developing strategies to mitigate cost shifting, reduce health insurance premiums and increase overall transparency and accountability. Policy development and implementation work is occurring in each of these areas and is described in more detail in this Section, as well as Section A.

Apart from the Governor's direction on next steps for transformation, the model to be tested and the majority of Oregon's implementation and dissemination plans have not changed since the state submitted its original SIM application and 2013 Operational Plan. However, some activities have been adjusted and some new strategies for model implementation and spread have been identified in the interim. This section provides a brief review of significant model intervention accomplishments during Year 1 and updates on plans for Year 2. As in the original operational plan, this section is organized primarily around the multiple levers Oregon is using to implement and spread the model: financial, legal/regulatory, structural and cooperative. Throughout, we also highlight our efforts to engage government, CCOs and health system partners, and communities and consumers in the health system transformation that SIM supports.

## **Model implementation**

As CMMI is well aware, Oregon's coordinated care model was initially designed for and first implemented in the Medicaid program. With implementation of the Affordable Care Act and Oregon's Medicaid expansion, approximately 357,500 additional Oregonians have enrolled in the Oregon Health Plan, for a total of close to 1 million members (971,000 as of June 30, 2014). With close to a quarter of the state's population already participating in the intervention through Medicaid and many more to come in 2015 and 2016 via the Public Employees' Benefit Board, Oregon Educators' Benefit Board, and possibly other private coverage, model implementation is spreading across the state.

### **Using financial levers to implement and spread the model**

The financial levers that Oregon is using to implement and spread the coordinated care model include adoption of alternative payment methods and active purchasing within the Oregon Health Authority, as outlined in our October 2013 Operational Plan:

#### *Paying for value in Medicaid*

In June 2014, OHA published data on the first full year of CCO performance on a variety of quality measures. (The results were very encouraging and are described elsewhere in this report, particularly Section I. See Appendix 17 for the full report.) With these results, payment for

Medicaid services also entered a new phase in which – for the first time – part of the reimbursement for services provided to Oregon Health Plan members is based on quality performance. Under this payment model, OHA held back 2 percent of the monthly payments to CCOs and created a common “quality pool.” To earn their full 2 percent back, CCOs had to meet improvement targets on at least 12 of the 14 quality measures and have at least 60 percent of their members enrolled in a patient-centered primary care home. All CCOs showed improvements in multiple areas of performance and 11 out of 15 met 100 percent of their improvement targets. The proportion of CCO reimbursement that is performance based will increase incrementally over time.

In addition, CCOs continue to hold down costs. Oregon is staying within the capped rate of growth for Medicaid spending, meeting its commitment to Centers for Medicare and Medicaid Services.

#### *Supportive payment for patient-centered primary care*

With the support of the SIM grant, Oregon contracted with Oregon Health and Science University’s Evidence-Based Practice Center in 2013 to convene and facilitate a Multi-Payer Primary Care Payment Strategy Work Group. The result was a multi-payer consensus agreement to use Oregon’s patient-centered primary care home standards as a basis for structured payments to support patient-centered primary care homes. The agreement includes all the major commercial insurers in the state; Medicaid CCOs, the Public Employees’ Benefit Board and Oregon Employees’ Benefit Board will align with this agreement through their contracting processes. Payers have the latitude to establish the amount, the type of payment and timeline for implementation with the providers in their networks. (For example, the Public Employees’ Benefit Board provides an age-adjusted; per-member-per-month incentive payment to Tier 2 or Tier 3 recognized primary care homes in the statewide plan, administered by Providence Health & Services. In addition, members in the statewide plan have lower cost share for primary care services when they access care through a recognized primary care home – from 15 to 10 percent.) The state Patient-Centered Primary Care Home program will continue to work with the plans and payers to monitor the impact of the collaborative efforts to support primary care.

#### *Active purchasing*

As the purchaser of health care benefits for more than 130,000 Oregonians, the Public Employees’ Benefit Board uses its buying power to get the best health care available from health plans that serve its members. The board explicitly designed its 2015 benefit year request for proposals and resulting contracts in alignment with the coordinated care model. The recently executed contracts will hold health plans accountable for the way they provide care, requiring reporting on a standard set of quality measures and attaching penalties/bonuses to performance starting in 2016. Contracted plans will be held to a fixed rate of growth similar to the rate that Oregon has committed to achieving in Medicaid. And as direct evidence of coordinated care model spread, the new plans include two CCOs as well as two other insurers closely involved with CCOs.

## Using legal and regulatory levers to implement and spread the model

The legal and regulatory levers at Oregon's disposal to promote the coordinated care model include legislation mandating or enabling adoption of key model elements in different settings; contracting language and administrative requirements that help to operationalize the model; and formal mechanisms to connect reform in different sectors.

### *Metrics alignment*

Establishing standards and holding plans and providers accountable for quality performance are important elements of the coordinated care model. But aligning metrics across payers is critical to send consistent signals to providers and reduce the measurement burden on all parties.

Oregon's 2013 legislative session featured several bills about metrics alignment (these are also described in Section A):

[HB 2118](#) required Cover Oregon to establish a health plan quality metrics work group to identify appropriate health outcomes and quality measures for Oregonians enrolled in qualified health plans available through Cover Oregon and the Oregon Educators' Benefit Board and Public Employees' Benefit Board contracted health plans. The group delivered its final report to the Legislature in May (available here: <https://www.coveroregon.com/docs/HB-2118-Recommendations.pdf>). The report identified 13 measures that can be used immediately and 15 more that could be reported when data systems mature and measure specifications are further developed. The vast majority of those measures overlap with metrics being tracked in Medicaid as either CCO incentive measures or state performance measures. The work group's direction was that the participating entities should incorporate the initial 13 quality measures into their contracts at the next available opportunity. For Public Employee's Benefit Board plans, this will be the 2015 plan year contracts.

[HB 2216](#) directed OHA and a new hospital performance metrics committee to recommend a small number of quality measures and related benchmarks to be used to reward hospitals for their performance, as referenced under "Using financial levers" above. The group has identified seven measures; OHA is currently developing detailed measure specifications and negotiating with CMS on the details of the incentive pool. More information is available here: <http://www.oregon.gov/oha/Pages/http.aspx>

[HB 2013](#) specified that OHA and Oregon's Early Learning Council should work collaboratively with CCOs to develop performance metrics for prenatal care, delivery and infant care that align with early learning outcomes. In September 2014, a Child and Family Measures Work Group will be convened to identify a set of shared measures and potential incentives that cross early learning, health and human services. The cross-sector work group membership has been finalized following a public request for nominations, and an external consultant with measurement expertise will be secured to support the work group and staff.

In another example of metrics alignment, the state's first year of a unified kindergarten assessment was completed in October 2013. Kindergarten assessment data, a proxy for kindergarten readiness, will be aggregated by CCO enrollment and brought back to the CCO

Metrics and Scoring Committee for further discussion of kindergarten readiness as a potential future CCO incentive metric for 2015.

In a step towards metrics alignment for the broader commercial market, both inside and outside the exchange, Oregon's Insurance Division asked carriers to report their performance on five metrics when submitting their 2015 rates for approval. The measures align closely with the CCO incentive measures and measures recommended by the HB 2118 Health Plan Quality Metrics Work Group (above). This is the first time carriers have been asked to report quality information with rate requests and the policy is a direct result of Governor Kitzhaber's 2013 request to enhance the rate review process and consider opportunities to spread the coordinated care model. At this stage, the metrics will be used for informational purposes only, to promote marketwide transparency and alignment (see: [www.oregonhealthrates.org](http://www.oregonhealthrates.org)).

#### *Contracting language and standards*

Oregon has already reported earlier in this section and elsewhere in this update that Public Employee's Benefit Board 2015 plan year contracts will incorporate a number of coordinated care model elements. Another example of contracting language that is helping to spread the coordinated care model is the requirement for CCOs to complete community health assessments and develop and implement community health improvement plans. In keeping with the model's emphasis on integrating health care with community health improvement, CCOs were required to work closely with local public health departments, hospitals, service providers and community groups to develop a comprehensive assessment and plan for action. It is important to note that these assessments and plans are to address the entire population within a CCO service area and are not limited to CCO members. The assessments and community health improvement plans were due to OHA July 1, 2014, and are currently being reviewed by staff from the Transformation Center, the Public Health Division and the Office of Equity and Inclusion. Themes and opportunities for technical assistance will be identified and incorporated into technical assistance offerings in the next periods to support population health goals. This review will also inform work on the Population Health Roadmap (see Appendix 19).

Another first year accomplishment in the category of legal or regulatory levers was implementing revised standards for patient-centered primary care homes in Oregon. The updated 2014 recognition criteria, introduced in January 2014, will provide a more comprehensive roadmap for primary care practices choosing to continue along the path of transformation. The patient-centered primary care home program also launched a new online application system based on the 2014 recognition standards and is offering a range of consultation, technical assistance and evaluation services (described more under "Using structural levers") to support primary care practice transformation.

#### *Formal mechanisms for connecting reform across sectors*

Oregon's October 2013 Operational Plan described Governor Kitzhaber's ambitious plans for educational reform. One key area in which health care transformation and educational reform are closely intertwined is early learning; good health and appropriate childhood development are prerequisites to successful learning and engagement in school. The Oregon Early Learning Council has just completed a final request for application process to determine the state's early learning hubs – self-organized, community-based coordinating bodies that will work to improve

the efficiency and outcomes for Oregon's youngest children using a systems approach (see also Section A). There are now 14 hubs responsible for coordinating services across sectors, moving away from the isolated impact of a programs approach and toward the collective impact of a systems approach, including the health system. Hubs were selected, in part, for how well they demonstrated coordination with their local CCO(s).

Although long-term care services and supports were legislatively excluded from some of Oregon's Medicaid transformation plans, officials are proactively working to ensure coordinated care for people who interact with both systems. One formal mechanism for this is required annual memoranda of understanding between CCOs and local Area Agency on Aging or Aging and People with Disabilities offices. These agreements must include how the organizations will work together and hold each other accountable in five required areas of care coordination including the prioritization of high needs members, shared care plans, transitional care services, member preferences and engagement, and shared care teams. (Eight optional areas of care coordination activities may also be included.) The Long-Term Services and Supports Innovator Agents have worked with stakeholders to update 10 of 17 agreements so far in 2014, with the remainder due before October.

### **Using structural levers to implement and spread the model**

Structural levers include all the technical assistance, consultation and infrastructure support Oregon is offering to assist health system stakeholders with transformation. This includes both SIM-funded resources like the Transformation Center and Patient-Centered Primary Care Institute learning collaboratives and activities supported wholly or in part by other resources such as health information technology and exchange infrastructure development and the CCO Innovator Agents.

A great deal of activity has taken place during the first year of SIM under the category of structural supports for transformation and has been described in detail in Oregon's quarterly reports. The following constitutes highlights only:

#### *CCO summit*

In December 2013, the Transformation Center, in partnership with the Northwest Health Foundation, sponsored the first Coordinated Care Organization Summit. This was the first convening of the CCO community since inception. Governor Kitzhaber provided opening remarks. The chief executive officers of all the CCOs participated in a plenary session and shared innovative success stories from the first year of operations. Additionally, members from the community advisory councils were brought together for networking and support for development of the advisory councils. The summit was well attended with about 500 participants, and evaluations reflected a high value for the learning opportunities provided.

#### *Learning collaboratives and other technical assistance*

Thanks to SIM support, the Transformation Center launched five learning collaboratives: 1) Quality and Health Outcomes Committee learning collaborative includes CCO medical directors, behavioral health directors and quality improvement coordinators; 2) community advisory council learning collaborative includes consumers and community partners including some local

public health agencies; 3) Complex Care Collaborative includes multiple provider disciplines; 4) Innovator Agents' learning collaborative; and 5) the Improvement Science in Action collaborative.

As described earlier in this update, the Transformation Center also launched a Council of Clinical Innovators in summer 2014. The council is a cadre of 14 providers who serve as champions of change and support the implementation of the coordinated care model through their innovation projects and provider-to-provider conversations. This "Transformation Academy" will promote spread of the coordinated care model principles across many practice areas as the champions carry out their in-service commitments across the state in multiple practice settings and specialties. A second cohort will be chosen for Year 2. Through participation in a year-long learning experience with emphasis on health system transformation projects in their local communities, this select group of Clinical Innovators will develop and refine skills in leadership, quality improvement, implementation and dissemination science, all of which creates a network of expertise supporting the Oregon coordinated care model. Detailed information on the first cohort of Clinical Innovators and their projects is available at: <http://transformationcenter.org/cci/>

The Patient-Centered Primary Care program expanded its capacity for technical assistance for primary care transformation by contracting with 10 clinical consultants to provide technical assistance and act as clinical champions for practice transformation and by hiring five positions (three supported by SIM funds) to provide consultation, technical assistance and evaluation services through clinic site visits as well as develop strategic communication and marketing strategies.

The Patient-Centered Primary Care Institute offered nine webinars on topics including "How to Use Patient Experience of Care Surveys in your Practice" and "Motivational Interviewing in Primary Care;" hosted a Technical Assistance Expert Learning Network Conference in which more than 60 quality improvement, technical assistance and primary care home experts from more than 30 organizations in Oregon convened to network, share tools and resources and brainstorm solutions to primary care transformation challenges; and provided two week-long trainings to over 40 clinics on integrating behavioral health in primary care. Webinar recordings and all materials associated with these events are located at [www.pcpci.org](http://www.pcpci.org)

Oregon established seven Long Term Services and Supports Innovator Agent positions (SIM resources support three of these positions) to address consumer and systems issues to facilitate better outcomes, lower costs and avoid cost shift between social and medical systems. High-cost, heavy utilizers who are dually eligible (Medicare/Medicaid) or triply eligible (eligible for Medicare, Medicaid and long-term services) are a priority for intervention.

OHA contracted with the Institute for Healthcare Improvement to offer two training conferences for system change agents on the Science of Improvement and Improvement in Action. The first was attended by OHA leaders, Innovator Agents and the quality improvement coordinators in the Division of Medical Assistance Programs, and the second by CCOs, OHA quality improvement project coordinators and the Innovator Agents.

The Transformation Center and the Northwest Health Foundation convened a statewide summit for members of the CCO community advisory councils. The conference included updates from Oregon Health Authority leaders, CACs sharing about their work, networking, breakout sessions and a panel of foundation funders. There were 151 attendees, which included 116 community advisory council members and representatives from all CCOs. Overall, a high majority of participants reported that they found the summit valuable. Many have requested more opportunities to gather and receive technical assistance.

#### *Advancing health equity and population health*

OHA selected three proposals to establish regional health equity coalitions, bringing the total number of operational coalitions to six across the state. These coalitions have been fully established thanks to SIM support, and the Office of Equity and Inclusion has completed a round of site visits to each of the coalitions. Please see Appendix 20 for a summary of the site visit findings.

Twenty-one new participants joined the DELTA (Developing Equity Leadership through Training and Action) initiative to build the capacity and commitment of health leaders to eliminate health disparities. The DELTA program creates opportunities to share strategies and challenges across organizations and programs; builds camaraderie and relationships with current and future organizational partners; provides concrete, applicable tools; and supports leadership to integrate health equity and inclusion strategies into organizations for improved access and quality of care.

The Public Health Division awarded funding for four community health improvement projects jointly planned and implemented by CCOs, local public health departments and other partners. The projects will use evidence-based strategies to address the leading causes of death and disability and community health priorities in their areas. In addition, division staff and contractors analyzed 31 public health indicators by race/ethnicity and by CCO region to assist CCOs with identifying areas for further population health improvement, particularly around the prevention of disease and disability. The public health indicators were shared with CCOs, and consultants are working with OHA to determine the most appropriate data display and publication method.

#### *Health information technology and health information exchange supports for transformation*

As noted in Sections A and E, OHA collaborated with the Oregon Health Leadership Council, Oregon hospitals and health systems and others to implement the Emergency Department Information Exchange: a real-time alert system for emergency department clinicians. OHA used SIM funding to subsidize the first year's costs, on the condition that the vast majority of Oregon hospitals agree to participate. With this leverage, the council was able to get agreements from all 59 Oregon hospitals to participate and all are expected to go live by the end of 2014. Section E notes several other significant steps forward for health information technology and exchange infrastructure to support transformation.

#### *Analytic supports for transformation*

With support from SIM resources, OHA has launched a multi-payer dashboard to provide data on health care cost and utilization, health insurance coverage and quality of and access to care

across markets including commercial insurance carriers, Medicare and Medicaid. (The dashboard is described also in Sections D and I.) Trends will be tracked over time and new data sources and lines of business will be added as they become available. The multi-payer dashboard is available online here: <http://www.oregon.gov/oha/OHPR/RSCH/Pages/dashboards.aspx>.

Thanks to SIM support, on April 14, the Public Health Division released version 2.2 of the Oregon Public Health Assessment Tool, which includes a redesigned, more user-friendly interface and updated mortality data. Infant mortality data was updated in June. In addition, Public Health Division staff are promoting the assessment tool to local public health authorities and other users in the community to assist targeting efforts to improve population health.

### **Using cooperative levers to implement and spread the model**

Cooperative levers for transformation include the many stakeholder engagement and collaborative planning/implementation efforts that are a hallmark of Oregon's health system transformation. Many of the activities described earlier in this section could also be categorized under cooperative strategies, since few would be possible without the active participation and partnership of different health system constituents.

#### *Patient-centered primary care*

In early 2014, Oregon reached a significant SIM milestone ahead of schedule when more than 500 clinics in the state achieved Patient-Centered Primary Care Home recognition. This was our goal for Year 2. The patient-centered primary care home model can function as a critical starting point for further delivery system and payment reform, so increasing adoption of the standards around the state supports spread of the coordinated care model. OHA has taken an engagement model approach to encourage practices at various stages on the transformation spectrum to pursue this voluntary recognition and to continue to make incremental improvements once recognized.

Another cooperative success for patient-centered primary care was described under financial levers earlier in this section: the 2013 multi-payer consensus agreement to support recognized patient-centered primary care homes with structured payments.

SIM funding continues to support Oregon's [Patient-Centered Primary Care Institute](#), which was established in partnership with the Northwest Health Foundation. The institute is housed at the Oregon Health Care Quality Corporation. The institute provides practice-level technical assistance to further the patient-centered primary care home model adoption including hands-on learning collaboratives as well as web-based resources. The institute will be focusing on developing sustainability plans to include resources from payers outside OHA as well as other stakeholders. Broadening the pool of supporting resources will allow the institute to reach additional providers, allow further spread of best practices and transformation, and also ensure sustainability of these activities beyond the SIM grant demonstration periods.

#### *Cooperation for health information exchange*

The establishment of Oregon's Emergency Department Information Exchange (EDIE) is another example of advancing transformation through cooperation. As described under structural levers,

OHA and the Oregon Health Leadership Council (OHLIC)—representing the leadership of health care purchasers across the state—were able to secure an agreement from all 59 Oregon hospitals to participate and financially support EDIE. OHA anticipates expanding on EDIE by adding inpatient and discharge data and making hospital event notifications available to CCOs, plans, providers and HIEs through the PreManage program (see also Section E).

## **Years 2 and 3**

### **Financial levers**

Little has changed in Oregon's Year 2 and 3 plans for using financial levers to implement and spread the coordinated care model. The state will continue to encourage the adoption of alternative payment methods in Medicaid and others markets. The importance of multi-payer engagement in payment reform was noted in Oregon's October 2013 Operational Plan; one specific activity not envisioned at that point was a contract with OHSU's Center for Evidence-based Practice to solicit feedback on payment reform options from Oregon's health transformation stakeholders. Oregon will consider the results of that process and the associated evidence review in developing specific strategies to advance alternative payment methods in Years 2 and 3 of the SIM grant.

Similarly, OHA will continue to use its purchasing power to spread the coordinated care model. With Public Employees' Benefit Board contracts executed, Oregon Educators' Benefit Board 2016 plan year contracts are the next opportunity to incorporate key elements of the coordinated care model (the request for proposals will go out in 2015). Work will also continue on establishing a hospital payment incentive program in Medicaid, complementing the CCO incentive payments.

As mentioned in Sections A and B, payment reform strategies also are being developed and tested within a subset of Oregon Federally Qualified Health Centers. Through a state plan amendment submission to CMS for alternative payments, Oregon is paying pilot clinics on a per-member, per-month basis instead of on a per-visit basis for individuals on the Oregon Health Plan.

One new activity not reflected in the October 2013 Operational Plan is a work group on cost containment born from the Governor's 2013 request to the Oregon Health Policy Board to take further steps on health system transformation. The Sustainable Health Expenditures Work Group (see also Section A) was formed in spring 2014 to develop a methodology for establishing a statewide health care cost growth benchmark for health entities and health plan premiums. The long-term goal is to consider ways to share statewide accountability for a sustainable, predictable rate of growth in health care spending. The group has representatives from multiple payers and health care sectors, as well as economic and actuarial expertise, and is scheduled to deliver its proposed methodology by the end of 2014. More information is available online here: <http://www.oregon.gov/oha/Pages/srg.aspx>.

## Legal and regulatory levers

As with the financial levers, Oregon has not made substantive changes to plans for using legal and regulatory levers to advance the coordinated care model in Year 2. Working with the Oregon Educators' Benefit Board and Cover Oregon to incorporate coordinated care model elements into their request for proposal, certification and contract language remains a key strategy. A new development since Oregon's October 2013 Operational Plan submission is that the Oregon Health Policy Board has decided to form a dedicated committee to support spread of the coordinated care model to the Public Employees' Benefit Board, Oregon Educators' Benefit Board and, importantly, to the commercial market including employers. The Coordinated Care Model Alignment work group is described in more detail under cooperative levers, since it will focus on developing tools and templates to support *voluntary* alignment across markets.

## Structural levers

Technical assistance and other structural supports for transformation will continue to be a significant part of the state's strategy for implementing and spreading the coordinated care model in Year 2. Some specific future activities that were not described in Oregon's 2013 Operational Plan include:

### *Additional technical assistance*

This includes:

- New learning collaboratives developed in response to stakeholder requests and identified needs. Several additional collaboratives are in the planning stages including health equity; traditional health workers; adverse childhood experiences (ACEs) and trauma-informed care; dental integration; and flexible services.
- A Technical Assistance Bank developed by the Transformation Center, offering a menu of technical assistance topics that CCOs may access upon request. Initial areas of assistance include community health improvement plan implementation and evaluation; community advisory council development; health equity; patient engagement; oral health integration; public health integration and tools for measuring improvement.
- A new learning collaborative series hosted by the Patient-Centered Primary Care Institute for 24 primary care clinics, representing over 280 providers and 115,000 patients. The collaboratives will focus on the following topics:
  - Improving Patient Experience of Care (two collaboratives) includes the implementation of a patient experience of care survey, patient engagement methods, and design of quality improvement projects in a way that addresses multiple patient-centered primary care home standards.
  - Improving Access through Patient-Centered Primary Care Homes includes understanding practice supply and demand and how to move to an Open Access scheduling model. The collaborative will be tailored to support particular access needs related to absorbing many new patients, creating more same-day capacity, reducing backlog and utilizing all team members in non-face-to-face visits.
  - The Patient-Centered Communication Skills, Behaviors and Attitudes Collaborative includes embedding the spirit of patient-centered communication in your organizational culture, identifying ways to measure

patient-centeredness, mastery of basic patient-centered office skills, cultural agility, health literacy and self-management support.

The Health Evidence Review Commission's process in the development and spread of clinical guidelines review by the Center for Evidence-Based Policy using stakeholder outreach is nearing its conclusion, with recommendations forthcoming in summer 2014. These will be implemented in Years 2 and 3, in an effort to better translate evidence to support the provider networks of the Medicaid CCOs and other providers as the coordinated care model is spread to improve care and lower costs.

*Increasing the number of qualified and certified health care interpreters*

As CMMI is aware, Oregon's plans for increasing the number of qualified and certified health care interpreters have changed substantially from the time of the October 2013 Operational Plan. In June 2014, OHA received CMMI approval to move forward with developing a learning collaborative to support the use of qualified and certified interpreters in health system transformation. Please see Appendix 21 for detailed information. The Office of Equity and Inclusion has hired the coordinator to facilitate this work and activity will ramp up in Year 2.

*Continued development of health information technology and exchange functionality*

Oregon will continue to develop Phase 1.5 health information technology and exchange services and plans to release procurement request for proposals in 2014 for several services, including provider directory, clinical quality metrics registry, and technical assistance for Medicaid practices. (See Section E for more details.) In 2015, OHA expects to have a legislative ask to enable continuation and expansion of Phase 1.5 services and statewide hospital notifications. The legislation aims to enable OHA's authority to offer health information technology services beyond Medicaid or other OHA programs, participate in partnerships with private partners, and modify existing Health Information Technology Oversight Council legislation to more accurately reflect the council's ongoing work and anticipated role in the future.

Finally, the telehealth pilot projects that were described in the 2013 Operational Plans should begin in Year 2; OHA is working with the Office of Rural Health at Oregon Health & Science University to create a call for proposals to process these SIM-funded pilots.

*Support for behavioral health integration*

The Transformation Center is supporting OHA and stakeholder efforts to develop a comprehensive strategic plan for an integrated, coordinated and culturally competent behavioral health system that provides better health, better care and lower cost for all Oregonians. Thanks to SIM support, the center has contracted with Oregon Health & Science University to conduct an environmental scan of current behavioral health integration activities in Oregon and has engaged a second consultant to develop a program of technical assistance for CCOs on behavioral health integration.

*Population health*

Over the course of Years 2 and 3, OHA will continue to integrate population health in its overall approach to spreading the coordinated care model. OHA's Public Health Division has planned to revise Oregon's Healthy Future, the state health improvement plan published in 2013 as a part of

the state's accreditation efforts, to receive additional stakeholder input on Oregon's priorities and strategies for improving population health. OHA's Public Health Division also acknowledges the need to revise the plan in light of Oregon's rapidly transforming health system.

Between May and August 2014, leadership from OHA's Public Health Division are meeting with local public health authorities, CCOs and community advisory councils, academic partners, local elected officials, providers and community-based organizations. Once stakeholder meetings are complete, feedback will be compiled and an achievable number of strategic priorities will be identified for inclusion in the new state health improvement plan, which will guide population health priorities during 2015 through 2020. Where priorities are identified, OHA Public Health Division staff will convene working groups to draft strategies to meaningfully impact priority health areas by 2020. Strategies will be vetted through OHA leadership and programs before being shared back with external stakeholders for review and comment. OHA's Public Health Division will finalize the state health improvement plan by December 2014.

### **Cooperative levers**

As in Year 1, stakeholder consultation and collaboration will feature significantly in Oregon's Year 2 SIM activities. One particular way Oregon will use cooperative levers to help spread the coordinated care model is the newly formed Coordinated Care Model Alignment Work Group, also described briefly in Section A. This group will include public and private purchasers (including representatives from self-insured and fully insured groups and both large and small businesses) and will focus on developing tools and templates (for example, model request for proposal and contract language) to support voluntary adoption of the coordinated care model in new markets. Work group members will help disseminate information and tools in their professional communities and will advise OHA and the Oregon Health Policy Board on additional strategies for model spread. The health policy board approved the charter for this group in July 2014 (see Appendix 3); a website is under development and the group will meet for the first time in August.

In Year 2, Oregon will also take steps to improve alignment between Medicare and Medicaid materials and policies to improve the experience and coordination of care for individuals who are eligible for both programs. This work was originally slated to begin in Year 1 but was delayed due to the priority work of Medicaid expansion. Oregon is committed to proceed with this work as we enter Year 2, and we intend to work closely with the Office of the Duals and CMMI to accomplish the activities outlined in our 2013 Operational Plan. We have seen over 50 percent of those dually eligible for Medicare and Medicaid voluntarily enroll in the Medicaid CCOs, approaching our goal of at least 65 percent by the end of Year 3.

Section H

## **Participant Retention Process**

Not applicable.

## Overview

Oregon's SIM-specific goals, targets and monitoring activities (including accountability measures and self-evaluation plans) are described primarily in Section R – Evaluation. This section provides updates and outlines future plans for general health system performance monitoring in Oregon. Because measuring performance is a foundational element of the coordinated care model, there is a good deal to report in this section.

### Year 1 accomplishments

#### CCO metrics and Medicaid measurement strategy

As described in the state's original operational plan, Oregon has committed to a rigorous performance measurement program in Medicaid and pledged to reduce the growth trend in Medicaid costs while maintaining or improving access and quality. In the first year of the SIM grant, Oregon has:

- Produced regular public reports on CCO incentive (pay-for-performance) measures and state performance measures, as well as Medicaid cost and utilization. Measures are reported in aggregate and by CCO, against a baseline period (usually 2011). Final 2013 data were released in June 2014 and the results are promising. They include:
  - Decreased emergency department visits and expenditures
  - Increased primary care visits and expenditures, and increased enrollment in patient-centered primary care homes
  - Increased use of developmental screening in the first 36 months of life
  - Decreased hospitalizations for congestive heart failure, chronic obstructive pulmonary disease and adult asthma
  - Increased adoption of electronic health records among CCO providers
  - Decreased early elective deliveries

Progress is unlikely to be uniform or linear but these early results are promising. The reports, including quality and financial results, are in Appendix 17 and are also available online at: <http://www.oregon.gov/oha/Metrics/Pages/index.aspx>

- Made the first performance incentive payments to CCOs who met performance benchmarks or improvement targets on the incentive measures. To earn their full payment, CCOs had to show improvement toward the goals on 12 of the 17 incentive measures. All CCOs showed improvements and 11 out of 15 earned 100 percent of their quality pool (incentive) payments.
- Met its commitment to reduce Medicaid spending trend on a per person basis by two percentage points.
- Assisted CCOs to develop technology plans that will allow electronic reporting of clinical quality data for three CCO incentive measures: depression screening, diabetes control and hypertension control. These technology plans are a first step towards ensuring that CCOs can leverage certified electronic health record technology to access individual-level electronic clinical quality measure data on their beneficiaries from providers.

- Fielded the first of what will be annual experience of care surveys among the Medicaid population (CAHPS). Results will be available in summer 2014.

Medicaid performance measurement is guided by OHA's Metrics & Scoring Committee (<http://www.oregon.gov/oha/Pages/metrix.aspx>) and a Metrics Technical Advisory Work Group (<http://www.oregon.gov/oha/Pages/metricsTAG.aspx>).

### **Performance measurement in other markets**

Consistent with the spread of the coordinated care model, Oregon is working to expand and align performance measurement across markets (see Appendix 4 for a crosswalk of measures associated with different payers or initiatives). Much of this work is ongoing and described under "Years 2 and 3." Accomplishments in the first year of SIM have already been noted in preceding sections. Additional details provided below.

#### *First multi-payer dashboard*

OHA accomplished one of its major goals for enhanced transparency by developing a multi-payer, multi-source dashboard providing data on health care cost and utilization, health insurance coverage, and quality of and access to health care. The dashboard makes frequent use of Oregon's All-Payer, All-Claims data system, among other sources, and aims to provide a clear view of Oregon's health system performance across markets including commercial insurance carriers, Medicare and Medicaid. Trends will be tracked over time and new data sources and lines of business will be added as they become available. By mapping the shifting terrain of Oregon's health care landscape, OHA seeks to inform policymakers, health care providers, insurers, purchasers and individuals about the impact of transformations. The multi-payer dashboard is available online here:

<http://www.oregon.gov/oha/OHPR/RSCH/Pages/dashboards.aspx>

#### *Metrics alignment*

As directed by HB 2118 from Oregon's 2013 session, Oregon's Exchange convened a health plan quality metrics work group to make recommendations on appropriate health outcomes and quality measures to be used by Cover Oregon, Oregon Health Authority, the Oregon Educators' Benefit Board and the Public Employees' Benefit Board. The group's final recommendation (available here: <https://www.coveroregon.com/docs/HB-2118-Recommendations.pdf>) was delivered to the Legislature in May 2014 and identified 13 measures that can be used immediately and 15 more that could be reported when data systems mature and measure specifications are further developed. The vast majority of those measures overlap with metrics being tracked in Medicaid as either CCO incentive measures or state performance measures. The work group's direction was that the participating entities should incorporate the initial 13 quality measures into their contracts at the next available opportunity.

#### *Paying hospitals for care improvements*

HB 2216 from Oregon's 2013 session established the nine-member Hospital Performance Metrics Advisory Committee and tasked the group with identifying three to five performance measures and targets for hospitals to advance health system transformation, reduce hospital costs and improve patient safety. The committee's recommended performance standards will be used

to determine incentive payments to diagnosis-related group hospitals through 2015 from a share of Oregon's hospital assessment revenue. The committee has been working to select measures and design the incentive; a final plan is anticipated in late summer 2014. Information on the committee's work is available here: <http://www.oregon.gov/oha/Pages/http.aspx>.

#### *Incorporating quality information into rate review*

As a first step in this process, Oregon's Insurance Division asked carriers to report their performance on five metrics when submitting their 2015 rates for approval. The measures align closely with the CCO incentive measures and measures recommended by the HB 2118 Health Plan Quality Metrics Work Group (above). At this stage, the metrics will be used for informational purposes only, to promote marketwide transparency and alignment (see: [www.oregonhealthrates.org](http://www.oregonhealthrates.org)). Oregon will consider whether to tie performance more closely to rate approval in the future.

#### *Incorporating greater accountability into the recently signed Public Employees' Benefit Board contracts*

New accountability and quality metrics, aligned with Oregon's CCO incentive metrics, have been built in to Public Employees' Benefit Board health plan contracts to ensure plans are improving care in key areas. OHA will be further refining the process and implementing incentive payments for health plans in the future.

### **Population health measurement**

Population health initiatives under SIM are discussed in Sections D and G of this operational plan update and in the "Population Health Plan Roadmap." However, two Year 1 accomplishments regarding population health measurement should be noted here:

- OHA began data collection on a Medicaid-specific Behavioral Risk Factor Surveillance System survey. In partnership with CDC, Oregon and many other states use the general survey to monitor trends in health status and health behavior at a population level. This Medicaid-specific fielding of the questionnaire will provide CCOs and the state with a snapshot of the health status and needs of the Medicaid population and will be used to help prioritize health improvement work with Medicaid beneficiaries. The sample was designed to allow CCO-specific estimates and comparisons between traditional Medicaid eligible and the ACA expansion population. Results are expected in late 2014.
- In spring 2014, OHA released version 2.2 of the Oregon Public Health Assessment Tool, which offers a redesigned, more user-friendly interface and updated 2012 mortality and infant mortality data. In fall 2013, the tool was updated to include the following 2012 data: birth risk factors, fertility, population estimates, communicable disease and pregnancy/abortion.

### **Capacity**

In addition to these substantive accomplishments, SIM funding has allowed OHA to strengthen and stabilize its capacity for performance measurement, analysis and reporting transparency. Establishing expertise and capacity in these areas is a strategy for Oregon's SIM project, as OHA

believes that measurement and accountability will help drive change across the health care system. In Year 1, Oregon:

- Brought on 8.0 FTE positions in Health Analytics. Individuals in these positions are directly involved in creating CCO metrics, the dashboards and analytic products described above, in improving and validating key data sources such as the All-Payer, All-Claims data system, and in evaluating Oregon's health system transformation efforts. Efforts are underway to assess future sustainability after SIM ends for these key functions, as the OHA looks to do its own internal transformation across its programs.
- Executed a contract with the Center for Outcomes, Research and Education to build an Accountable Care Data System. This will be an interactive data and dashboard system that tracks cost and quality measures over time, compares CCO performance and allows for dynamic exploration of outcomes by key subgroups.
- Executed a contract with a data layout consultant to help present dashboards and other products for external audiences, including the general public. The benefits of this contract can be seen in the clear and engaging presentations of data on the CCO and multi-payer dashboards on OHA's website.
- Continued to collect data and improve operations of the All-Payer, All-Claims data system, working with contractor Milliman.
- Executed a contract with Bailit Health Purchasing to provide consulting services to OHA for health system performance measurement and metrics development; development and implementation of health care alternative payment methods; and tools and strategies to help purchasers adopt elements of Oregon's health system transformation initiatives.

### **Years 2 and 3**

A great deal of the performance measurement work described above will continue through Years 2 and 3 of the SIM grant, as outlined in our original Operational Plan. For example, the CCO and multi-payer performance dashboards will continue to be produced regularly and improved over time, the Consumer Assessment of Healthcare Providers and Systems survey will be fielded annually for the Medicaid population, and alignment of metrics across payers will increase as the Public Employees' Benefit Board, Oregon Educators' Benefit Board and Cover Oregon incorporate the HB 2118 aligned metrics into their contracts. The Public Employee's Benefit Board contract negotiations are complete (June 2014) and successfully incorporated many of the coordinated care model principles. Contracts for 2015 include data collection and reporting on aligned metrics, which will be tied to incentive payments in future contracts. Open enrollment is scheduled to begin October 1, 2014, for the 2015 benefit year. Additionally the coordinated care model principles are being operationalized in the Cover Oregon metrics alignment work group for qualified health plans offered on the exchange

In addition, the following performance measurement and analytic activities are anticipated in Years 2 and 3:

- Acquisition of Medicare fee-for-service data, which will be included in the All-Payers, All-Claims database to develop a full picture of the health care delivery system. Oregon has been working with CMMI and Research Data Assistance Center to finalize release of the data.

- Oregon is convening an All-Payers, All-Claims technical advisory group that will assist with further development of this important data source by making recommendations related to new data fields, validation practices and analytic tools such as groupers or risk adjusters.
- The next round of the Oregon Health Insurance Survey will be fielded in 2015, likely a month or so after the 2015 open enrollment period ends. The survey is Oregon's primary method for monitoring health care coverage and the 2015 survey will provide important information about the impact of ACA coverage expansions in the context of the coordinated care model.
- Development of an internal analytic training program to improve analyst capacity as well as sustainability of the analytic model. The purpose is to provide a customized training program and materials to teach Health Analytics staff how to optimize and integrate the use of SAP BusinessObjects tools with other software and internet products to produce high-quality; accurate statistical and analytical reports for the web (see Section D for more information).
- Development of online dynamic web tools, which will provide an efficient, centralized location for the data elements, metrics and measures that are currently reported through segmented channels. More significantly, it will provide the viewer with the ability to filter the data elements to create automated custom reports using aggregate data. Currently being developed is a strategy for how to organize this effectively and present the information of the most interest to stakeholders. As part of its Phase 1.5 health information exchange development plans, Oregon will establish a clinical quality metrics registry. CCOs will be among the earliest users of this registry, submitting data for the three CCO incentive measures based on electronic medical record data. Plans for a clinical quality metrics registry are discussed more fully in Section E, Alignment with State HIT Plans.

Section J	<b>Appropriate Consideration for Privacy and Confidentiality</b>
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The October 2013 Operational Plan outlines the considerations Oregon is requiring, in alignment with federal law, for privacy and confidentiality. The state will continue those efforts in Years 2 and 3. Our noted challenge continues to be the sharing of behavioral health information to maximize care coordination.

**Year 1 accomplishments**

Oregon has engaged in technical assistance provided through CMMI related to 42 CFR, Part 2, including several conference calls. Oregon participated in developing the SIM testing state's written response to HHS rule changes related to 42 CFR, Part 2 and joined the letter as a signatory.

## Years 2 and 3

No significant changes from the originally approved operational plan are expected for project strategies or timelines in this section.

Section K

## Staff/Contractor Recruitment and Training

### Year 1 accomplishments

The October 2013 Operational Plan described our continued efforts to ensure the SIM investment in Oregon is supported with well-trained staff and that there is ongoing support. Staff recruitment and training continues to be vital to the success of the implementation and spread of the coordinated care model.

## Years 2 and 3

No significant changes from the originally approved operational plan are expected for project strategies or timelines in this section.

Section L

## Workforce Capacity and Monitoring

### Overview

Oregon's health care workforce is a vital engine for transformation. Ultimately, it is providers who will make the practice changes that lead to better care, lower costs and improved health, and none of Oregon's transformation plans can succeed if there are not enough providers to meet the demand for care. The state has a number of workforce capacity development and monitoring initiatives under way that will help ensure that Oregon has the health care workforce needed to support transformation. SIM funding provides support for a few specific workforce development projects but much of the work described below is funded with other resources.

### Year 1 accomplishments

#### Practice transformation assistance for providers

With direct support from SIM, the Transformation Center and the Patient-Centered Primary Care Home Program and Institute are providing resources and technical assistance to help Oregon's workforce transform how care is delivered. Year 1 accomplishments in this area are described in more detail in Section G, but they include the Transformation Center's ongoing Complex Care learning collaborative, the establishment of four practice facilitation and site visit/compliance positions in the patient-centered primary care home program, and focused technical assistance for practices on behavioral health integration, just to name a few. Also in Year 1, Oregon selected its first cohort of SIM-supported Clinical Innovators who will act as champions for innovative clinical delivery system reform projects in their local communities. More information about the Council of Clinical Innovators can be found in Sections A and G.

## **Traditional health workers**

As a means of supporting the coordinated care model and whole-person care, Oregon is promoting the engagement and utilization of the traditional health workforce, which includes community health workers, peer support and peer wellness specialists, personal health navigators and doulas. These development activities are not funded by SIM but there are several accomplishments to report. In the last year, OHA established a Traditional Health Worker Commission to support and foster the use of the traditional health workforce; the commission has sub-groups working on scope of practice, systems integration and training evaluation/program scoring. Final administrative rules for statewide traditional health worker certification were adopted and an application process and certified traditional health worker registry have been established. The commission has approved a number of Oregon training programs that meet the standards for certification and more are reviewed each month. Please see this website for more information: <http://www.oregon.gov/oha/oei/Pages/traditional-health-worker-commission.aspx>

## **Medicaid Primary Care Loan Repayment Program**

As part of its 2012 Medicaid waiver, Oregon committed to providing \$2 million annually in educational loan repayment to primary care providers willing to serve Medicaid clients (and others) in underserved areas of the state for the 2013–2015 biennium. During Year 1, the program was officially launched and quarterly award cycles began. Eleven awards have been made so far to physicians, nurse practitioners and dentists who will serve Medicaid clients in underserved and rural areas of the state. The program accepts applications on an ongoing basis and will be targeting outreach to behavioral health providers in upcoming cycles. More information about the program is online at: <http://www.ohsu.edu/xd/outreach/oregon-rural-health/providers/loan-repayment/ompclrp.cfm>.

## **Oregon Health Policy Board Health Care Workforce Committee**

As described in Oregon's original operational plan, the Oregon Health Policy Board's Health Care Workforce Committee does a range of policy development and coordination work on health care workforce topics. During the first year of SIM (which does not support the committee's activities), OHA and the committee contracted with workforce and economic modeling experts to project the 10-year demand for primary care providers in Oregon, adjusted for the likely effects of new models of care. The analysis used projections of insurance take-up developed by the State Health Access Data Assistance Center, utilization data from Oregon's All-Payer, All-Claims data system and workforce data collected when professionals renew their licenses. Overall, the projections suggest a 16 percent growth in demand for primary care providers over 10 years but that figure varies considerably when different scenarios about changes in the care model are incorporated. The full report is available here: <http://tinyurl.com/lwn2n6y>.

The Healthcare Workforce Committee is currently developing two sets of recommendations that will be delivered to the OHPB in August 2014: 1) strategies for expanding primary care residency training in Oregon; and 2) recommendations for aligning, evaluating and targeting the various health care provider incentive programs (loan repayment, loan forgiveness, tax credits, etc.) in Oregon.

## **Integrative Medicine Advisory Group**

The Integrative Medicine Advisory Group was established in the fall of 2013 to advise the director of OHA on ways to promote the use of integrative medicine disciplines within Oregon's health care delivery system, including CCOs. The advisory group consists of the five integrative medicine professions in Oregon that have a federally-recognized accrediting agency and a state-level health care regulatory board. These include acupuncture and Oriental medicine, chiropractic, direct-entry midwifery, massage therapy and naturopathic medicine. Advisory group participants also include CCO medical directors and a commercial health plan medical director. The advisory group has met monthly since fall 2013, serving as a valuable forum for discussion from the various viewpoints of the participants. The group has discussed key topics such as consumer access and choice, best practices and roles focusing on the CCO incentive measures and key cost drivers, integration models in patient-centered primary care homes and CCO credentialing, in support of the triple aim.

### **Years 2 and 3**

With the exception of plans to increase the supply of certified health care interpreters and a network adequacy initiative, described more fully below, Oregon's workforce development plans have not changed substantially from the initial operations plan. The Oregon Health Policy Board Health Care Workforce Committee will continue to address workforce policy questions as directed by the board and Governor's Office. Workforce capacity monitoring is ongoing; the next report from Oregon's health care workforce licensing database is anticipated in January 2015. The Traditional Health Worker Commission will continue to promote the use of the culturally competent, diverse traditional health worker workforce. Finally, the Transformation Center and the Patient-Centered Primary Care Home Program and Institute will continue their efforts to engage health care providers and support them in transforming care at the clinical and system levels. See Section G for more on Transformation Center and patient-centered primary care home plans.

#### **Health care interpreters**

As CMMI is aware, Oregon has adjusted its original plans for health care interpreter workforce development. With final CMMI approval as of June 3, 2014, Oregon will test a learning collaborative model of health care interpreter workforce development with three cohorts of individuals over the course of the SIM grant. The collaborative will provide education and skills development sessions required for qualification and/or certification of health care interpreters and increase CCOs' and other health plans' access to and use of qualified or certified health care interpreters to deliver services to their members.

#### **Network adequacy**

Oregon's Insurance Division has convened a group of stakeholders to advise it on updates to network adequacy requirements for commercial insurers. Updates are needed not only to bring the insurance code into compliance with ACA provisions on non-discrimination and other topics

but also to align network adequacy expectations across markets in Oregon, particularly for commercial plans sold inside and outside the exchange. OHA’s chief medical officer, and SIM principal investigator, is serving on the advisory committee along with other stakeholders involved in Oregon’s transformation center to ensure the new regulations anticipate the spread of the Coordinated Care Model and its integration of care and providers across traditional silos.

Section M	<b>Care Transformation Plans</b>
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### **Overview**

Oregon is committed to developing and supporting transformative practices across the health delivery system. With SIM funding and other resources, work is underway to: identify and share best and promising practices across the delivery system through the Transformation Center; support innovation in primary care clinics across the state through the Patient-Centered Primary Care Institute; and to foster a quality improvement mindset at all points in the system.

A great deal of Oregon’s activity in these areas is also highlighted elsewhere in the operational plan – particularly in Section G – so some of the content in this section may be familiar.

### **Year 1 accomplishments**

#### **Science of improvement**

Thanks to SIM resources, Oregon was able to offer seminal training in improvement methods to delivery system partners to all but one coordinated care organization as well as key OHA staff. Experts from the Institute of Health Care Improvement provided both trainings: a three-day training in the Science of Improvement in May 2013 and a second three-day training on the Science of Improvement in Action in 2014 (followed by three webinars for additional support). As part of the second event, each CCO and OHA work group developed an improvement project, including a driver diagram, charter and performance measures. IHI provided information on run charts, identifying improvement when it happens, and other tools and approaches to assist in spreading a culture of innovation and practice. Additionally, OHA’s Innovator Agents have received consultation from Neil Baker, MD, an expert on the “people side” of change to support the development of a culture of innovation.

#### **Transformation Center technical assistance and quality improvement**

Care transformation and accelerating the spread of best practices is the core business of OHA’s Transformation Center. As outlined in Section G, the Transformation Center has established itself as the go-to entity for resources and technical assistance on both clinical and health system transformation. Some of the ways in which the center is cultivating a culture of improvement include five active learning collaboratives and the creation of the first Council of Clinical Innovators in summer 2014. Please see Section G for more information.

## **Patient-Centered Primary Care Institute technical assistance and quality improvement**

The Patient-Centered Primary Care Institute is the centralized “front door” for primary care provider-level quality improvement training and technical assistance. The institute works with various stakeholder community-based organizations to leverage existing expertise through the Expert Oversight Panel, a multitude of technical assistance subcontractors and the Technical Assistance Learning Network, all designed to bring together technical assistance experts, academic medical centers, independent physician associations and other learning networks to identify resources gaps and strategically deploy needed provider-level supports. In the first year of SIM, the institute offered nine webinars, a Technical Assistance Expert Learning Network Conference, and two week-long trainings provided to over 40 clinics on integrating behavioral health in primary care. Webinar recordings and all materials associated with these events are located at [www.pccpi.org](http://www.pccpi.org). Please see Section G for more information.

The patient-centered primary care program expanded its capacity for technical assistance for primary care transformation by contracting with 10 clinical consultants to provide technical assistance and act as clinical champions for practice transformation and by hiring five positions (three supported by SIM funds) to provide consultation, technical assistance and evaluation services through clinic site visits as well as develop strategic communication and marketing strategies.

## **Quality improvement and care transformation in long-term care**

As described elsewhere in this document and Oregon’s October 2013 Operational Plan, the role of Long-Term Services and Supports Innovator Agents was explicitly created to transform care and improve quality for individuals who interact with both the medical care system and long-term care services and supports. In the first demonstration period, Oregon hired seven Long-Term Services and Supports Innovator Agents (SIM resources support three of these positions) and assigned each to a specific region. Those agents are now working directly to address consumer and systems issues to facilitate better outcomes and lower costs, and avoid cost shift between social and medical systems. Their work involves helping CCOs, local and state long-term care offices, other health and social service agencies, and individual consumers engage with each other under a new model of care focused on quality improvement.

## **Clinical evidence for better care**

Oregon has almost completed a detailed review of the processes used by the Health Evidence Review Commission’s to develop and disseminate clinical guidelines. Input from a wide variety of stakeholders will be used to make improvements in the coming months, in an effort to better translate evidence as the coordinated care model spreads to support providers to improve care and lower costs.

## **Data infrastructure for quality improvement**

Because timely, actionable data are a necessary support for quality improvement, it is worth noting several data infrastructure accomplishments in the first year of SIM. However, these topics are covered in more detail in previous sections (D, E and I).

- Oregon began regular publication of dashboard reports, both a statewide multi-payer performance report with quality measures, utilization statistics and expenditure trends by major payer category, and a CCO performance dashboard, including quality measures and cost and utilization trends for Medicaid.
- The CCOs completed technology plans outlining how they will develop the ability to electronically report clinical quality data for three CCO incentive measures: depression screening, diabetes control and hypertension control. These technology plans are a first step towards ensuring that CCOs can leverage certified electronic health record technology to access individual-level electronic clinical quality measure data on their beneficiaries from providers.
- Oregon should receive Medicaid fee-for-service data to incorporate into the state's All-Payer, All-Claims database in summer 2014.
- Current implementation of the Emergency Department Information Exchange in all of Oregon's hospitals and future plans will allow providers, health plans and CCOs, and regional health information exchanges to access this data as real-time notifications when their member or patient has a hospital or emergency department event.
- Statewide data on population health status and behaviors and on kindergarten readiness (collected under the auspices of the Early Learning Council and hubs) are being cut by CCO region to inform CCOs' efforts to bridge gaps between medical care, community health and education.
- The Public Health Division released a new version of the Oregon Public Health Assessment Tool with a redesigned, user-friendly interface and updated data.

## **Transformation grants**

As noted in the October 2013 Operational Plan, Oregon's 2013 Legislature allocated \$30 million to support innovation and further CCOs' efforts to transform health care delivery in Oregon. CCOs collectively agreed to hold back \$3 million of that total to serve as the state share of funding for CareAccord direct secure messaging and other statewide services, but the remainder was disbursed to all 16 CCOs for specific projects tied to their required Transformation Plans. The transformation work supported by these grants includes initiatives to improve care coordination for high-risk members, community health integration, payment reform, regional health information exchanges and more. The Transformation Center will receive regular reports on CCOs' progress toward the goals outlined in their grant applications.

## **Years 2 and 3**

Supporting quality improvement and fueling transformation will continue to be priorities for Oregon throughout the SIM grant period. Some activities in this area that were not described in the October 2013 Operational Plan include:

- Several new learning collaboratives developed in response to stakeholder requests and identified needs. Several additional collaboratives are in the planning stages including: health equity, traditional health workers, adverse childhood experiences and trauma-informed care, dental integration and flexible services.
- A Technical Assistance Bank developed by the Transformation Center, offering a menu of technical assistance topics that CCOs may access upon request (see Section G).
- A new learning collaborative series hosted by the Patient-Centered Primary Care Institute for 24 primary care clinics, representing over 280 providers and 115,000 patients. The collaboratives will focus on patient evidence of care, improving access and patient-centered communication skills, behaviors and attitudes (see Section G).
- As noted above, the Health Evidence Review Commission will begin to implement process improvements based on the stakeholder input and review conducted in the first half of 2014.
- The new staff hired in the patient-centered primary care home program (see above) will begin a renewed cycle of site visits, offering practice facilitation and other technical assistance to help clinics advance along the spectrum of transformation.

### **CCO transformation plans**

Oregon's Medicaid CCOs are responsible for developing plans for transformation in eight specific areas including integrating care across silos; patient-centered primary care; alternative payment methods; community health assessments and improvement plans; health information technology and health information exchange; and three components of health equity. Initial plans were due when organizations responded to the CCO request for applications and included specific milestones for 2014 and benchmarks for 2015. OHA recently received transformation plan updates from each of the CCOs reporting on progress toward the 2014 milestones and providing updates on transformation activities. Staff at the Transformation Center will review these updates in detail to inform the provision of future technical assistance and rapid-cycle quality improvement. Evaluation staff from Health Analytics will also review the updates as part of Oregon's SIM self-evaluation.

### **Population health**

Over the course of Years 2 and 3, OHA will continue to integrate population health in its overall approach to spreading the coordinated care model. OHA's Public Health Division has planned to revise the State Health Improvement Plan, which was developed in 2012 as a part of the state's accreditation efforts, to receive additional stakeholder input on Oregon's priorities and strategies for improving population health. OHA's Public Health Division also acknowledges the need to revise the plan in light of Oregon's rapidly transforming health system. This work will feed directly into Oregon's SIM Population Health Roadmap (see Section G for more information).

Also as noted in Section G, OHA staff will be reviewing the CCOs' required community health assessments and related improvement plans. Themes and opportunities for technical assistance will be identified and incorporated into technical assistance offerings in the next periods to support population health goals.

### Overview

The Transformation Center is initiating development of a contract for a consultant to work with stakeholders and potential funders to develop a sustainability plan for the Transformation Center. The center has already attracted support from local foundations, such as the Northwest Health Foundation, to support some efforts with the community advisory council learning collaborative. Additional collaboration and partnership with local and national foundations is being discussed and planning is moving forward.

As noted in Section G, OHA originally partnered with the Northwest Health Foundation to establish Oregon's [Patient-Centered Primary Care Institute](#), which is now housed at the Oregon Health Care Quality Corporation. The institute provides practice-level technical assistance to further the patient-centered primary care home model adoption. While SIM funding continues to support the institute's technical assistance activities, including hands-on learning collaboratives and web-based resources, the institute will be focusing on developing sustainability plans to include resources from payers outside of the OHA as well as other stakeholders. Broadening the pool of supporting resources will allow the institute to reach additional providers, allow further spread of best practices and transformation, and also ensure sustainability of these activities beyond the SIM grant demonstration periods.

The Oregon Legislature appropriated \$30 million dollars to fuel innovation and transformation among the sixteen coordinated care organizations in the current biennia. These resources have also contributed to spreading the coordinated care model, supporting community-based health initiatives and health information technology investments across the state. Whether to continue this investment at the current level or a different level is expected to be a legislative conversation in the upcoming session. Additionally, the Transformation Center and other program areas within the Oregon Health Authority have proposed policy option packages for state general funds to commence support for key activities at the sunset of SIM funding in September 2016.

### Years 2 and 3

No significant changes from the originally approved operational plan are expected for project strategies or timelines in this section.

The October 2013 Operational Plan describes Oregon's efforts for this section, and there are no significant updates. We intend to continue to proceed into Years 2 and 3 as outlined in this section of the 2013 plan.

**Section P****Implementation Timeline for Achieving Participation and Metrics**

A detailed SIM project management plan with milestones can be found in Appendix 22. Please also see Appendix 23 for a high-level visual timeline of Oregon's innovation and health care transformation plans and Appendix 24 for Oregon's vision of the evolution of coordinated care models.

**Section Q****Communications Management Plans**

The October 2013 Operational Plan details our efforts leading up to the implementation of the coordinated care model in Medicaid, as well as Oregon's extensive work with stakeholders. That effort continues, thanks to SIM funding, as outlined in Section C. We will continue to be active partners with our providers, stakeholders, health systems, health plans and the public as we move into Years 2 and 3.

**Year 1 accomplishments**

OHA has an extensive web presence. The website can be viewed at: [www.Health.Oregon.gov](http://www.Health.Oregon.gov). Media clips can be viewed at: <http://www.oregon.gov/oha/news/Pages/clips.aspx>

OHA's use of social media can be found on Facebook and Twitter.

**Years 2 and 3**

No significant changes from the originally approved operational plan are expected for project strategies or timelines in this section.

**Section R****Evaluation Plan**

Oregon has worked closely during this year with CMMI and the national SIM consultants to develop the Oregon SIM Self-Evaluation Plan, including accountability targets. Please see this separate document as part of Oregon's non-competing SIM application.

**Section S****Fraud and Abuse Prevention, Detection and Correction**

As outlined in our 2013 Operational Plan, we have incorporated protections and built in requirements to potential fraud and abuse in our coordinated care model. We have these elements in place with our Medicaid CCOs and now as we move forward to spread to the state employees. SIM funding is integral to the success of Transformation in Oregon, and state processes and procedures have and will continue to ensure that grant expenditures are regularly monitored and tracked to ensure they are used to their intended intent.

**Years 2 and 3**

No significant changes from the originally approved operational plan are expected for project strategies or timelines in this section.

Section T

## Risk Mitigation Strategy

Please see Oregon's Risk Mitigation Plan – updated in spring 2014 – which is included as a separate document in our non-competing SIM application.