



Appendices

State Innovation Model

2015 Operational Plan Update

Appendices

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Appendix 1

Media Coverage and Press Releases on Oregon Health Transformation

Appendix 1

Media Coverage and Press Releases on Health Transformation

CCO projects \$3 million-plus surplus

Central Oregon's coordinated care organization, PacificSource Community Solutions, rounded out 2014 with a more than \$3 million surplus its leaders are still deciding how they'll spend. ... The surplus might mean that OHP beneficiaries did a better job seeking out preventive care before health issues required more expensive interventions ... Or that the new OHP beneficiaries who came on board this year — the first year the program was expanded to include all adults up to 138 percent of the federal poverty level — were healthier than expected. Or that they didn't try to see doctors as much as expected. ... It could also signal something less rosy: Not that people didn't try to see doctors, but that they couldn't.

<http://www.bendbulletin.com/home/2738106-151/cco-projects-3-million-plus-surplus>

New Oregon Health Plan Enrollees Skew Younger And Healthier

The hundreds of thousands of Oregonians who signed up for Medicaid under the Affordable Care Act last year, are younger and healthier than expected — according to a new study out of the state. The age and health of new Oregon Health Plan enrollees is important, because on average a population is more expensive to care for if it's older and sicker. But Lori Coyner with the Oregon Health Authority says the 380,000 Oregonians who were added to Medicaid last year, tended to be young and healthy.

<http://www.opb.org/news/article/new-oregon-health-plan-enrollees-skew-younger-and-healthier/>

With 380K new patients, Oregon's Medicaid transformation continues to bend the cost curve

Even with an influx of 380,000 new Medicaid enrollees last year, Oregon's Coordinated Care Organizations managed to contain cost growth and hold down emergency room use and diabetes-related hospital admissions. The Oregon Health Authority's Office of Health Analytics reported on various metrics in its 2014 Mid-Year Performance Report, out this morning, which spans July 1, 2013, through June 30, 2014. It found that newly enrolled members use ERs less frequently than existing members. Overall, ER visits decreased 21 percent since 2011.

<http://www.bizjournals.com/portland/blog/health-care-inc/2015/01/with-380k-new-patientsoregons-medicare.html>

Health systems transformation report shows progress

Oregon's mid-year Health System Transformation report lays out the progress of Oregon's coordinated care organizations on key quality and financial measures. For the first time, the report includes a special section with data on the new Oregon Health Plan members who have joined since January 1, 2014, as more people became eligible for Medicaid through the Affordable Care Act. The report, which covers July 1, 2013, through June 30, 2014, shows continuing improvements in areas such as enrollment in patient-centered primary care homes, decreased emergency department visits, and hospital admissions from chronic diseases. Additionally, financial data indicate coordinated care organizations are continuing to hold down costs. Oregon is staying within the budget that meets its commitment to the Centers for Medicare

and Medicaid Services to reduce the growth in spending by two percentage points per member, per year.

http://www.thenewsguard.com/regional/article_51446000-9c0f-11e4-87c6-db3810368ba6.html

Pilot program aims to curb health care costs by pumping money into primary care

Starting this month, the Community Health Centers of Benton and Linn Counties are taking part in a one-year pilot program that pays them a flat monthly rate for providing a full range of services to the 6,322 Oregon Health Plan members assigned to the county-run clinics in Corvallis, Monroe and Lebanon. Rather than billing OHP (Oregon's version of Medicaid, the federal insurance program for the poor and disabled) on a fee-for-service basis, the Community Health Centers will receive a single payment each month from the InterCommunity Health Network, the regional coordinated care organization for Linn, Benton and Lincoln counties.

http://www.gazettetimes.com/albany/news/local/pilot-program-aims-to-curb-health-care-costs-by-pumping/article_67ae18d6-d5ad-5885-a7dd-e2b76f7a6b95.html

A look at the hospital tax and Kitzhaber's Oregon Health Plan budget

If all goes according to plan, there won't be any change to the hospital tax in the next biennium. Gov. John Kitzhaber's budget assumes it will remain at 4.5 percent of net patient revenue. In addition, there is a 1 percent assessment for the Hospital Transformation Performance Program. Combined, the tax can't be more than 6 percent, according to the Centers for Medicare and Medicaid.

<http://www.bizjournals.com/portland/blog/health-care-inc/2015/01/a-look-at-the-hospital-tax-and-kitzhabers-oregon.html>

Oregon Medicaid Reforms Meet Savings Goals

The state of Oregon recently reported that the 380,000 of its citizens who are newly enrolled in Medicaid are younger and healthier than previously expected. For this reason, the coordinated-care system did not adversely impact the ability to meet the targeted savings of \$11 billion over 10 years. There was a 21 percent decline in emergency department visits for patients served by the coordinated-care organizations in Oregon since 2011. In addition, the state reported there was a 48 percent decrease in hospital admissions related to chronic obstructive pulmonary disease and a decrease of 9.3 percent in hospital admissions that were linked to short-term diabetes problems. Furthermore, reports show that Oregon Health Plan members had lower utilization rates than existing members in the plan and inpatient costs have fallen since 2011.

<http://mbamedical.com/oregon-medicaid-reforms-meet-savings-goals/>

WSJ: Why Oregon's 'innovative approach' could lead the U.S.

Gov. John Kitzhaber's Medicaid transformation has received a shout out from an unlikely quarter — the Opinion page of the Wall Street Journal. In a "[Politics & Ideas](#)" piece today, William A. Galston asserts that "Oregon's innovative approach shows that states may lead the way."

<http://www.bizjournals.com/portland/blog/health-care-inc/2015/01/wsj-why-oregons-innovative-approach-could-lead-the.html?ana=twf>

Health care: Growth amid change

Local health care providers are moving ahead to expand services and add staff this year, even though the future of the Affordable Care Act — a driver of rising demand for medical services

— remains far from clear. Last year, hundreds of thousands of uninsured Oregonians got health care coverage because of the Affordable Care Act and the expansion of the Oregon Health Plan, the state's version of Medicaid — the government health plan primarily for low-income people. In June 2014, about 5 percent of Oregonians were uninsured, down from 14 percent a year earlier, according to a recent Oregon Health and Science University study.

<http://registerguard.com/rg/news/local/32662608-75/health-care-growth-amid-change.html.csp>

Coordinated Care Organization awards funds

Columbia Pacific Coordinated Care Organization (CCO) recently awarded more than \$85,000 to eight community wellness programs throughout Columbia, Clatsop and Tillamook counties.

http://www.dailyastorian.com/Local_News/20150219/coordinated-care-organization-awards-funds

Oregon House extends hospital tax

Oregon's hospitals will continue to pay a tax that allows the state to recoup billions in federal money to pay for health care for low-income people. The Oregon House voted 56-2 on Wednesday to extend the tax by four years — double the usual two-year renewal — and send House Bill 2395 to the Senate. Oregon has had a provider tax in some form since 2003. The current version has been endorsed by a coalition of groups.

<http://portlandtribune.com/pt/9-news/253422-123198-oregon-house-extends-hospital-tax>

Oregon lawmakers approve \$7.3 billion measure to fund Medicaid

Lawmakers on Tuesday passed a \$7.3 billion funding measure to pay for Oregon's Medicaid program over the next four years. The bill extends a \$1.9 billion tax on hospitals over the next two budget cycles. In return, the state will receive \$5.4 billion in federal matching funds, which are then given to hospitals in the form of Medicaid payments.

http://www.oregonlive.com/politics/index.ssf/2015/03/oregon_lawmakers_approve_7_bil.html

After concerns, Oregon's 2015 Medicaid rates set for an overhaul

The Oregon Health Authority is re-doing the reimbursement rates it's paying this year to the Coordinated Care Organizations. The move comes as the group hopes to make the state's health reforms financially sustainable. "We reevaluated and assessed the work we did, after concerns were expressed by the CCOs in January," said OHA Director Lynne Saxton, who was just confirmed as OHA head earlier this month.

<http://www.bizjournals.com/portland/blog/health-care-inc/2015/03/after-concerns-oregon-health-authority-opts-to-re.html?ana=tw&page=2>

Central Oregon docs start project to curb opiate abuse

In 2016, a community standard will limit the daily dose of opiate drugs prescribed for Central Oregon's Medicaid patients: No more than the equivalent of 120 milligrams of morphine. ... Central Oregon's effort is kicking off with support from Central Oregon's coordinated care organization, which administers care for Medicaid, or Oregon Health Plan, patients. CCO data on Central Oregon's OHP population were what initially pushed Mann and other providers to launch the opiate project.

<http://www.bendbulletin.com/health/3033516-151/central-oregon-docs-launch-project-to-curb-opiate>

On the road for health in Grant County

Driving the highways of Grant County is nothing new for Kathy Cancilla, Healthy Together Project coordinator who lives near John Day. Getting Grant County residents talking about local health issues and ways to resolve them was the purpose of the Eastern Oregon Coordinated Care Organization's (EOCCO) health transformation grant to Community Counseling Solutions, which contracts to provide health services in Grant and three other Eastern Oregon counties. <http://www.bluemountaineagle.com/People/20150505/on-the-road-for-health-in-grant-county>

Health Share Looks “Upstream” at Legal, Housing Issues that Affect Health

Medical-legal partnerships and the connections between health and housing dominated the May 1 meeting of Health Share's Community Advisory Council. “We're trying to think upstream, about the social determinants of health,” said Rachel Arnold, contracting and provider relations manager.

<https://www.thelundreport.org/content/health-share-looks-%E2%80%9Cupstream%E2%80%9D-legal-housing-issues-affect-health>

Redmond 'community paramedic' a first for Oregon

Redmond Fire and Rescue's mobile paramedic program plays an important role in the community health of Central Oregonians by helping high-risk patients avoid preventable health emergencies. When Doug Kelly, Redmond Fire and Rescue EMS division chief, heard about mobile paramedic programs in Texas and Colorado, he was convinced such a program could make a difference for rural Oregonians. Kelly worked with PacificSource Community Solutions, the coordinated care organization in Central Oregon, and St. Charles Health System to set up the state's first grant-funded mobile paramedic program.

<http://www.ktvz.com/news/Redmond-community-paramedic-a-first-for-Oregon/33170636>

Financial Filings Portray Ups and Downs of CCOs Early Growth

Oregon's 16 coordinated care organizations, born out of the Affordable Care Act to provide healthcare to people on Medicaid, appear to be entering their financial adolescence: reporting stronger profits as they grow, but not yet fully mature or ready for long-term independence. All were profitable in 2014, according to internal financial statements published Friday by the Oregon Health Authority, and several CCOs have strong cash reserves. But others reported limited cash, sometimes only enough cash to last a few days in a crisis – though Mark Fairbanks, chief financial officer at the Oregon Health Authority, says he's not concerned.

<https://www.thelundreport.org/content/financial-filings-portray-ups-and-downs-ccos-early-growth>

Columbia Gorge 'Veggie Rx' program writes prescription for free food

Even as farmers markets and CSAs -- community supported agriculture programs -- become more common in the Columbia Gorge, about 30 percent of people in the area reportedly worry about running out of food. [Gorge Grown Food Network](#), a nonprofit made up of farmers and advocates, is trying to bring that number down with a program that gives families vouchers for free vegetables. ... The Columbia Gorge Coordinated Care Organization Community Advisory Council, a group under the state's umbrella, conducted a study that found up to 34 percent of

households in the five Columbia Gorge counties have run out of food at some point, even with the help of government welfare programs.

http://www.oregonlive.com/business/index.ssf/2015/06/columbia_gorge_veggie_rx_progr.html

OHA gives \$128M to state's Medicaid providers for quality improvements

Even with 434,000 more Oregonians on the Oregon Health Plan last year, the coordinated care model continued to show improvements in several areas, according to the 2014 annual report.

Among those areas of care:

- Emergency room visits decreased 22 percent from 2011.
- Hospital admissions dropped 27 percent for short-term complications from diabetes and 60 percent for chronic obstructive pulmonary disease.
- Enrollment in patient-centered primary care homes increased 56 percent.
- The percentage of adult patients that had appropriate screening and intervention for alcohol or other substance abuse rose.

Each of the state's 16 Coordinated Care Organizations, which delivery Medicaid services to 1 million Oregonians, were evaluated based on 17 quality measures. One room for improvement cited in the 2014 Final Report is screening for cervical cancer and chlamydia.

<http://www.bizjournals.com/portland/blog/health-care-inc/2015/06/oha-gives-128m-to-states-medicaid-providers-for.html>

New Report Says Oregon Health Reform Is Working

Oregon's health care reform efforts appear to be working, according to [a new report](#) on outcomes and finances. The report looks at how Oregon's system of Coordinated Care Organizations are doing under the Oregon Health Plan. That population ballooned last year by more than 400,000 people as part of the Affordable Care Act. Nobody was quite sure whether they'd swamp the system.

<http://www.opb.org/news/article/new-report-says-oregon-health-reform-is-working/>

Local clinic gets state's first 3 STAR rating

Winding Waters Clinic of Enterprise is leading the pack in Oregon patient care by becoming the first and only health care clinic in the state to receive a 3 STAR designation by the Oregon Health Authority. The clinic is recognized by the OHA as one of 560 PCPCHs in the state. A PCPCH is a health care clinic recognized for its patient-centered, comprehensive, team-based, coordinated, accessible care while maintaining a focus on quality and safety. The 3 STAR designation is reserved for clinics that go above and beyond the guidelines of the PCPCH framework.

http://www.wallowa.com/local_news/20150706/local-clinic-gets-states-first-3-star-rating

National

Oregon Medicaid reforms meet savings goals as more enroll

Oregon's 380,000 new Medicaid enrollees are younger and healthier than anticipated, so the influx into the state's coordinated-care system did not negatively affect its ability to meet targeted savings of \$11 billion over 10 years, the state reported Wednesday. A 21% decline occurred in emergency department visits for patients served by Oregon's coordinated-care organizations since the 2011 baseline, the state reported. Also reported—a 9.3% decline in

hospital admissions related to short-term diabetes complications, and a 48% decrease in hospital admissions for chronic obstructive pulmonary disease.

http://www.modernhealthcare.com/article/20150114/NEWS/301149981?utm_source=twitterfeed&utm_medium=twitter&utm_campaign=social

Web Briefing: Early Impacts of the Medicaid Expansion for the Homeless Population

The Affordable Care Act's Medicaid expansion provides a significant opportunity to increase health coverage and improve access to care for individuals experiencing homelessness, who historically have had high uninsured rates and often have multiple, complex physical and mental health needs. On Monday, December 15, 2014, the Kaiser Family Foundation hosted a web briefing to examine the early impacts of the ACA's Medicaid expansion on the homeless population, as well as opportunities and challenges looking forward.

<http://bit.ly/1fi8miX>

Some 'Safety Net' Health Clinics See Drop in Uninsured Visits Under Obamacare

The expansion of Medicaid under the Affordable Care Act is reducing the number of uninsured patient visits to community health centers, new research suggests. In the January/February issue of the *Annals of Family Medicine*, researchers from Oregon Health & Science University (OHSU) report there was a 40 percent drop in uninsured visits to clinics in states where Medicaid was expanded during the first half of 2014, when compared to the prior year. At the same time, Medicaid-covered visits to those clinics rose 36 percent.

<http://health.usnews.com/health-news/articles/2015/01/12/some-safety-net-health-clinics-see-drop-in-uninsured-visits-under-obamacare>

Ore. Coordinated Care Organizations Backed by Analytics, HIE

Oregon's coordinated care organizations (CCOs) are well ahead of HHS Secretary Sylvia Burwell's desire to bring accountable care to the majority of patients in the United States. In just a few short years, the state's Medicaid program has cut emergency department visits by 21 percent, decreased diabetes-related hospital admissions by 9.3 percent, and boosted patient-centered medical home (PCMH) enrollment by a staggering 55 percent since 2011.

<http://healthitanalytics.com/2015/02/02/ore-coordinated-care-organizations-backed-by-analytics-hie/>

Walk-in behavioral health clinics emerge as potential trend

Historically, if a person with behavioral health issues needed immediate attention, there were only two viable options: a trip to the emergency department of the local hospital or a phone call to a 24-hour crisis hotline. Now, the emerging trend in walk-in behavioral health facilities is providing a potentially better alternative. In the last several months, Urgent Psych Care was launched as the first walk-in facility in the Houston area, dedicated solely to psychiatric treatment and medication management. Additionally, in January, the Eugene, Ore., Rapid Access Center (RAC) and Medical Clinic hosted the grand opening of its facility.

<http://www.behavioral.net/article/walk-behavioral-health-clinics-emerge-potential-trend?page=2>

A Unicorn Realized? Promising Medicaid ACO Programs Really Exist

Some people used to say that accountable care organizations (ACOs) are like unicorns—they sound amazing but nobody has seen one in real life. However, with hundreds of ACOs now

sprouting up in an array of shapes and sizes in Medicare, Medicaid, and the commercial sector, this saying has finally been put to rest. Still, until recently, it's been unclear whether ACOs can live up to the hype or are just a passing health care reform fad. Although the results are preliminary, the experiences of Medicaid ACO programs in [Colorado, Minnesota, and Oregon](#) show that this model of coordinating care—and then sharing in the resulting savings with payers—holds real promise.

<http://www.commonwealthfund.org/publications/blog/2015/mar/unicorn-realized-medicaid-acos>

Survey: Nearly 9 in 10 US adults now have health insurance

Underlining a change across the nation, nearly 9 out of 10 adults now say they have health insurance, according to an extensive survey released Monday. As recently as 2013, slightly more than 8 out of 10 had coverage.

<http://www.cbsnews.com/news/nearly-9-in-10-u-s-adults-now-have-health-insurance-survey/>

Study Finds Broad Rise in Medication Use by Those Newly Joining Medicaid

People newly covered by Medicaid drove a significant increase in prescription drug use in 2014, even as those with private commercial coverage filled fewer prescriptions and, over all, patients did not visit the doctor as often, according to a new report by the IMS Institute for Healthcare Informatics, which tracks the health industry. [The report](#), released on Tuesday, offers a window into how consumers used their insurance in 2014, the first full year after millions of Americans gained coverage through the health care law, which expanded eligibility for Medicaid in many states and set up marketplaces where consumers could shop for insurance.

<http://www.nytimes.com/2015/04/14/business/study-finds-broad-rise-in-medication-use-by-those-newly-joining-medicaid.html?ref=health&r=0>

Does EHR Coverage Data Affect Continued Patient Care?

A new study shows that health insurance use and continued patient care among this segment of the population may be enhanced with the integration of EHR systems among medical facilities. With a large amount of new patients entering the medical care continuum, EHR coverage data could potentially be better utilized to track how and when consumers obtain healthcare services. The researchers from the Oregon Health and Science University published their paper on this subject in the [Journal of the American Medical Informatics Association \(JAMIA\)](#). The study focused on three data sets, which includes reimbursement information, Medicaid coverage data, and EHR coverage data. The researchers followed more than 69,000 pediatric patients within these data sets who received care across 96 Oregon safety net clinics within the Oregon Community Health Information Network.

<https://ehrintelligence.com/2015/05/12/does-ehr-coverage-data-affect-continued-patient-care/>

Oregon Telehealth Projects Target Population Health Improvements

The State of Oregon has awarded grant funding for five one-year telehealth projects that support the state's healthcare system transformation efforts. Each project will work to address a unique population and system challenge in areas such as behavior health, youth dental, dementia care, HIV services and connecting paramedics to clinics in rural areas. In April 2013, the Center for Medicare & Medicaid Innovation awarded a State Innovation Model grant to Oregon, a portion

of which is dedicated to supporting and accelerating statewide health IT initiatives.
<http://www.healthcare-informatics.com/article/oregon-telehealth-projects-target-population-health-improvements>

Ore. Accountable Care Organizations Continue to Boost Quality

Oregon's network of sixteen coordinated care organizations (CCOs), similar to accountable care organizations springing up across the nation, are continuing their steady march towards improved quality and cost savings, the Oregon Health Authority's latest measurement report reveals <http://www.oregon.gov/oha/Metrics/Documents/2014%20Final%20Report%20-%20June%202015.pdf>. Thirteen out of the sixteen participating organizations earned back all of their available quality-based financial bonuses in 2014, the report states, while the remaining three CCOs made measurable progress on at least some of the required clinical quality measures.
<http://healthitanalytics.com/news/ore.-accountable-care-organizations-continue-to-boost-quality>

Opinion

The Secret to Taming Health-Care Costs

Monday's report from the Congressional Budget Office on the country's long-term economic outlook underscores what budget experts have long known: The rising cost of health care is the single largest driver of the gloomy long-term fiscal outlook for the U.S. Yes, the pace of increase has moderated in recent years. But many of the factors reducing cost increases are likely to prove transient. There are grounds for hope, however. As often happens in the federal system, state experimentation may be blazing a trail for national policy. Oregon offers one of the most promising models. In 2011, facing a \$2 billion shortfall in its Medicaid budget, Gov. John Kitzhaber struck an innovative deal with the Obama administration: upfront bridge funding from the federal government over five years in return for a verifiable slowdown in the rate of increase in yearly per capita Medicaid spending, to a level two percentage points below the national average. At the same time, Oregon promised to maintain—and, if possible, improve—health-care access and quality.

<http://www.wsj.com/articles/william-galston-the-secret-to-taming-health-care-costs-1422402320?KEYWORDS=Galston>

Maintain CCOs' mission

When the state Legislature created Community Care Organizations to manage the expanding Oregon Health Plan, no one was certain that the concept, so sensible it was radical, would work. A big for-profit health care company's agreement to buy Lane County's CCO is evidence that it's working very well indeed. The challenge now is to ensure that it continues working for the people who were intended to benefit — the people receiving Medicaid services provided by the OHP, and the taxpayers who support the program.

<http://registerguard.com/rg/opinion/33165356-78/maintain-ccos-mission.html.csp>

Appendix 2

Coordinated Care Model Alignment Joint Workgroup Charter

Coordinated Care Model Alignment Joint Workgroup Charter

Approved by OHPB on May 6, 2014

I. Authority

Through its 2013 recommendations for aligning the Affordable Care Act with Oregon's health system reform, the Oregon Health Policy Board (Board) directs the Administrator of the Public Employee Benefits Board (PEBB), the Administrator of the Oregon Educators Benefits Board (OEBB) and the Director of the Oregon Health Authority (OHA) to jointly charter a workgroup charged with spreading Oregon's coordinated care model.

The workgroup will be guided by (1) the Triple Aim of better health, better care and lower costs; (2) the OHPB's Coordinated Care Model Alignment Workgroup report (December 2013), which outlines coordinated care model attributes and organizational examples; and (3) Oregon's coordinated care model principles as listed below:

- Use best practices to manage and coordinate care;
- Share responsibility for health;
- Measure performance;
- Pay for outcomes and health;
- Provide information so that patients and providers know price and quality; and
- Maintain costs at a sustainable level.

II. Membership

The director shall appoint workgroup members and a workgroup chair. The workgroup shall include the PEBB and OEBB Administrator, industry stakeholders as determined by the director, and a consumer advocate. Workgroup members serve at the pleasure of the director of OHA. Workgroup membership is limited to 2 years. The workgroup's charter shall expire at the discretion of the director after June 2016.

III. Charge

The workgroup is expected to do the following:

- Develop a timeline and work plan to spread the Coordinated Care Model;
- Conduct and publish an environmental scan assessing broad market needs regarding implementation and spread of coordinated care model principles;
- Develop common contract terms and "tool-kit" (e.g. Coordinated Care Model RFP template) for interested purchasers;
- Develop and adopt a process for organizational alignment and shared learning among purchasers to foster broad implementation of the coordinated care model and aligned purchasing policies and standards;
- Support systems wide measure and metrics alignment;

- Collaborate with private purchasers to spread the coordinated care model and support alternative payment methodologies; and
- Provide workgroup progress reports at least bi-annually to the Director of OHA and the Board.

IV. Committee Membership

Membership will include representatives from the following entities:

- PEBB Administrator
- OEBC Administrator
- Business representatives
- Local government purchasers
- Consumer advocate
- Commercial health benefit plan(s)
- CCO(s)
- Health Insurance Exchange representative
- Oregon Insurance Division

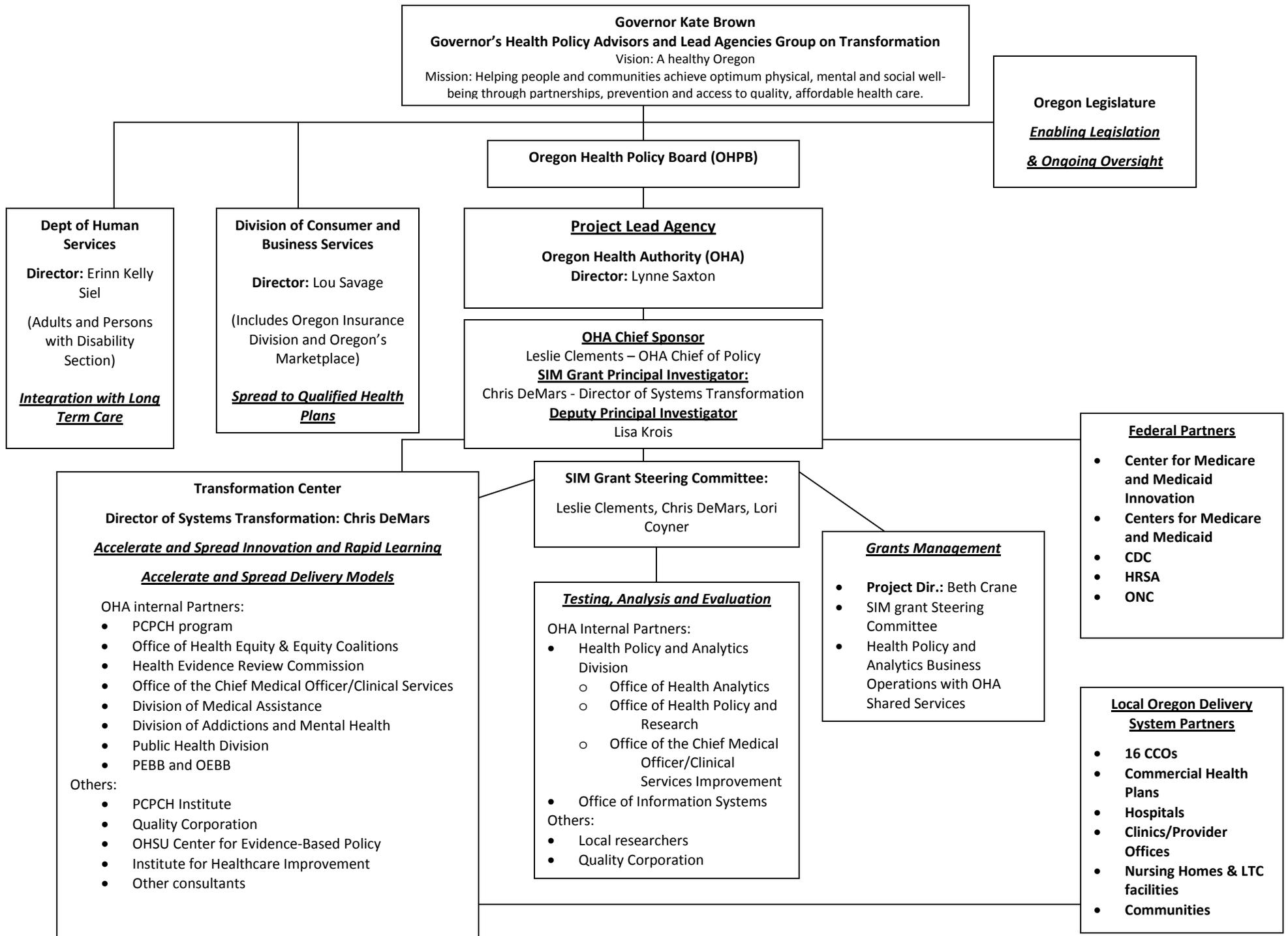
V. Resources

Internal staff resources will include the following:

- Executive Sponsor: Kelly Ballas, OHA Chief Financial Officer
- Staff support:
 - OID Director's Office
 - OHA Director's Office
 - Oregon Health Policy and Research Office
 - PEBB & OEBC
 - Oregon Insurance Division staff, as appropriate
 - Health insurance exchange staff, as appropriate

Appendix 3

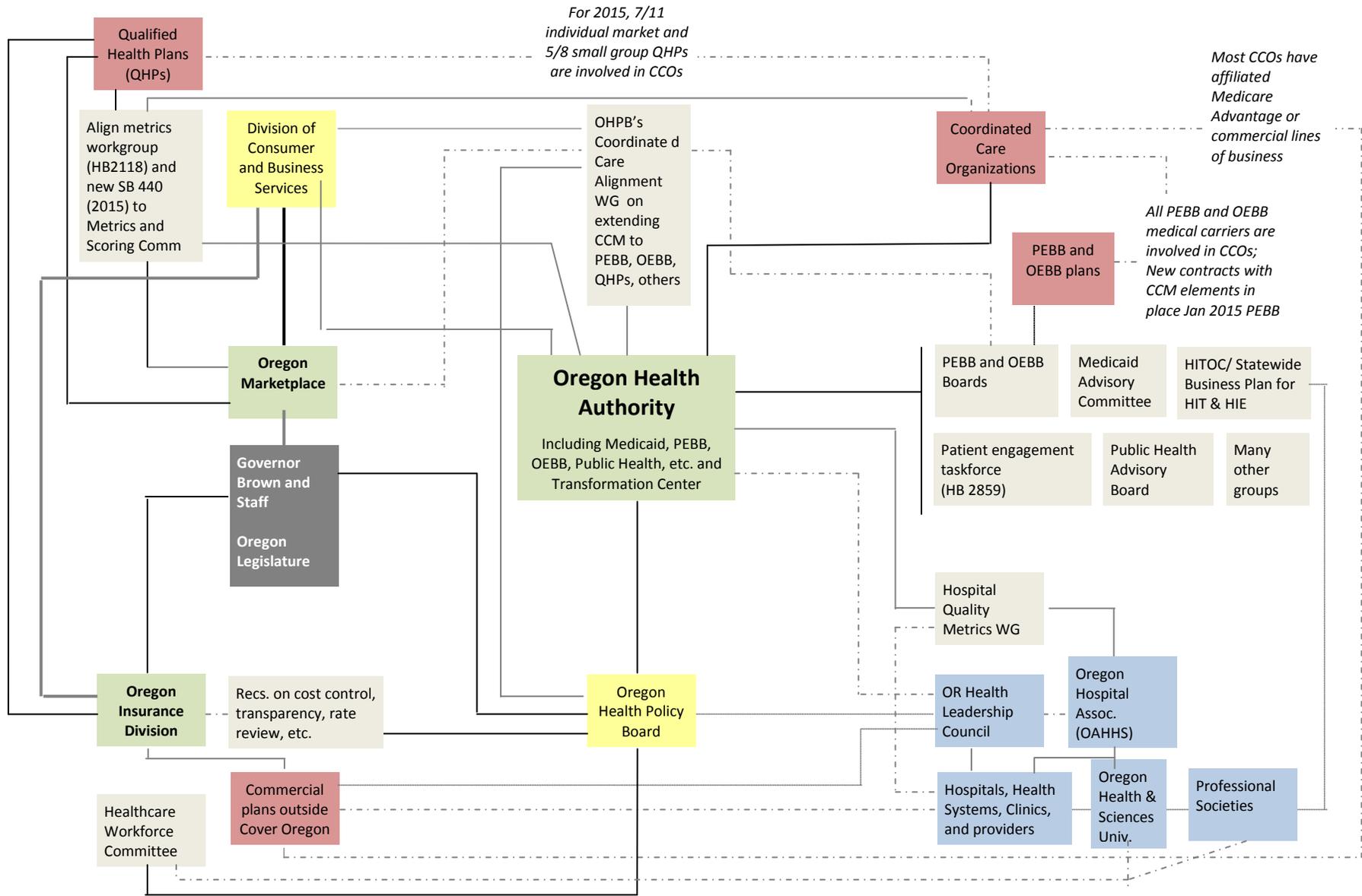
Oregon's 2015 Revised Governance Structure for State Improvement Model Grant/Health System Transformation Activities



Appendix 4

Select Connections between
Oregon Health System
Transformation Stakeholders

Select connections between Oregon health system transformation stakeholders



Key:

- Institutional, oversight, or regulatory relationship _____
- Formal relationship (required participation, membership, etc.) _____
- Informal relationship (shared membership, consultation, etc.) - - - - -

Appendix 5

Adult Medicaid Quality Grant Program Semi-Annual Progress Report

ADULT MEDICAID QUALITY GRANT PROGRAM SEMI-ANNUAL PROGRESS REPORT

Grantee State Name:

Performance Period:

December 21, 2014 through June 20, 2015

Date Due to CMS:

July 20, 2015

The purpose of this annual progress report is to assist the Centers for Medicare & Medicaid Services (CMS) in accurately assessing the progress each Grantee is making towards accomplishing the goals and objectives of the Adult Medicaid Quality grant program. The more details Grantees include in the Semi-Annual Progress Report, the greater the ability CMS has to accurately assess the progress made in the past 30 months.

I. Summary of Grant Project Activities:

Describe the progress made towards implementation of the grant project goals over the past 30 months of the grant with emphasis on the last six months. Include in the summary completed and in-progress goals and objectives. Please include quantifiable progress achieved (e.g. reached 25 of 30 providers targeted, improved from a baseline of 25% to 40%).

OHA regularly produces a set of 17 CCO incentive metrics, of which 4 are AMQ and 7 are CHIPRA, as well as the set of 33 quality and access “test” metrics under the 1115 demonstration waiver. OHA has reported 2011 baseline and CY 2013 performance on these metrics at the state and CCO level, as well as stratified by race and ethnicity.

The just-released 2014 Final Performance Report (<http://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx>) shows that the coordinated care model continues to show large improvements in some of the key measures for the state’s Medicaid enrollees, including steady decreases in emergency department utilization.

The Office of Health Analytics has been engaged in a broad-ranging analysis of training needs for staff. New onboarding processes are focused on identifying professional development needs early on and providing resources for individualized training using online resources.

The Statewide PIP focused on improving diabetic monitoring (annual HbA1c and LDL-C testing) in people with co-occurring diabetes and schizophrenia or bipolar disorder. It concluded at the end of the second re-measurement period (June 30, 2015). Overall, in this last six month period, CCOs focused on continuing to monitor current interventions.

All CCOs utilized some type of care coordination case management (by RNs or MH case managers) to engage study members who had not received diabetic testing. In addition, most CCOs had developed pilot integrated clinics or instituted co-located physical health or mental health providers at one or more clinics. While these projects were not developed solely as a response to the statewide PIP, CCOs noted that the clinic populations included and addressed the needs of many of their study eligible members. Additionally, CCOs predicted that strategies to improve data integration and EHR use would also support and advance care coordination efforts. Turnover in quality improvement staff was identified as the leading barrier to effective implementation of study interventions. At the time of this report, all vacancies had been filled. Despite challenges around staff and member turnover and lack of data integration, CCOs reported improved communication between mental health and physical health providers, improved monitoring of study eligible members, development of care coordination processes, and a better understanding of data system needs. Going forward, CCOs will evaluate

their current PIP interventions and determine how to incorporate and sustain study processes and procedures into their routine workflow.

The second PIP is focused on increasing the proportion of Medicaid enrollees with access to Patient-Centered Primary Care Homes (PCPCHs) through two learning collaboratives. The Patient Experience Learning Collaborative was launched in June 2014 and culminated in June 2015. Nine primary care practices were chosen to participate and were assigned to work with two contractors who provided technical assistance (TA) and will continue to work with the practices for the remainder of the grant period. The participants received practice-level facilitation, guidance on integrating patients within their quality improvement projects, fielding of CAHPS Clinical and Group (CG) Survey Patient Centered Medical Home (PCMH) Item set, and opportunities to attend face-to-face learning sessions.

The Behavioral Health Home Learning Collaborative is focused on “reverse” integration to provide whole person care to the high-needs population with severe and persistent mental illness or substance use disorder. The Learning Collaborative is working with organizations that are integrating primary care into their behavioral health settings to enhance their capacity in the 4 core areas of behavioral health homes, as defined by SAMHSA:

- Screening/referral for needed physical health prevention;
- Registry/tracking system for physical health needs/outcomes;
- Care management; and
- Prevention and wellness support services.

OHA has contracted with the Oregon Rural Practice-based Research Network (ORPRN) to provide intensive practice coaching to 13 behavioral health agencies across Oregon (10 in Year 1 and 9 in Year 2). Practice coaches (Practice Enhancement Research Coordinator – PERCs) use a range of organizational development, project management, quality improvement, and practice improvement approaches and methods to help participating organizations identify barriers to integration and conduct improvement activities to address them. To date, we have had four in-person Learning Sessions where participating organizations have had opportunities to interact with their peers in other organizations pursuing similar integration efforts and to receive specialized training in critical components of the behavioral health home model. In addition, we have provided specialized training in care management and will be conducting webinars specifically designed to familiarize behavioral health practitioners with care management guidelines for diabetes and hypertension.

II. Programmatic Goal: Testing and evaluating the collection and reporting of the Medicaid Adult Core Set Measures

In the final column of the table, “*Measures Selected*,” CMS asks Grantees to identify the measures (mark with an X) that may be collected and reported for next year’s measurement reporting cycle (December 31, 2015). Though this is an optional request we strongly encourage grantees if at all possible to continue their contributions of data to further enrich state and national level data.

NQF #	Measure Steward	Measure Name	Measures Selected for Collecting and Reporting (Jan 2016) (OPTIONAL)
Preventive Care			
0032	NCQA	Cervical Cancer Screening (CCS)	X
0033	NCQA	Chlamydia Screening in Women (CHL)	X
0039	NCQA	Flu Vaccinations for Adults Age 18 and Older (FVA)	X
0418	CMS	Screening for Clinical Depression and Follow-Up Plan (CDF)	X
2372	NCQA	Breast Cancer Screening (BCS)	
NA	NCQA	Adult Body Mass Index Assessment (ABA)	
Maternal and Perinatal Health			
0469	TJC	PC-01: Elective Delivery (PC01)	X
0476	TJC	PC-03: Antenatal Steroids (PC03)	
1517	NCQA	Prenatal & Postpartum Care: Postpartum Care Rate (PPC)	X
Behavioral Health and Substance Use			
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	X
0027	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)	X
0105	NCQA	Antidepressant Medication Management (AMM)	X
0576	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH)	X
NA	NCQA	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA)	X
Care of Acute and Chronic Conditions			
0018	NCQA	Controlling High Blood Pressure (CBP)	X
0057	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C)	X
0059	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC)*	X
0272	AHRQ	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01)	X
0277	AHRQ	PQI 08: Heart Failure Admission Rate (PQI08)	X
0275	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05)	X
0283	AHRQ	PQI 15: Asthma in Younger Adults Admission Rate (PQI15)	X
1768	NCQA	Plan All-Cause Readmissions (PCR)	X
2082	HRSA	HIV Viral Load Suppression (HVL)	
Care Coordination			
2371	NCQA	Annual Monitoring for Patients on Persistent Medications (MPM)	
Experience of Care			
0006	AHRQ	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey, Version 5.0 (Medicaid) (CPA)	X

Summarize the challenges and successes faced over the past six months related to implementing this programmatic goal. *Note: CMS is looking for Grantee success/challenges related to programming the measures, contracting with vendors, purchasing software, etc.*

- Challenges:

There are a few measure-specific challenges that we would like to highlight:

Joint Commission measures: While important, the Joint Commission measures (i.e. PC-01 Elective Delivery and PC-03 Antenatal Steroids) pose a unique challenge because they are facility-based measures, are not applicable to small hospitals, and are not produced with final payer information.

Measures that require chart reviews: Measures that require chart reviews are labor intensive and expensive. The results, because they are a sample, are not considered as actionable as those that can be connected more universally to individual patients and providers.

Staff: Recruitment and retention of skilled health services analysts has always been challenging; recently it has become even more so.

- Successes:

OHA regularly produces a set of 17 CCO incentive metrics, of which 4 are AMQ and 7 are CHIPRA, as well as the set of 33 quality and access “test” metrics under the 1115 demonstration waiver. OHA has reported 2011 baseline and CY 2013 performance on these metrics at the state and CCO level, as well as stratified by race and ethnicity.

The just-released 2014 Final Performance Report (<http://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx>) shows that the coordinated care model continues to show large improvements in some of the key measures for the state’s Medicaid enrollees:

- Decreased emergency department visits. Emergency department (ED) rates for people served by CCOs have decreased 22 percent since 2011 baseline data. While some of the improvements seen may be due to national trends, CCOs have implemented a number of best practices for reducing emergency department utilization rates, such as the use of emergency department navigators. One such program now includes referrals to a patient-centered primary care home for members who do not have a primary care provider, as well as referrals to dental services, drug and alcohol services, and intensive management for members that have had 3 or more ED visits in the last 6 months.
- Decreased hospital admissions for short-term complications from diabetes. The rate of adult members (ages 18 and older) with diabetes who had a hospital stay because of a short-term problem from their disease dropped by 26.9 percent since 2011 baseline data.
- Decreased rate of hospital admissions for chronic obstructive pulmonary disease. The rate of adult members (ages 40 and older) who had a hospital stay because of chronic obstructive pulmonary disease or asthma decreased by 60 percent since 2011 baseline data. |
- Strong improvement to the Screening, Brief Intervention, and Referral to Treatment (SBIRT) measure. This measures the percentage of adult patients (ages 18 and older) who had appropriate screening and intervention for alcohol or other substance abuse. Two coordinated care organization have exceeded the benchmark, a great accomplishment given the statewide baseline of almost zero. Initiation of alcohol and drug treatment has also increased. However, engagement of treatment has held steady, indicating room for improvement.
- Other measures in this report that highlight room for improvement include cervical cancer and chlamydia screenings for women. The reduction in these screening rates may be due to changes in national guidelines reported in 2012, which recommended women wait 3 to 5 years between Pap tests and do not have their first Pap test until age 21.

Coordinated care organizations are developing the ability to leverage certified electronic health record technology to access individual-level electronic clinical quality measure data on their beneficiaries from providers. Using electronic clinical quality measure data, CCOs are building capacity to conduct analytics and performance monitoring to support population health management, care coordination activities, and develop alternate payment methodologies.

OHA recognizes that federal standards change over time, and that not all CCOs are in the same place when it comes to electronic health record adoption, health information exchange, and meeting Meaningful Use. OHA's goal is that Oregon providers meet Meaningful Use Stage 2 requirements and that CCOs take action to move their networked providers towards 2014 certified EHR technology. Oregon has a unique opportunity to invest in the infrastructure that will move us toward the vision for electronic reporting of clinical quality data. Accordingly, OHA has adopted a technology plan as the first step in this direction.

The year one technology plan provided OHA with an environmental scan of the CCOs' current technological capacity, including electronic health record (EHR) adoption, health information exchange (HIE), and health information technology projects already underway. The year one technology plan also outlined how CCOs plan to develop technological infrastructure to support electronic reporting of clinical quality data. They describe the CCO's proposed sample for the proof of concept data, and how the CCO will submit to OHA the proof of concept data which will include a sample of electronic clinical quality data for each of the three CCO incentive measures: depression screening, diabetes control, and hypertension control.

OHA received and reviewed year one technology plans from all CCOs in advance of the year one proof of concept data submission. All CCOs were able to successfully submit a sample of clinical data extracted from EHRs across their provider networks, although a number of challenges were identified, including inconsistent measurement periods and potential inconsistent interpretation of measure specifications for CCOs that developed custom queries to extract the data, where Meaningful Use measures were not programed or accessible within the certified EHR technology. This was a particular challenge for the depression screening measure, as it was not included in 2011 certified EHRs, and not all participating providers were using 2014 certified EHRs.

We previously reported that OHA is engaged in a parallel effort to develop a website that would enhance our ability to share data with a much broader audience. An RFP for that project is still in development, but OHA intends to have an online platform that will enable public access and interaction with our most requested metrics and data sets, including AMQ measures, CCO incentive measures, survey data sets, and Medicaid enrollment information. The website will ultimately be dynamic, allowing outside researchers to create simple reports and analyses on their own, thereby freeing up OHA staff to do more complex analysis, improving transparency, and enhancing the overall analytical capacity of the community.

- List any Medicaid Adult Core Set measures that the Grantee planned to collect, but has not yet been able to do so. Include a description of reasons and barriers.

None.

- Provide feedback on the accuracy and usability of measurement specifications and methodologies provided by CMS (if applicable, please list name of performance measure and high-level description of the issue).

Note: If you have submitted a question previously to the TA mailbox, do not include here. CMS is looking for high-level comments on the measures that have been the most difficult to collect and the reasons why.

III. Programmatic Goal: Develop Staff Capacity

Summarize progress-to-date in meeting this programmatic goal. In this section, CMS would like to understand how Grantees are using funding to build staff capacity, including:

- What activities that were developed as a result of this grant and fall under the umbrella of “developing staff capacity” will continue beyond the performance period of this grant? *Note: Please include activities related to the development state infrastructure for quality measurement and analysis.*

The AMQ grant has supported OHA’s efforts to improve our ability to collect and report on the quality measures. As noted above, using other resources, we intend to carry the work forward in the coming years by developing better methods to make data accessible to a wider audience through interactive, online dashboards. Licenses for online resources to promote individualized professional development will continue beyond this grant.

- What are the plans for project staff hired for the AMQ grant after the grant funding ends?

Two staff were hired under the AMQ grant within the Office of Health Analytics: a specialist in performance measurement and a project manager. The performance measurement position is being retained and support for the staff person will be shifted to the SIM grant at the conclusion of this grant. The project manager position is directly tied to the activities supported by the AMQ grant and will not be continued. OHA is committed to using other funds to support the position through March 2016 in order to bring all the AMQ activities to completion. We hope to retain the staff person in a similar capacity, but a position has not yet been identified. OHA is currently undergoing significant restructuring; organizational needs will be assessed closer to the end date of this project.

- Summarize staff trainings (both formal and informal) and other ways the Grantee has worked to build staff capacity related to quality improvement and performance measurement.

As reported previously, OHA sponsored the participation of two staff people at the Institute for Healthcare Improvement’s Breakthrough Series College in 2014. Health Analytics recently reviewed and revamped its “onboarding” process to ensure that new staff are integrated quickly and efficiently into the team. Part of the new process is identifying training needs for new staff at the outset and developing an individualized plan for professional development going forward.

Accordingly, OHA has decided to procure access to online resources that will allow staff to access a wide range of modules that can provide specific training to meet their individual needs. Both Pluralsight and Lynda.com offer a broad spectrum of technical and office-specific curricula that will enhance the knowledge base and capacity of staff in both the technical research arena and the administrative area of the Office of Health Analytics. These courses are an online format that will allow each user to tailor their courses for efficacy in skill building and efficiency in time management. There is an administrator for each

site that will provide management with usage reports on all staff enrolled that will assist them in designing professional development plans that meet the needs of the staff member and the overall function of Health Analytics. Coursework on both sites will increase the professional skill base of participating staff members and allow them to be more effective within the demands of their positions and overall goals of the Office of Health Analytics. The Lynda.com is now available to all Health Analytics staff members. We will shortly be purchasing 15 licenses for Pluralsight for selected staff.

- Have all planned contracts or contract extensions been executed at this time? If not, provide a status update to include anticipated execution date and plans to address this gap.

Licenses for Pluralsight will be ordered imminently.

IV. Programmatic Goal: Conduct at least two Quality Improvement Projects (QIP)

Grantees must implement two quality improvement projects tied to at least one of the 26 Medicaid Adult Core Set measures and maintain implementation of the quality improvement projects over the entire grant period.

A large portion of these tables were included in the previous progress reports. As part of the semi-annual progress report, CMS asks that you provide updated and more detailed information. *Note: In these charts, CMS is looking for specific information about the projects. This level of detail would include detailed intervention information, quantifiable targets, preliminary data, and baseline data, as available.*

QIP Project Table 1a

Quality Improvement Project 1: Project Summary Chart	
Topic	The quality improvement focus area of the Statewide Collaborative Performance Improvement Project (PIP) is the integration of primary care and mental health. The topic is: Diabetes Monitoring for People with Diabetes and Schizophrenia or Bipolar Disorder
Target population	The target population for this PIP is Medicaid and Children’s Health Insurance Program (CHIP) enrollees with co-occurring diabetes and schizophrenia or bipolar disorder. <u>Denominator Inclusion Criteria</u> <ul style="list-style-type: none"> • Medicaid/CHIP-enrolled • Continuous enrollment • Adults: age 18–75 years at final day of the measurement year • Diagnosis of diabetes Diagnosis of schizophrenia or bipolar disorder
Health care service delivery model and scope of QIP	Service Delivery Model: <i>Example- managed care (MC) only, fee-for-service (FFS) only, across multiple models such as FFS, MC, Accountable Care Organizations (ACO), etc.</i>
	Coordinated Care Organizations (CCO)

	Scope: <i>Example – Statewide, regional, # of counties, # health plans, practice sites, etc.</i>			
	Statewide all CCOs			
<p>Key project aims/goals (must be specific and measurable) Goals must include at least one Adult Core Set measure. Additional non-Core Set measures/goals may also be utilized.</p>	<p>Specify the Adult Core Set measure(s) being collected for this QIP <i>Note: If using additional measures for this QIP please add additional line per measure below.</i></p>	<p>Baseline Rate</p>	<p>Current Rate for QIP* <i>*If not available please use statewide rate</i></p>	<p>Goal: Target Rate</p>
	<p><i>Comprehensive Diabetes Care: Hemoglobin A1c Testing</i></p>	<p>65.88%</p>	<p>N/A</p>	<p>N/A</p>
<p>Preliminary Outcomes</p>	<p>Provide preliminary outcomes data for this project: Outcomes information should include both process measures and performance measure data. <i>Provide these data or insert table or attachments below.</i></p>			
	<p>The study question for this PIP was: <i>Will local integrated care interventions by CCOs increase the percentage of individuals with co-occurring diagnoses of diabetes and schizophrenia or bipolar disorder who receive both: at least one or more HbA1c test and at least one or more LDL-C test during the measurement year?</i></p> <p>The aim/goal is statistically significant improvement over baseline in the percentage of statewide study eligible enrollees who have received both LDL-C and HbA1c testing. Target goals were set by each of the CCOs as they will be conducting their own root cause analyses and implementing interventions designed to address the specific needs of their individual Medicaid populations.</p> <p>At the time of this report, the contractor is working on completing the final report for this project, due on July 31. They are still working on analyzing data and formulating findings, but initial reports suggest that the preliminary findings we reported in our January report remain largely valid.</p> <p>In terms of root cause of the gap/problem, the following three high-level themes were common to all of the CCOs:</p> <ol style="list-style-type: none"> 1. Mental health and physical health systems have historically been separated and there is limited communication across the systems. The lack of a shared data system between the mental and physical health systems greatly exacerbates communication barriers. 2. There are characteristics and needs specific to the SPMI population, such as fear around blood draws or interacting with unfamiliar medical staff and cognitive limitations, which may interfere with consistent management of their chronic physical health issues. 3. Mental health and physical health providers may feel uncomfortable, have limited 			

	<p>resources, or have limited knowledge related to working with members diagnosed with SPMI and chronic physical health conditions.</p> <p>With these barriers in mind, six high-level themes were identified from the CCOs’ documentation that described the interventions selected for this PIP. The six intervention themes include:</p> <ol style="list-style-type: none"> 1. Facilitate communication with mental and physical health providers to increase awareness of members in the study population and encourage outreach, especially to those members who have not received HbA1c and/or LDL-C labs. 2. Utilize existing or create new interdisciplinary teams to facilitate care coordination for members included in the study population. 3. Utilize existing or develop co-located clinical settings (mental health staff in primary care clinics and PCPs in mental health clinics) for members included in the study population. 4. Engage and communicate with members included in the study population about the importance of chronic disease management. 5. Utilize traditional health workers and peer wellness specialists to assist with the coordination of care for members included in the study population. 6. Educate mental and physical health providers about characteristics and treatment approaches specific to members of the study population. <p>Two other intervention strategies were mentioned, but to a lesser extent. These included developing plans to implement integrated data systems for mental and physical health providers and plans for incorporating this PIP into a larger improvement strategy.</p> <p>Due to some unanticipated difficulty in data collection, the end of the second re-measurement period had to be extended to June 30, 2015. Claims data will be available approximately 90 days after that date.</p>
<p>Challenges with Implementing Project</p>	<p>Challenges/obstacles faced with implementing this particular project.</p> <p>Data: In their quarterly reports, CCOs cited discrepancies between internal data and OHA data as a barrier to the effective implementation of their interventions.</p> <p>Differences between CCOs: The study data is aggregated across 16 CCOs, but the CCOs are not standardized as to study population, level of physical and behavioral health system integration or study interventions. These differences between CCOs are reflected in the wide range in the calculated study indicators at both baseline and first re-measurement.</p> <p>Validity of the study indicator: At least one CCO observed that despite improvement in the CCO indicator, discussions with physical health and mental health staff demonstrated that there was a “lack of active coordination.” The improvement in the study indicator could reflect more efficient data collection processes and more effective case management (from a single mental or physical health agency rather than increased integration of the two systems).</p> <p>Internal factors: Turnover in quality improvement staff was identified as the leading barrier to effective implementation of study interventions. The staff issues led to variability in the timing and duration of interventions across the CCOs during the study period. Structural and capacity issues also presented challenges. Integration between physical health and behavioral health continues to be hampered by limitations imposed by EHRs, ranging from difficulties in collecting data to communication between practitioners.</p>

	<p>External factors: January 2014, the Accountable Care Act Medicaid expansion was enacted, providing more low-income Oregonians with health care coverage. The OHA estimated that more than 340,000 people obtained health insurance since the first of the year. According to their quarterly reports, CCOs were overwhelmed by the response and processes that had been functioning well prior to the expansion often suffered as a result of inadequate resources and staffing. Another factor affecting the validity of the study results is the inclusion of study enrollees in other ongoing CCO interventions such as those targeting super-utilizers, establishing Patient Centered Primary Care Homes, or implementing tobacco cessation programs. It is possible that diabetes-related testing occurred as a result of these other interventions.</p> <p>Effective implementation of the interventions: Each CCO was tasked with the tracking and monitoring of its own interventions and reporting those results quarterly. This lack of clear and thorough documentation is a limitation on the reliability of the findings, but most CCOs supported the notion that the study interventions were implemented effectively.</p> <p>Appropriateness of the study indicator: an improvement in their study indicator did not necessarily mean improvement in integration between physical and mental health. The lesson learned was the importance of first selecting a measure that was a valid indicator for integration rather than selecting an indicator and then working backward by using the measure to promote integration.</p>
	<p>Remediation Strategy: What are your plans to overcome these challenges?</p>
	<p>Despite challenges, CCOs reported improved communication between mental health and physical health providers, improved monitoring of study eligible members, development of care coordination processes, and a better understanding of data system needs. Going forward, CCOs will evaluate their current PIP interventions and determine how to incorporate and sustain study processes and procedures into their routine workflow.</p>
<p>Alignment with other initiatives?</p>	<p>If yes, describe the other initiatives.</p> <p>Acumentra Health continued to provide technical assistance to CCOs through June 2015 during the second re-measurement period for this PIP. Technical assistance included both phone conferences around the quarterly report and a PIP training to educate new QI staff about key QI concepts. In addition, Acumentra Health conducted a workshop in 2nd quarter 2015 to discuss the selection of a new PIP beginning in July 2015.</p>

Progress with Interventions: Using Table 1b below, provide a detailed timeline and summary of the progress to-date in implementing interventions related to the QIP described above. *Note: If the QIP has not yet been fully implemented, provide (in the table below) a detailed description of activities-to-date that demonstrate your progress toward implementation along with a timeline for the activities that are planned until full implementation.*

QI Project Table 1b

<p>Quality Improvement Project 1: Intervention Information</p>	
<p>Detailed Descriptio</p>	<p>Describe each intervention that has been implemented over the last 30 months and the month/year it was operationalized.</p>

n of Interventions	CCO	Improvement strategies	Barriers and how they were addressed
	<p>AllCare</p>	<p>There has been little change in intervention since the last report</p> <ul style="list-style-type: none"> • PCP co-located at Options outpatient mental health clinic since September 2013. • Started a mobile physical health clinic (Birch Grove) at Jackson County Mental Health outpatient clinic • Quality Measures Provider Manager educates PCPs in Josephine, Jackson and Curry Counties about the PIP. • AllCare reviews quarterly patient lists from OHA and shares the list of members still needing testing with the Community Mental Health Programs (CMHP). • Conducted monthly integration and care coordination meetings 	<ul style="list-style-type: none"> • Communication between Primary Care and CMHP providers still needs improvement - <i>AllCare continues to explore processes and venues for increasing communication and coordination.</i> • SPMI symptomology presents different for each member – <i>care plans are individualized to address</i> • Dual eligible members did not have Medicaid claims – <i>educate providers</i>
<p>CHA</p>	<p>There has been little change in the interventions since the last report:</p> <ul style="list-style-type: none"> • Conducted interdisciplinary team meetings (PCPCH/PCP case managers, DHS or APD case managers, MH, PH and SUD clinicians, CHA case managers, other stakeholders, such as DOJ) to discuss individuals and treatment planning. • Educated medical residents who rotate through clinic about the importance of conducting necessary testing for SPMI population. • Conducted monthly meetings with CHA case managers, MH providers, and SUD providers to discuss outstanding issues. • Klamath Basin now has a Navigator in place that 	<ul style="list-style-type: none"> • CHA did not become a CCO until 9/1/2013, resulting in limited access to data and staff feeling overwhelmed. • Claims data has been limited and tracking member PCP assignments has been difficult. <i>Resolved as of April 2014.</i> • Vacant QI Director over a long period of time has negatively affected the establishment of a solid QI Plan/Department • Dual eligible members are being tested, but claims are not captured by the state and the plan. • Dual diagnosis members seem less likely to be willing to complete lab draws, especially LDL which requires fasting. • Continuing communication gaps between physical health and mental health providers 	

		<p>coordinates care with PCPs.</p> <ul style="list-style-type: none"> • The incentive program to encourage enrollees to comply with the Standard of Care tests was discontinued due to lack of response, • Rolled out JHIE Community Health Record (CHR) to “Beta” Clinics who are validating JHIE • Established a program where Non-Emergent Medical Transport (NEMT) & Community Health Workers assist with transportation and navigating the health system for high risk members. 	
	<p>CPCCO</p>	<p>There has been little change in interventions since the last summary:</p> <ul style="list-style-type: none"> • <u>Targeting behavioral health providers:</u> After receipt of OHA data GOBHI will ask the local county MH offices to track the dates when testing was discussed with the member. Also, GOBHI will provide CareOregon with the names of the mental health providers of members who had not received testing. • <u>Targeting physical health providers:</u> Send letters to PCPs about members needing tests; letters will also include the name of the mental health provider involved in the member’s care. • <u>Co-location:</u> Behaviorists have been co-located at the following clinics: Tillamook Family Health, Dunes Family Medicine, Reedsport Medical, Scappoose, Legacy, Clatskanie Family Medicine and Reinhardt. 	<ul style="list-style-type: none"> • QI Analyst vacancy September – December 2014 – <i>QI analyst is still learning about the PIP and working with the behavioral health organization’s data analyst.</i> • Validation of the initial report shows inconsistencies when compared against state data. <i>Barrier is being addressed by having analysts review the report code and revalidating the data.</i> • Dual eligible members: CPCCO is not able to verify test results for dual eligible members not enrolled in CareOregon’s Medicare Plan. • Competing CCO priorities: “Competing priorities at the CCO level remain a barrier to implementing interventions for this PIP.” <i>Barrier addressed by ensuring that interventions align with larger organizational efforts around integration of BH and physical health.</i> • Poor response/lack of cooperation from county mental health departments regarding tracking of PIP study enrollees. <i>CPCCO continues to “struggle with report outs.”</i> • Dramatic increase in CCO population affected access to primary care and behavioral health services.

	<ul style="list-style-type: none"> Health resilience workers are being deployed in the community and will focus on the SPMI population, and specifically the PIP study population. The workers provide individualized high-touch, trauma-informed care to high utilizers. A PCP will be co-located at Columbia County Mental Health. 	
EOCCO	<p>EOCCO had developed a number of processes and procedures under the umbrella of “intensive care coordination.” Each quarter the CCO analyzed the patient list from OHA and mailed customized letters to PCPs and MH providers about members still needing testing. RNs and case managers then followed up with physical health and mental health providers and members. In the April 2015 report, EOCCO observed that their current processes and procedures were not sustainable in the long run. “2015 Q1 was spent analyzing existing data from the quarter, and determine t the most effective method for outreach. EOCCO analyzed trends among compliant, non-compliant, and partially compliant members (members who received one but not both necessary screenings”</p>	<ul style="list-style-type: none"> Data discrepancies: Investigation of enrollees with no tests revealed that some enrollees were dual eligibles or incorrectly diagnosed with diabetes. <i>EOCCO corrected its own data base and is still developing a process to deal with dual eligibles.</i> There is a core group of enrollees who are non-compliant despite multiple outreach efforts. <i>EOCCO is using an intensive care management approach with these enrollees.</i> PCPs do not respond to EOCCO’s reminder letters Current processes are time and labor intensive – <i>EOCCO is analyzing data and re-evaluating interventions</i>
FamilyCare	<ul style="list-style-type: none"> Using Rosewood Clinic, a physical health clinic, as a pilot project Member navigator makes reminder calls prior to appointments and follows up “no shows.” Embedded a CCO service 	<ul style="list-style-type: none"> Lack of perceived benefit and lack of response related to receiving lab results were the primary barriers Staff turnover at both the CCO and provider level had a negative effect on the implementation of the PIP PH providers unwilling to take on any new tasks, and believing that

		<p>coordinator in clinic who can access files and the EHR.</p> <ul style="list-style-type: none"> • Behavioral Health Lead met with clinic staff to discuss the PIP • Mailers sent out to members needing testing • Developed an internal CCO PIP workgroup to problem solve barriers • MH case managers are encouraged to attend PH appointments with member and discuss any physical health problems 	<p>communication is the responsibility of MH staff – <i>continue to meet with providers to discuss collaboration</i></p> <ul style="list-style-type: none"> • Providers confused about need for ROI to share information with other providers – <i>educate providers about regulations</i> • Lack of accurate member contact information • Members do not return phone calls
	<p>Health Share</p>	<ul style="list-style-type: none"> • The CCO-sponsored intervention has been the establishment of an integrated clinic through Oregon Partnership for Health Integration (OPHI)-Cascadia. Following assessment, members are assigned a Peer Wellness Specialist who provides support and helps with compliance. Data shows improvement in ED utilization and cost of care. • RAE-specific interventions: <ul style="list-style-type: none"> - Tuquity: the QI Coordinator has started to send patient lists to clinics regarding members needing testing. Community outreach specialists work with PCP clinics around testing (and care) - Kaiser Permanente: does outreach when receives list of eligible study members - Providence: Case and disease management contacts members who need labs - Providence Health 	<ul style="list-style-type: none"> • Member churn/enrollees coming on and off the list provided by the state – <i>Created a master list from two quarterly lists.</i> • Discrepancy with state data (duals) – <i>Submission of Medicaid claims for members with dual eligibility continues to be a challenge</i> • Size and complexity of the organization – <i>HealthShare discontinued efforts to collaborate on a single project, but instead is identifying existing successful RAE projects suitable for expansion.</i> • Staff turnover delayed PIP implementation at Washington County in the first quarter – since resolved.

		<p>Assurance: RN case managers contact members who need testing and “warm hand off” to the PCP.</p> <ul style="list-style-type: none"> - Washington County: NAMI chapter provides limited information and education to families and members - CareOregon: Is focused on its Outside In clinic. - Clackamas County: Buy-in from the FQHC on this PIP waned over the past few months. Clackamas has been working on a pilot combined medical record between their physical health and mental health clinic. 	
	<p>IHN</p>	<p>There has been little change in the interventions since the last report.</p> <ul style="list-style-type: none"> • Distribute lists of members in need of tests to PH providers. • IHN and PH providers collaborate with Linn County Mental Health (LCMH) to identify members with persistent mental illness and promote communication between PH and MH providers. • LCMH hired a medical assistant who focuses on engaging providers regarding their SPMI members who need testing • Pilot intervention at Geary Street Clinic with one provider. • Health Psychologist at Geary Street Clinic does initial MH assessment for Linn County MH and works with SPMI members at Geary Street Clinic. 	<ul style="list-style-type: none"> • Data discrepancies – <i>established master list of members in the study population.</i> • No central data repository – <i>will try to assign responsibility to one person at Geary Street clinic until repository developed.</i> • Non-compliant members • Analyzing quarterly lists is labor intensive and not sustainable • Health psychologist found to have very limited time. - <i>a referral process was established so that the psychologist can focus on members with SPMI.</i>

	<p>JCC</p>	<p>There has been little change in the interventions since the last report</p> <ul style="list-style-type: none"> • Each quarter, the JCC RN Case Manager and JCMH Clinical Nurse Specialist follow up with study members in need of testing. • The JCC RN Case Manager, JCMH UC and JCMH RN specialist engage high utilizing members, identify and remove drivers for utilization. • Implemented an integrated clinic -Birch Grove clinic – in JCMH that will accept members with SPMI diagnoses. • Written outreach to busy providers was seen as ineffective and discontinued as an intervention 	<ul style="list-style-type: none"> • Timely data – Need to generate internal report to identify members who meet inclusion criteria for the study population in order to provide timely lists to MH and PH providers. • Data inconsistencies – Validation of the initial report shows inconsistencies when compared against state data. <i>Barrier is being addressed by having analysts review the report code and revalidating the data.</i> • Study members can be difficult to reach • PCP refuses to do LDLs for members because he does not feel it is indicated. • Regulatory requirements around bidirectional referrals between Birch Grove and Mental Health have delayed full integrated care.
	<p>PSCS - CO</p>	<ul style="list-style-type: none"> • Plans to engage PH providers in ordering non-fasting LDL test have been discontinued due to a change in the NCQA guidelines on LDL screening • Integrated co-location sites <ul style="list-style-type: none"> - Deschutes County Annex/Mosaic clinic does primary care one day/week and currently sees 125 members - 50% of physical health clinics have BH staff onsite - 20% of clinics have case managers to assist with coordinating care • PSCS BH staff will facilitate training for Mosaic staff on incorporating physical health conditions and prevention into the mental health treatment plans and how to code or encounter that service. 	<ul style="list-style-type: none"> • CCO staff turnover delayed PIP implementation – <i>QI coordination position was filled April 20, 2015.</i> • Small study numbers • Competing priorities for BH providers prevented implementation of a BH training intervention. • NCQA no longer endorses routine LDL screening for the general diabetic population. Even though LDL screening is still appropriate for the SPMI population, physicians are reluctant to apply separate guidelines to a subset population – <i>PSCS will consider getting physician input from the CCO physician-staffed Quality Assurance Utilization Management Pharmacy and Therapeutics Committee.</i> • Encounters for dual-eligible members are not being submitted by Medicaid providers. • Point of service labs are often not being billed.
	<p>PSCS - CG</p>	<ul style="list-style-type: none"> • Plans to engage PH providers in ordering non-fasting LDL test have been discontinued 	<ul style="list-style-type: none"> • CCO staff turnover delayed PIP implementation– <i>QI coordination position was filled April 20, 2015.</i>

		<p>due to a change in the NCQA guidelines on LDL screening</p> <ul style="list-style-type: none"> • CCO BH staff provides technical assistance to providers and clinics as needed on a case by case basis. • Integrated co-location sites <ul style="list-style-type: none"> • Four PH clinics have a BH component. • The largest PH provider has a chronic illness management program. • Mid-Columbia Centers for Living, an outpatient BH provider, has co-located a clinician in two locations. 	<ul style="list-style-type: none"> • Change in CCO infrastructure – there are now two distinct regions, and the Columbia Gorge study population is very small. • NCQA no longer endorses routine LDL screening for the general diabetic population. Even though LDL screening is still appropriate for the SPMI population, physicians are reluctant to apply separate guidelines to a subset population – <i>PSCS will consider getting physician input from the CCO physician-staffed Quality Assurance Utilization Management Pharmacy and Therapeutics Committee.</i>
	<p>PHJC</p>	<ul style="list-style-type: none"> • <u>Fine tuning existing communications between MH and PH</u> <ul style="list-style-type: none"> - PHJC implemented the Inteligenz analytics program, which contains both physical and mental health data. All labs are scanned and all EZ Cap data along with PH Tech data from Options is collected in the new program. - Two of the PCP offices, which see the largest number of members, started scanning in all paperwork received from outside sources, making it easier to locate labs and ordering provider. - The first reports, including diabetes reports, from the Inteligenz analytic program have been run and are being distributed to clinics. - Medical assistants are flagging very specific medical information for PCPs. “This has led to several attempts 	<ul style="list-style-type: none"> • Difficulty reconciling inconsistencies between OHA data and Inteligenz (new data system) database – weekly conference call with Inteligenz staff and PHJC to discuss issues. • The analytics vendor did not program the diabetes patient list to follow the PIP denominator rules (include ALL MH diagnoses). This makes identifying study members difficult. • Competing priorities: PHJC has prioritized other projects, some related to the incentive measures, leaving little time for this PIP.

		<p>and restarts to make sure the flagging was for very relevant information and testing.”</p> <ul style="list-style-type: none"> - PHJC, Options and clinics continue to have quarterly meets and chart review to assess data and making necessary modifications. <ul style="list-style-type: none"> • <u>Mental Health First Aid Training</u> <ul style="list-style-type: none"> - In May 2014, a MH 1st Aid Training was held at Options. “Several providers were in attendance.” - Options have offered two Youth Mental Health trainings to the community. Post-training evaluation feedback has been very positive. Options continues to offer trainings • <u>Co-location</u>: Options opened a primary care clinic in one of its mental health facilities 	
	<p>TCHP</p>	<p>There has been little change in the interventions since the last report</p> <ul style="list-style-type: none"> • Use community health workers to assist with transportation. • Each quarter, distribute lists of study members needing tests to MH providers. • MH personnel will assist members with getting labs. • Increased member enrollment in BH and PH medical homes decreases barriers to member communication and increases access to PH care 	<ul style="list-style-type: none"> • Members with no contact information and difficulty contacting members – <i>continues to be problematic.</i> • Member enrollment changes and new members add/drop from the study population. • PH providers unable to participate due to workload as access issues increase – <i>still a barrier.</i> • After reopening following a temporary closure, the CCO gained approximately 15,000 new members. • Data discrepancies, possibly due to member turnover • Changes in CCO staffing and ownership

	<p>UHA</p>	<ul style="list-style-type: none"> • Continues to run the extended care clinic where members can receive integrated PH and BH services in one location. <ul style="list-style-type: none"> - A Care Coordinator takes responsibility for case management (including communicating lab results, conducting patient education and developing a care plan). • Douglas County has received a grant to fund a mobile crisis team, which will respond to mental health crisis situations and appropriately manage the SPMI population. 	<ul style="list-style-type: none"> • Data challenges <ul style="list-style-type: none"> - UHA has not been able to isolate PIP study members from the general SPMI population. Also, not all of the enrollees eligible for the study are seen in the ECC – <i>ECC Team reviews some of the statistical reports.</i> - Data collection for LDL and other clinical outcomes is done by chart review, which is labor intensive and there is not enough staff - <i>QI staff has been hired to help with analyzing ECC data.</i> • Unanticipated need for certain staff skill sets - <i>UHA reconfigured ECC team staff for a better fit.</i> • Organizational culture tended to be more traditional and hierarchical, which did not work well in new integrated team model. - <i>ECC has committed resources to improving team dynamics and relationships.</i> • Increased clinical time demands due to multiple and complex needs of patients – <i>Constant monitoring (in daily huddles) allows ECC to adjust schedule accordingly.</i> • Change in PCP leadership, key staff members and some of the ECC clinic operations • Unanticipated need for member education – <i>UHA is getting better results after educating members around how integrated care works</i>
	<p>WOAH</p>	<p>There has been little change in the interventions since the last report</p> <ul style="list-style-type: none"> • Create list that is continually updated to track members in the study population: current PCP, BH prescriber, and labs received. • Monthly meetings between PH case managers from WOAH and MH case managers from Coos County Mental Health to identify study 	<ul style="list-style-type: none"> • Continued lack of communication and flow of information between the PCPs and MH providers – <i>WOAH is investigating a software solution, but in the meantime have case managers ensure the chart is accurate as regards diagnoses and care management.</i> • Testing of dual eligible is not being captured • Past staff turnover had a negative impact on PIP development and implementation – <i>new QI staff have</i>

		<p>members who need testing, verify data, engage in corrective action when intervention is needed, and undertake continuous process of member education and engagement.</p> <ul style="list-style-type: none"> • MH case managers responsible for engaging members in scheduling medical exams and ensuring attendance at scheduled exams, tracking members for completion of tests, and ongoing continuous member education and engagement. • Use care management meetings to foster communication between MH and PH providers and teams. • Information given to PCPs about members' MH providers and to MH case managers about members' current PCP. 	<p><i>been hired and received PIP training</i></p>
	<p>WVCH</p>	<ul style="list-style-type: none"> • ENCC sends letters to PCP offices about PIP and followed up about enrollees not receiving MH services. • PIP team contacted MH agencies about those enrollees receiving MH services to expand services, outreach strategies. Initiated November and December 2013. • MVBCN staff contacted FQHC, which provides mental and physical health and houses the local homeless outreach program, in October 2013 about the PIP and internal procedures for required testing. • Educated MH providers and medical clinics about chronic disease self-management 	<ul style="list-style-type: none"> • Data: <ul style="list-style-type: none"> - Delays in receiving State data - Discrepancies between OHA and CCO data, especially around DM diagnoses and CCO enrollment. - Lab data was incomplete due to staff absences. - BH staff, who were funded through a grant process, did not encounter services, making it difficult to monitor intervention effectiveness • Influx of new members has increased challenge of providing access and addressing chronic health issues. • Difficulty getting MH providers to respond to MVBCN messages about the PIP. • Some psychiatrists are resistant to receiving practice guidelines from non-medical staff and input from the MVBCN medical director and to the concept of shared decision-making.

		<p>programs (CDSMPs)</p> <ul style="list-style-type: none"> • Training of CCO and MVBCN staff in the use of patient activation measure (PAM) discontinued as did not improve member engagement • MVBCN and WVP staff has developed an algorithm focused on reducing metabolic side effects of psychiatric medications. WVCH described the selection and prioritization process for this intervention. The algorithm and training/education has been presented to MH agencies in June 2014, to the Clinic Advisory Panel in July 2014, and will be presented to PCPs. Algorithm includes dietician consults, diabetes classes, living well classes. A variety of different wellness classes are offered to all CCO members (including the study population). • Peer support specialists are available to coach mental health staff on outreach efforts and to do in-home engagements and accompany members to appointments. • April 2014 – Behavioral health consultants were added to nine PCPCHs, who serve the bulk of the CCO members. 	<ul style="list-style-type: none"> • Individuals with mental illness refuse or drop out of care or change PCPs with some frequency. • Staff are busy and having to squeeze this project into scarce time. • WVCH ENCC staff is not always available for meetings. • Poor member response attendance to CDSMPs – <i>WVCH will conduct focus groups</i> • Peer support specialist too busy to attend or lead CDSMPs.
	<p>YCCO</p>	<p>There has been little change to the interventions since the last report. For those not receiving MH services, each quarter:</p> <ul style="list-style-type: none"> • QI staff initially sent letters to PCPs that discussed the PIP, described available services and asked PCPs to reach out to their patients. • MH RN made follow phone 	<ul style="list-style-type: none"> • Crimson data tool has not yet been implemented, so MH and PH data remain separated. • Shifting study population • Delays in receiving data from OHA make it difficult to conduct rapid-cycle work. • MH staff do not have access to PCP lab results and must either call the PCP or re-order the labs - Consider giving QI staff access to the MH claims data via

		<p>calls to the PCPs.</p> <p>For those receiving MH services:</p> <ul style="list-style-type: none"> • MH RN called each PCP office to ask about what services had been offered and challenges encountered. • MH RN met with supervisor of intensive MH services and peer staff in November and December 2013 to identify members who could benefit from peer services. • Behaviorists and PWS received trained on using Patient Activation Measure (PAM) in order to engage members, assist with tailoring health education and measure changes in health activation over time. • Work with Yamhill County Yamhill County Health & Human Services, Mental Health • In February 2014, MVBCN required YCHHS to develop a corrective action plan for monitoring individuals receiving anti-psychotics. Although mental health services have transitioned from MVBCN to Yamhill County Mental Health, YCCO plans to continue to focus on metabolic syndrome screening. <p>Co-location</p> <ul style="list-style-type: none"> • Plans to locate primary care services at McMinnville MH in August 2014 (no update provided) • Existing co-location services at Virginia Garcia 	<p>PH Tech.</p> <ul style="list-style-type: none"> • Multiple staff challenges and major organization restructuring has resulted in delayed implementation of this PIP – <i>now that roles and reorganization are complete, work on the PIP will resume.</i> • The primary MH provider has been slow to incorporate metabolic monitoring. • YCPH has not been able to readily access data from EHR – <i>but ability is improving.</i> • Shared MH and PH data gaps • Low organization priority to focus on a small cohort of members.
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	<table border="1"> <tr> <td></td> <td>Medical Clinic, Newburg</td> <td></td> </tr> </table>		Medical Clinic, Newburg	
	Medical Clinic, Newburg			
Effectiveness of the Interventions	<p>What methods have you used to determine the effectiveness of interventions? Include frequency of review(s).</p>			
	<p>In addition to regular technical assistance to the CCOs, Acumentra has continued to provide quarterly reports detailing the progress of the interventions. Baseline data for each CCO was collected at the beginning of the study and two re-measurements have occurred to track the impact of interventions.</p>			
	<p>Which have been your most effective interventions?</p>			
	<p>Due to unexpected technical issues the second re-measurement required additional time, delaying the final report which will clarify the results of the various interventions. At the time of this report, those findings are not available, but are due on July 31 from Acumentra. We will share those findings in the close-out report in March 2016 or could provide a supplementary document prior to that date if CMS would prefer a more timely report.</p>			
	<p>Which have been your least effective interventions? What steps, if any, have you taken to improve their effectiveness?</p>			
	<p>See response above. This project concluded in June. The following interventions were planned for the second quarter of 2015 and at the time of this report have only just been completed. The final report with findings from the project is due on July 31, 2015.</p>			
Planned Interventions	<p>Describe interventions planned for expansion and/or implementation over the next six months (6/20/15-12/20/15) or until the end of your grant period with estimated implementation dates.</p>			
	<p>This project concluded in June. The following interventions were planned for the second quarter of 2015 and at the time of this report have only just been completed. The final report with findings from the project is due on July 31, 2015.</p> <table border="1"> <thead> <tr> <th>CCO</th> <th>Next steps</th> </tr> </thead> <tbody> <tr> <td>AllCare</td> <td> <ul style="list-style-type: none"> Continue to work with the CMHPs on identifying members diagnosed with </td> </tr> </tbody> </table>	CCO	Next steps	AllCare
CCO	Next steps			
AllCare	<ul style="list-style-type: none"> Continue to work with the CMHPs on identifying members diagnosed with 			

	<p>both SPMI and diabetes</p> <ul style="list-style-type: none"> • Work collaboratively with other CCOs to standardize processes with CMHPs. • Continue to train new staff about the PIP • By August 2015, develop a process whereby PCPs and CMHP providers can communicate. • Train Community Health Workers and Peer Wellness Specialists to assist members (including study eligible members) access primary care.
CHA	<ul style="list-style-type: none"> • Klamath Basic is exploring co-location of MH provider in PCP clinics • Continue to address outstanding issues at MH monthly meetings. • Support the work of new case managers at provider agency as they work to ensure that eligible members receive testing. Case management training is scheduled for May or June 2015. • Develop an integrated resource directory and make it available in providers' offices and online. • Continue to identify members eligible for the NEMT program • Hire a 4th Community Health Worker • Developing EHR integration processes • Testing member access to health records
CPCCO	<ul style="list-style-type: none"> • Current interventions are being continued
EOCCO	<ul style="list-style-type: none"> • Discontinue outreach letters to PCPs • Use the data trends identified in Q2 to target outreach to Lifeways Inc., largest mental health provider, and continue to track outreach. • Identify and adopt best practice outreach methods that are sustainable in the post-PIP time period. • Target specific counties identified in Q2 for outreach and partnership in care coordination • Compare results of PCP outreach with results of MH outreach next quarter.
FamilyCare	<ul style="list-style-type: none"> • Continue with current interventions
Health Share	<ul style="list-style-type: none"> • Clackamas: Develop a new project on screening and care coordination around metabolic syndrome. The FQHC plans to hire a clinical pharmacist. Once hired, the PIP will be "reopened." • Kaiser Permanente: continue intervention • Tuality Alliance: Is still working on a tracking and reporting system • Cascadia pilot project: Continue to track data and outcomes
IHN	<ul style="list-style-type: none"> • Continue interventions • Conduct monthly meetings with Geary Street, LCMH and IHN to update list of members needing testing • Investigate how best to develop a centralized data repository.
JCC	<ul style="list-style-type: none"> • Continue implementing and monitoring all current interventions. • Clinical Nurse Specialist is working with the Community Outreach Program Manager to overcome referral barriers.
PSCS - CO	<ul style="list-style-type: none"> • Continue to work with Deschutes County MH and Mosaic on PIP

	<ul style="list-style-type: none"> • Still planning to write article for provider newsletter • Analyze how many clinics are ordering non-fasting LDLs. • PSCS-Co continues to meet and exceed the benchmark and will continue the intervention.
PSCS - CG	<ul style="list-style-type: none"> • As testing compliance continues to be high, PSCS-CG plans to continue the current interventions •
PHJC	<ul style="list-style-type: none"> • Continue interventions as study indicator data indicate continued good performance
TCHP	<ul style="list-style-type: none"> • Continue interventions
UHA	<ul style="list-style-type: none"> • ECC team and clinic COO will continue to meet on a weekly basis to discuss work flow issues, re-engaging patient, and focus on lab studies. • ECC team continues to meet on a daily basis to discuss and plan for patients scheduled for each day. The team will continue to meet and fine tune patient access, case management and integrated care. • Extension of expanded care at another UHA network clinic.
WOAH	<ul style="list-style-type: none"> • Although this PIP is coming to a close, WOAHA continues to explore ways to improve the integration of physical and mental health • Develop MH care management plans that include strategies to facilitate member education and participation in annual preventive care strategies and chronic care management plans identified by the members' PCPs • Expand the Mental and Physical Health Integration program to include representatives from the local FQHCs. <p>Developing enhanced data tracking systems within Coos County Mental Health</p>
WVCH	<ul style="list-style-type: none"> • Exploring sustainable processes to identify lab needs. Committee to discuss why MH agencies not responding to inquiries about lab results reporting • Developing a variety of care management processes • Continue all interventions • Working on planning collaboratives between behavioral and physical health providers around promoting dialogue around integration issues. • Use focus group feedback to revise strategies around CDSMPs
YCCO	<ul style="list-style-type: none"> • Continue interventions, analyze results and re-evaluate

OIP Project Table 2a

Quality Improvement Project 2: Project Summary Chart	
Topic	Access to Patient-Centered Medical Home: Patient Experience of Care and Behavioral Health Homes

Target population	Medicaid and CHIP enrollees who receive care through Coordinated Care Organizations			
Health care service delivery model and scope of QIP	Service Delivery Model: <i>Example- managed care (MC) only, fee-for-service (FFS) only, across multiple models such as FFS, MC, Accountable Care Organizations (ACO), etc.</i>			
	CCOs			
	Scope: <i>Example – Statewide, regional, # of counties, # health plans, practice sites, etc.</i>			
	Regional			
Key project aims/goals (must be specific and measurable) <i>Goals must include at least one Adult Core Set measure. Additional non-Core Set measures/goals may also be utilized.</i>	Specify the Adult Core Set measure(s) being collected for this QIP <i>Note: If using additional measures for this QIP please add 1 additional line per measure below.</i>	Baseline Rate	Current Rate for QIP* <i>*If not available please use statewide rate</i>	Goal: Target Rate
	CAHPS Health Plan Survey v 5.0 – Satisfaction with Care	NA	83.9% (adults statewide)	
	Controlling High Blood Pressure	NA	64.6% (statewide)	
	Medical Assistance with Smoking and Tobacco Use Cessation	50%	51.4% (statewide)	
	Comprehensive Diabetes Care: A1c Testing	NA	88.8% (statewide)	
Adult BMI Assessment	NA	42.0% (statewide)		
<p>This PIP is designed to expand the breadth and depth of OHP members who obtain care through Patient-Centered Primary Care Homes (PCPCH). One strategy is to improve care by emphasizing Patient Experience of Care; the other is to address physical health care needs within behavioral health settings (“reverse” integration). The primary mechanism for both strategies is the use of learning collaboratives and practice facilitation.</p> <ul style="list-style-type: none"> • To increase the number of OHP-covered individuals who have access to care through a recognized PCPCH <ul style="list-style-type: none"> ○ Increase the number of practices participating in a standardized deployment and analysis of CAHPS Clinic and Groups with PCMH Items and assess alignment with AMQ Adult CAHPS V5.0, thereby increasing, from baseline, the number of primary care clinics recognized as Patient Centered Primary Care Homes (PCPCHs) and 				

	<p>increasing the tier status of recognized practices</p> <ul style="list-style-type: none"> ○ Improve areas of access and care coordination reflected in the CAHPS C&G with PCMH items that are reflected in the Adult CAHPS Survey. Similarly, assess those measures that reflect access to care and care coordination for change at the practice level. <ul style="list-style-type: none"> ● To have behavioral health agencies incorporate primary care services into their existing behavioral health care setting (“reverse” integration) <ul style="list-style-type: none"> ○ To increase the number of persons experiencing severe and persistent mental illness or substance abuse disorders who are able to receive appropriate care of their physical health needs through their behavioral health providers ○ To increase the capacity of behavioral health agencies to provide whole-person care, including monitoring the physical health needs of their populations and providing appropriate and timely care for the management of chronic health conditions ○ To support participating agencies pursuing PCPCH status ○ To collate experiences and lessons learned by participants to provide some guidance to other behavioral health providers attempting integration and inform the establishment of state standards for Behavioral Health Homes
<p>Preliminary Outcomes</p>	<p>Provide preliminary outcomes data for this project: Outcomes information should include both process measures and performance measure data. <i>Provide these data or insert table or attachments below.</i></p> <p>Project 2a: Patient Experience of Care Learning Collaborative</p> <ul style="list-style-type: none"> ● Value of Facilitated Discussion of Systems-Level Data: Part of one learning session was devoted to presenting and discussing system level data. The participating practices stated that this was the first time they had had the opportunity to delve into these data and found the exercise illuminating and “critical for impacting change.” with no preparation. More opportunities to use CCO data to guide and inform community-level efforts could help promote a population, patient-centered focus. ● Importance of Motivation: Over the course of this project, engagement of sites fluctuated as they responded to competing internal and external factors. The greatest determinant of practice engagement appeared to be internal organizational commitment to the project. ● Project Timeline: The timeline for this project (one year) is not ideal. It is ending just as sites are really starting to dig in and use their CAHPS data. A lot of time was spent preparing for survey administration, and building/strengthening practice capacity for QI, which has created the infrastructure for practices to continue the work. Ideally, the learning collaborative would continue into the next phase of addressing deficiencies identified through the CAHPS data to achieve durable change. ● System-Level Dynamic: There was an interesting dynamic between some of the sites that made it hard to foster a sense of community. Rather than healthy competition, which is ideal in a learning community, there seemed to be more a sense of suspicion and even an adversarial tone at times. This is important to note for future work. It is important to consider system and community level factors impacting practice relationships when embarking on the creation of a learning community.

Project 2b: Behavioral Health Home Learning Collaborative (BHH LC)

Practice Coaching

On-site practice coaching has been the most effective intervention. Hearing or reading about why and how to integrate care is rarely sufficient to implement significant and durable change.

- No clear model yet on how to create and sustain a Behavioral Health Home, so every organization has to develop own strategy, internal structures & practices, relationship with payers
- Practice coaches provide targeted technical assistance specific to each site (especially useful when working with multiple organizations at different stages of integration)
 - Serve as external accountability structure to ensure regular, dedicated time to work on integration
 - External observer can help team see unrecognized barriers (e.g., unproductive team dynamics, misaligned or missing procedures or workflow, absence of critical actors in the integration team)

Leadership Commitment Critical

Successful integration is time-consuming, messy, and expensive, demanding an organization-wide commitment.

- Requires leadership commitment, clinician support, and, ideally, a clinical champion
- Clash of cultures between medical and behavioral practitioners is very common; most advanced sites say overcoming this barrier is the single most important predictor of successful integration
 - Integration may sound great in principle, but for people doing the work, it can devolve into a battle over turf and scarce resources unless they are actively involved in the process from the beginning and feel ownership of the change.
 - Senior leadership needs to take the time to explain the vision; get staff buy-in; and create structures to mediate inevitable conflicts and build trust across disciplines.

Care Management

Improving health outcomes is a team sport.

- Cross-disciplinary team needed to develop integration strategy and oversee care management and coordination on a regular and frequent basis (typically weekly huddles)
- Cross-training essential.
 - Medical practitioners are increasingly familiar with behavioral issues, but need more training in trauma-informed care.
 - Behavioral practitioners remain uncomfortable with medical side and unfamiliar with conditions, procedures, processes, and community resources.
 - Ideal is behavioral practitioners working to the top of their license.
- EHR incompatibility and confidentiality concerns are still major barriers to communication, data collection and analysis.

Patient Engagement

One of the primary advantages of the BHH model is that the patients are more likely to show up and engage in their own care.

- No shows still a major concern and a threat to financial sustainability.
 - Sites experimenting with various ways to improve performance (different timetables for reminder calls/texts; providing transportation; fetching clients; clustering different kinds of appointments to allow warm hand-offs, shifting hours of operation, etc.)

	<ul style="list-style-type: none"> • A big challenge is how to reach the patients who do not have a pre-existing relationship with the behavioral setting. <p><u>Financial and Organizational Sustainability</u> Each site has had to negotiate independently with payer(s).</p> <ul style="list-style-type: none"> • Typical expectations for empanelment and daily workload for medical personnel unrealistic when working with SPMI populations with complex, chronic conditions. • Very high turnover of behavioral staff is serious impediment to integration <ul style="list-style-type: none"> ○ High stress + low wages lead to burn out and job hopping ○ Three of the original 10 sites saw almost complete turnover of team involved in Learning Collaborative • Alternative payment models desperately needed. <ul style="list-style-type: none"> ○ Sites often experience long period of operating at a loss before payment model resolved. ○ Outcome-based payment models problematic. Patients with history of prolonged lack of health care plus complex, co-occurring conditions will require more intensive treatment and longer timeframe to show improvement. <p><u>Positive Results</u> Still works in process, but already showing benefits on the triple aims:</p> <ul style="list-style-type: none"> • One site reports diabetic patients with lower HgBA1c levels, decreasing hypertension, improved depression and anxiety scores. • Another site reports increasing the number of clients who are ready to quit smoking. • Another site reports lower hospital admission and ED visit rates. • Two sites achieved PCPCH status over the last year; two more hope to attest in the next 6 months.
Challenges with Implementing Project	<p>What have been the biggest challenges/obstacles faced with implementing this particular project?</p> <p>Project 2a: Patient Experience of Care Learning Collaborative As previously reported, we encountered a number of issues that delayed the start of this Learning Collaborative, including an unexpected difficulty in recruiting both participants and contractors for this Learning Collaborative, possibly related to “change fatigue” and limited capacity caused by the multiplicity of ongoing initiatives to transform health care in Oregon.</p> <p>Project 2b: Behavioral Health Home Learning Collaborative (BHH LC)</p> <p>There have been many challenges to this Learning Collaborative, but perhaps the most difficult has been staff turnover at the participating agencies and difficulty in finding qualified and appropriate replacements. Fully half of the original cohort of 10 agencies experienced significant personnel instability in critical roles, in one case involving multiple changes in a single position within a 6 month period. This extreme degree of turnover in some cases undermined the level of organizational commitment to this improvement project and in others made it difficult for the practice coaches to establish and maintain the kind of relationships that are a critical component of this intervention.</p> <p>The initial cohort of 10 agencies participating in the Behavioral Health Home Learning Collaborative ran the full gamut of integration, from relatively advanced to just starting out. It was challenging to</p>

develop a curriculum and a learning environment that would serve the needs of all participants regardless of where they currently lie on the integration spectrum.

Most of the sites are pursuing improvement projects that are intended to build their capacity to provide whole-person care to their challenging SPMI populations. A large proportion of the participating behavioral health organization do not have health record systems that are sufficiently robust to support easy sharing of information between behavioral health and physical health providers or permit extensive data collection and analysis. At the beginning of this project several agencies were still using paper records that made it extremely difficult to collect data or communicate efficiently across disciplines. Two of those agencies adopted EHRs in the last 12 months, ultimately increasing their capacity to collect data and implement quality improvement efforts, but the adoption process tended to be all consuming for 2-3 months, interfering with their ability to maintain consistent focus on the work of the Learning Collaborative.

Only one site, an early recipient of the SAMHSA Primary and Behavioral Health Care Integration (PBHCI) grant, currently has the capacity to collect and report population-level data on any of the core measures. Several other sites will likely be in a position to report selected data by the end of the grant period. The majority of the sites, however, are several steps away from having the capacity to track even process measures, never mind collect and report data on population-level health outcomes.

Through interviews and group learning activities including agency leadership as well as direct service providers, several common barriers to integrated care in a behavioral health setting have emerged. We are working directly with participating agencies and planning addition cross-agency collaborative training opportunities to further explore and address these challenges in the remaining six months of the BHH LC. These include:

- Establishment of formal workflows and processes to support cross-disciplinary care teams;
- Incompatible EHRs or insecure electronic communication, limiting information exchange between physical and behavioral health staff
- Regulatory confusion over 42CFR, which limits information exchange specific to addiction and treatment for SUD.
- Incompatible culture across established PCP and behavioral health teams – e.g., pace of work, documentation requirements, billing restrictions; and
- Knowledge gap – BH practitioners may be unfamiliar with chronic diseases and how they impact care management.

Remediation Strategy: What are your plans to overcome these challenges?

Project 2a: Patient Experience of Care Learning Collaborative

The number of practices participating in the Patient Experience of Care Learning Collaborative was smaller than initially anticipated (9 rather than 12). The two contractors were able to provide more hands-on technical assistance and tailor the learning sessions to the needs of the participating practices.

Project 2b: Behavioral Health Home Learning Collaborative (BHH LC)

Given that the initial cohort of participating agencies represented a wide diversity in readiness, we determined that the improvement projects would differ substantially in scope and ambitiousness. Practice coaches worked with each agency to develop and implement improvement projects that

	<p>were appropriate to their existing integration status and available resources. In several cases, this was the first attempt at a formal improvement project and the practice coaches spent a good deal of time providing training in basic tools of quality improvement (e.g., PDSAs, driver diagrams, minimal data sets).</p> <p>Following our receipt of the no cost extension, we required participating agencies to submit a formal letter of intent, including a brief description of the specific improvement project that they intended to pursue in Year 2. Four of the original 10 agencies opted not to continue. In February and March 2015, we issued a request for applications to fill those slots. Three new agencies joined the Learning Collaborative in April. This second cohort is far more homogenous in their degree of integration.</p> <p>Based on feedback from Year 1, we have doubled the amount of practice coaching available to participating agencies (up to 2x/month). We revamped our approach to the in-person Learning Sessions, with less time devoted to formal didactic sessions in favor of more opportunities for direct sharing of insights and problem-solving among the participating teams. We also contracted with a second vendor to provide specialized training in care management, including webinars (Diabetes 101 and Hypertension 101) that are intended to familiarize behavioral health staff with these most common chronic conditions.</p>
Alignment with other initiatives?	<p>If yes, describe the other initiatives.</p> <p>The Oregon Legislature established the Patient-Centered Primary Care Home Program in 2009. The program works with stakeholders across Oregon to set the standards for what high-quality, patient-centered primary care looks like. The program also identifies primary care homes, promotes their development, and encourages Oregonians to seek care through recognized primary care homes. The ultimate goal is that 75 percent of all Oregonians will have access to a primary care home by 2015. Both of the learning collaboratives serve the goal of increasing access to patient centered primary care homes.</p> <p>Participants in the Behavioral Health Home Learning Collaborative continue to express enthusiasm for pursuing “reverse” integration, but confusion about how to achieve it efficiently and sustainably. OHA has convened a Standards Advisory Committee to review the existing Patient-Centered Primary Care Home standards in light of the last five years of experience. Part of that committee’s work will be exploring standards for a behavioral health home designation in 2015. That committee includes representatives from the Behavioral Health Home Learning Collaborative and the OHA staff managing the standards work have been actively involved with the Learning Collaborative since its inception.</p> <p>Oregon has several initiatives that are designed to improve access to behavioral health services that mirror the national objectives outlined in the National Quality Strategy. Chief among them is creating better alignment in measure priority areas that span both CMS and SAHMSA. Oregon is one of the RWJ, Aligning Forces for Quality states that has placed emphasis on public reporting of quality measures, including CAHPS. Oregon is also a CMMI, State Innovation Model grantee and is working on ways to align primary care measurement of patient’s experience of care across multiple payers.</p> <p>In OHA’s 2015-2018 Behavioral Health Strategic Plan, a central goal is to “target and treat common chronic health conditions faced by people with severe and persistent mental illness, substance use disorders and co-occurring disorders.” This population is at increased risk of morbidity and mortality from chronic conditions including diabetes, heart disease and other metabolic disorders associated</p>

	<p>with smoking, alcohol consumption, poor nutrition, obesity and lack of exercise. Moreover, commonly prescribed antipsychotic medications can be associated with weight gain, diabetes, dyslipidemia, insulin resistance and metabolic syndrome.</p> <p>Oregon intends to apply for the Excellence in Mental Health grant opportunity to promote the creation of Certified Community Behavioral Health Centers and an alternative payment model to provide financial sustainability. The experiences of the participants in the Behavioral Health Home Learning Collaborative are informing Oregon’s application.</p>
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Progress with Interventions: Using Table 2b below, provide a detailed timeline and summary of the progress to-date in implementing interventions related to the QIP described above. *Note: If the QIP has not yet been fully implemented, provide (in the table below) a detailed description of activities-to-date that demonstrate your progress toward implementation along with a timeline for the activities that are planned until full implementation.*

QI Project Table 2b

Quality Improvement Project 2: Intervention Information				
Detailed Description of Interventions	Describe each intervention that has been implemented over the last 30 months and the month/year it was operationalized.			
	Project 2a: Patient Experience of Care Learning Collaborative			
	<p>The Patient Experience Learning Collaborative was launched in June 2014 and culminated in June 2015. Nine primary care practices were chosen to participate and were assigned to work with two contractors who provided technical assistance (TA). The participants receive practice-level facilitation, guidance on integrating patients within their quality improvement projects, fielding of CAHPS Clinical and Group (CG) Survey Patient Centered Medical Home (PCMH) Item set and opportunities to attend face-to-face learning sessions.</p> <p>Two contractors were engaged for this project; they designed two variants of this learning collaborative, dividing the participating practices between them. Both contractors began work in late spring 2014 and established a schedule of activities through June 2015.</p>			
		Learning Session #1	Learning Session #2	Learning Session #3
	Patient Experience (Oregon Pediatric Improvement Project)	Various sessions July-August 2014	01/27/15 Salem	04/22/15 Salem
	Patient Experience (Oregon Rural Practice-based Research Network)	08/36/14 Eugene 09/25/14 Bend	02/23/15 Eugene	06/08/15 Web
	<p>While the goal of both variants is the same, the contractors designed different methods to engage participating practices.</p> <p>In order to accommodate the timing of the CAHPS survey administration, the Oregon Pediatric Improvement Project (OPIP), employed a series of in-person meetings and webinars to provide information on the CAHPS survey sampling approach and help the practices prepare for its administration</p>			

using tools to engage both patients and staff as quickly as possible. These meetings took place June-August 2014 in lieu of a single in-person learning session. The focus of the work to date has been on collecting baseline data, understanding the context within each practice, and beginning to build capacity and infrastructure for quality improvement. All of the sites in this variant used the pre-survey engagement materials to discuss the purpose of the survey with both staff and patients. Given the time necessary to process the survey data, the subsequent learning sessions were moved to February and March in order to have meaningful results for the sites to use.

The second contractor, the Oregon Rural Practice-based Research Network (ORPRN), used a “boot camp” format. The participating practices were divided into two cohorts to reduce the travel burden for practices. Each practice was tasked with identifying a Patient Partner to participate in the Collaborative with them, including attending learning sessions and participating in as many coaching session meetings and calls as possible. All practices complied with this expectation. The effort was focused on providing participating practices with resources and coaching in Shared Decision Making to enhance patient experience. At the end of the project, this contractor did a second, convenient-sample fielding of the survey to gauge whether practices improved, especially regarding Shared Decision Making.

OPIP Learning Session #2

The goals for this meeting were to:

1. Highlight key CAHPS CG PCMH findings across the entire group of 6 practices participating in the Learning Collaborative
2. Provide an overview of resources and materials OPIP provided to each practice to support them in using the data and communicating key findings to their practice and patients.
3. Have practices that used the CAHPS CG PCMH in the past share how they used the findings to guide and inform improvements in their practice.

OPIP Learning Session #3

The goals for this meeting were to:

1. Highlight key finding from CAHPS data
2. Facilitate a conversation among practices who have implemented a version of the CAHPS to share experience with implementing patient centered improvements informed by CAHPS data to identify community level opportunities for improvement that address CAHPS findings.

ORPRN Learning Session #2

During their session on February 23, 2015, clinics reported out on their goals related to improving patient experience, especially related to the secondary focus on the Collaborative – Shared Decision Making (SDM). During the session, ORPRN delivered customized training materials to participants, including each clinic’s report from the administration of the CG-CAHPS survey. The practices reviewed their results and participated in a discussion about what stood out to them about their scores. The session specifically focused on the CAHPS items related to Shared Decision Making. Given their CAHPS data paired with the presentation and facilitation provided by ORPRN over the last several months, the clinics spent the remainder of the session planning QI goals related to improving their scores. ORPRN will be working with the practices to refine those goals, implement changes and then do a convenient sample of the SDM questions at the end of the project to see if the clinics have improved patient experience of care related to SDM.

ORPRN Learning Session #3

The final Patient Experience Learning Collaborative session was held via phone and web on June 7, 2015. Dr. L.J. Fagnan, ORPRN’s Director, shared a summary of shared decision making (SDM) and the importance of providers’ ability engage patients in this type of collaboration. He also provided some resources and recommended questions that should be asked to be effective in SDM. Other ORPRN staff reviewed some

ways clinicians have pushed back against SDM, and engaged some of the providers on the call on their thoughts. Group feedback included:

- Practices don't necessarily have to do SDM with all patients, but should at least recognize those that need it most
- Several providers agreed and noted that sometimes it's at least helpful for patients who could be prone to changing their minds about a decision that they've already made

Clinics reviewed the work they completed as part of the Collaborative, and identified where they are on implementing SDM. Each clinic discussed their primary goals and how they addressed the three primary/key activities relating to their goal.

ORPRN helped each practice administer a second CAHPS survey via convenient sample. During the session ORPRN reviewed the method of surveying each clinic used, and their respective response rates. Each clinic briefly discussed what they did and some of the barriers they experienced. ORPRN concluded the session with an overview of the responses practices gave during their exit interviews about what they learned and what is clear about the value of SDM.

Project 2b: Behavioral Health Home Learning Collaborative (BHH LC)

The Behavioral Health Home Learning Collaborative is intended to support the integration of primary care into behavioral health agencies ('reverse' integration) as part of the state's efforts to increase the percentage of Medicaid recipients enrolled in a Patient-Centered Primary Care Home (PCPCH) and improve care for SPMI populations. As noted in our previous reports, this project was delayed in starting, but has been very active since May 2014 and participating agencies have made substantial progress toward integration.

To date, we have engaged in the following activities:

- Ongoing practice coaching (1x/month in Year 1; 2x/month in Year 2)
- Four in-person learning sessions (July and October 2014, January and June 2015)
- Two webinars
 - Alternative models of reverse integration, drawing primarily from SAMHSA materials, and an overview of Oregon's Patient-Centered Primary Care Home program (May 2014)
 - The effective use of limited data sets that highlighted the experience of one of the sites in using PDSA cycles to improve the rate of physical health screening and follow up (November 2014)
- Specialized training in Care Management (May 2015)

The first cohort of participants in the Behavioral Health Home Learning Collaborative consisted of 10 agencies seeking to integrate primary care into existing behavioral health (mental health and substance abuse treatment) settings. As noted above, at the end of Year 1, four of the original sites decided not to continue, principally because of personnel issues. We recruited an additional 3 sites to join the Learning Collaborative for Year 2.

Practice coaching has been the principal intervention throughout this Learning Collaborative. The Behavioral Health Integration Capacity Assessment (BHICA) tool was used by the participating agencies to establish baseline data on their organizational capacity and clarify their integration goal. The practice coaches used the results of the BHICA assessment to assist agencies in designing and implementing their improvement projects.

In Year 1, the participating agencies engaged in rapid cycle improvement projects aimed at improving screening for physical health needs (N=5), building team-based care plans across primary care, mental health and addictions (N=3), creating registries of mental health clients in need of primary care (N=1), and promoting tobacco cessation among behavioral health clients (N=1). All the participating agencies reported that they emerged from the first year of the Learning Collaborative with a much clearer understanding of the needs of their population, their organizational strengths and challenges, and the next steps necessary to advance toward their integration goal.

In Year 2, participating agencies have developed improvement projects that have been informed by their experience in Year 1 of the Collaborative or other initiatives. These improvement projects are intended to increase the sites' capacity to address the following adult core measures:

- Controlling High Blood Pressure (N=5);
- Comprehensive Diabetes Care: HbA1c Testing (N=4),
- Tobacco cessation (N=1)
- Adult BMI Assessment (N=3)

(Several participating agencies are pursuing improvement projects related to more than one core measure.)

- Among the nine agencies participating in the second year of the learning collaborative, 4 are currently delivering integrated physical health services within the behavioral health facility to a growing panel of patients (Bridgeway Recovery Services, Center for Family Development, Old Town Recovery Center, Willamette Family, Inc.). Each of these agencies now provides both mental health and or addictions services on site, along with physical health care offered by licensed providers (e.g., MD, FNP, PA). These behavioral health home clinics have capacity to collect patient-level data through an electronic health record, and are building capacity to track patient data on adult core measures over time (including but not limited to ABA, CBP, and HPC). Further, they are building capacity to establish workflows that allow access to shared care plans across physical health and behavioral health providers.
- Cascadia Behavioral Health is delivering integrated services to a cohort of clients through a SAMHSA-funded partnership with the Outside In FQHC. Clinical services are provided on site at the behavioral health center on a mobile medical van. The SAMHSA grant requires detailed collection of physical health status and smoking cessation. Through the learning collaborative, Cascadia is engaged in an agency-wide planning process to establish its own permanent clinical space to support integrated health services delivery.
- Similarly, Lifeworks NW is offering on-site medical services through a cooperative arrangement with a local FQHC, Virginia Garcia. Through the collaborative, Lifeworks staff are building a registry of behavioral health clients in need of primary care services and working to expand enrollment of into the health home project, as well as reducing no-show rates and loss to follow up.
- The Birch Grove Collaborative is a unique clinic space within the larger La Clinica FQHC, built to care for patients referred by three specialty mental health and addictions partners in the region. The physical health clinic uses a standard EHR to collect and track patient-level data, and, through the learning collaborative, is developing workflows to more effectively share patient data using the Jefferson Health Exchange.
- The partnership between the Community Health Alliance (the county's contracted mental health provider) and its neighboring FQHC has identified up to 100 patients in need of integrated care through the FQHC's Expanded Care Clinic (ECC) project. The ECC is located at the FQHC, but is staffed in part by CHA behavioral health counselors and is relying heavily on the learning collaborative to develop workflows that involve inter-agency staff in the recruitment, tracking, and follow up of patients. ECC staff have already modified workflows to involve behavioral health counselors and FNPs in clinic visits to improve the efficiency and quality of physical health care

delivered to SPMI patients.

- Finally, the Mid-Columbia Center for Living (MCCFL), the newest member of the BHH LC, is in the earliest stages of planning for integrated care. MCCFL is its region’s community mental health center and partnered with One Community Health, the local FQHC, to submit an application for a new SAMHSA PBHCI grant. As part of their work in this collaborative, MCCFL will develop a registry of SPMI clients currently co-enrolled at OCH. They will work with OCH to use the Jefferson Health Information Exchange to pull physical health data, such as diagnoses, medications, and vitals, into the DHP module. This project will help MCCFL to develop workflows and processes of tracking clients’ physical health indicators and more effectively coordinate care with community PCPs.

Site Name	Project	Process Measures
Bridgeway Recovery Services	Improving Blood Pressure of BRS Patients with HTN	Developing and integrated team approach to monitor, educate and treat patients with HTN Design Interdisciplinary team (IDT) processes for shared care planning and patient progress review Develop process for BP evaluation and tracking to be done by BH staff in their Pt contacts Track BP changes and report progress to IDT and Patient Define and disseminate patient education and wellness materials Evaluate patient perception of wellbeing
Cascadia BHC	Developing a transition plan to support integrated and team based care at Woodland Park Outpatient Clinic, post SAMHSA funding for the OPHI program	Creation of shared vision and goals Identifying team roles/tasks/job descriptions/functions Development of outcomes for clients, staff, program, and clinic Creation of work flows Development of implementation plan
Center for Family Development	Lower/Control blood pressure for hypertensive mental health patients who are actively engaged with a mental health therapist. (N=23)	Number of therapists involved in the project

		<p>Number of patients who attend the educational Hypertension presentation</p> <p>Number of patients reached and educated</p> <p>Number of patient treatment plans created</p> <p>Number of blood pressure specific therapists and patient interactions post education</p> <p>Patient progress toward treatment plan goal(s)</p>	
	<p>The first goal will be to create and implement an integrated care plan within each client's electronic medical record (EMR). Our second goal is to effectively track no show appointments and same day cancellations.</p>	<p>Goal #1: Integrated Care Plan</p>	<p>Goal #2: Tracking No Shows</p>
<p>Community Health Alliance</p>		<p>Have access to the care plans within the EMR</p> <p>Create process for filling out individual care plans</p>	<p>Create spreadsheet of clients</p> <p>Identify an individual to keep track of the spreadsheet</p>
<p>La Clinica Downtown Clinic/Birch Grove Collaborative Partnership</p>	<p>Implement Jefferson Health Information Exchange (JHIE) at all four collaborative partner's location enabling us to share vital referral information in a timely and secure way.</p>	<p>Track the number of referrals to and from each agency.</p> <p>Track time from referral initiation to patient contact.</p> <p>Track open referrals.</p> <p>Increased closed-loop referrals.</p> <p>Communicating with providers securely inside and outside our network.</p>	
<p>Lifeworks NW</p>	<p>Increase enrollment in health home</p>	<p>Expand enrollment option to Farmington Site</p>	

		<p>Investigate connection of patients identified as “lost to follow up” to determine reasons for discontinuation of primary care services. Follow up with CCOs (HealthShare, FamilyCare, CareOregon) to ID LifeWorks NW clients that are not actively seeing a community PCP (request data on assigned PCP, last visit with PCP, and ED utilization) to target for health home enrollment. Implement continuous monitoring of patient-level and quality metric-level data.</p>
	<p>Mid-Columbia Center for Living (MCCLF)</p> <ol style="list-style-type: none"> 1. Implement, test and refine “Dr.’s Home Page” (medical component of EHR) to collect, track medical conditions as well as behavioral health disorders and enable ultra-sensitive exchange of information between external providers 2. Develop patient registry of high needs physical and mental health patients to enable effective practices based on data 	<p>Monthly Reports from EHR</p> <p>Ability to transmit and accept Continuity of Care document (CCD) from other health entities into MCCFL EHR.</p> <p>Timelines based on hiring NCM, chart reviews, obtain info from PCP’s, develop report</p>
	<p>Old Town Recovery Center</p> <p>Developing metabolic monitoring protocols and processes for IHART clients; regularly monitor clients and respond to abnormal lab values.</p>	<p>Continuously monitor the status of metabolic monitoring for IHART patients on 2nd generation anti-psychotics to ensure they stay up-to-date. Labs will be performed a minimum of once yearly, with more frequent rechecks as indicated by the IHART LMP and their OTC PCP. Order labs when needed in coordination with the client’s PCP Outreach to clients to alert them to the need for labs and facilitate getting them in to the clinic to have their blood drawn</p>

	<p>Respond to lab results in coordination with the patient’s primary care team and to monitor them on an ongoing basis</p> <hr/> <p>Willamette Family, Inc. Identify and track client population that is living with Diabetes; include sub-populations of DM type I and type II</p> <p>Improvements in blood pressure, HgbA1C levels, HRQOL score, GSE6 score</p> <p>Number of clients identified Number of clients enrolled Track: Weight; HgA1C values; HRQoL; GSE6; Blood pressure; Attendance in CBT/mindfulness group</p>
Effectiveness of the Interventions	<p>What methods have you used to determine the effectiveness of interventions? Include frequency of review(s).</p> <p>Project 2a: Patient Experience of Care Learning Collaborative Participating practices were asked to evaluate the learning sessions and the overall usefulness of the technical assistance provided by the two contractors.</p> <p>Project 2b: Behavioral Health Home Learning Collaborative (BHH LC)</p> <p>In addition to the participant evaluations for each in-person Learning Session, we are implementing a plan for a qualitative and quantitative evaluation of the Behavioral Health Home Learning Collaborative that is intended to provide case studies that document the variety of experiences among the participating agencies and extract lessons that can help guide future integration efforts by other organizations and inform policy making within Oregon. Data gathering activities are already underway using a variety of methods:</p> <ul style="list-style-type: none"> • Year 2 Kick-off meetings • Focus groups on behavioral health homes • Exit interviews • Administration and analysis of Behavioral Health Integration Capacity Assessment (BHICA) results (pre-, mid-, and post-Collaborative) • Analysis of site-specific data <p>We anticipate that the analysis of the qualitative and quantitative data will be completed by the end of January 2016 and findings will be reported in the close-out report in March 2016.</p> <p>Which have been your most effective interventions?</p>

Project 2a: Patient Experience of Care Learning Collaborative

This project ended only a few weeks prior to this report, so we do not yet have full evaluation findings to share.

Practice facilitation/coaching has proven to be the most effective intervention in both learning collaboratives. As part of the Patient Experience of Care Learning Collaborative, practice facilitators assisted the participating practices in fielding the CAHPS survey and understanding how it can be used to improve patient satisfaction and compliance. In addition, frequent, direct contact with practices clearly has been an important factor in generating and sustaining staff engagement in the process.

Below are summaries of the participants’ evaluations of the contractors and their experience in the Learning Collaborative.

Evaluation for OPIP Learning Session #2

1. Please rate the degree to which the following objectives of this learning session were met:

Objectives:	Completely met	Partially met	Not at all met	Not sure
a) To highlight key CAHPS CG PCMH findings across the entire group of practices participating in this learning collaborative.	93% (13)	7% (1)		
b) To provide an overview of resources and materials OPIP will provide you to support using the data, and communicating key findings to your practice and patients.	86% (12)	14% (2)		
c) To learn from practices who have used the CAHPS CG PCMH before about how they used findings to guide and inform improvements in their practice.	93% (13)	7% (1)		

Comments:

2. For each session, please indicate your level of agreement with the following statements:

Highlight of key findings across the entire group of practices participating in this Learning Collaborative. <i>-Colleen Reuland</i>	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
a) I acquired new knowledge in relation to topic discussed	57% (8)	43% (6)			
b) The content of the session provided useful information for my practice	57% (8)	43% (6)			

Comments:

- **“Enjoyed the speakers from the other practices.”**

Overall Evaluation of OPIP-led Learning Collaborative:

The majority of the practices in the OPIP Improving Patient Experience Collaborative found the learning session to be content appropriate and educational when it came to usable tools. The practices provided ratings across the board as *always* or *almost always* in relation to the learning session component of the Collaborative. The practices almost universally reported that the OPIP facilitators always encouraged the active participation of all team members during the sessions and that the facilitator allowed time for questions and answers.

The exception to the overwhelmingly positive feedback on the learning sessions is that some practices felt there may have not been enough time during the learning sessions to share experiences and advice with colleagues from other practices. However they all reported that their specific practice shared common attributes (e.g. priorities, challenges, patient population) with the other practices in the Collaborative.

The practices had an opportunity to comment on the OPIP staff and facilitators and how well they actively participated with the practices, answered questions, provided useful information and provided clearly defined next steps to the practices. Based on the majority of the practice responses it is clear that OPIP excelled in this area although it there was one practice that reportedly felt that OPIP satisfied these requirements only some of the time.

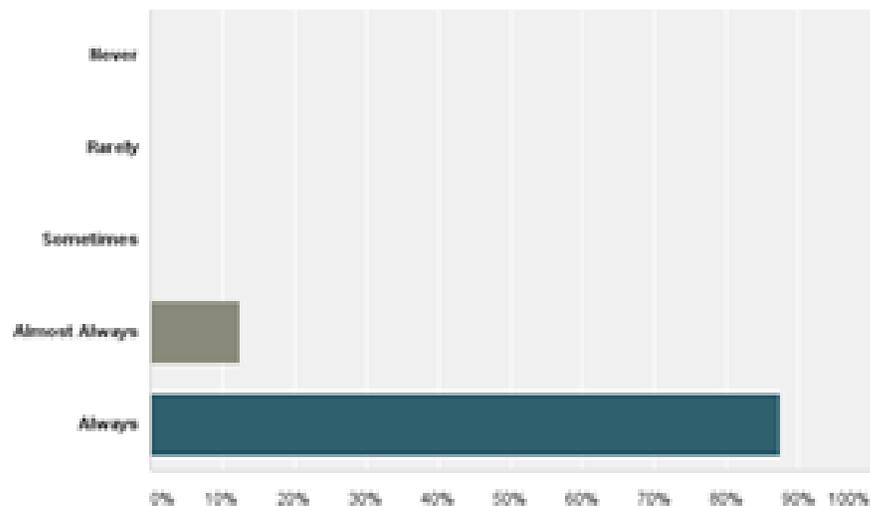
The practice were also very satisfied with OPIP's efforts to follow up on the progress that the practice was making towards their goals and helping them establish effective internal processes for quality improvement. The practices also felt that OPIP had the content knowledge to adequately support the practices.

When it came to communication, the practices felt that OPIP staff communicated with their team just enough. This implies that the practices desired a bit more communication from the staff yet they weren't entirely unsatisfied with the communication that that received and acknowledge that it was sufficient.

Overall the majority of the practices reported feeling very involved in the learning collaborative as a whole, including the learning sessions and practice coaching, which suggests that the efforts towards engagement of the practices on OPIP's behalf was satisfactory. Most of them reported that there were not any specific challenges that they had that OPIP overlooked and all of the practices reports that if they were given the opportunity to participate again, they definitely would.

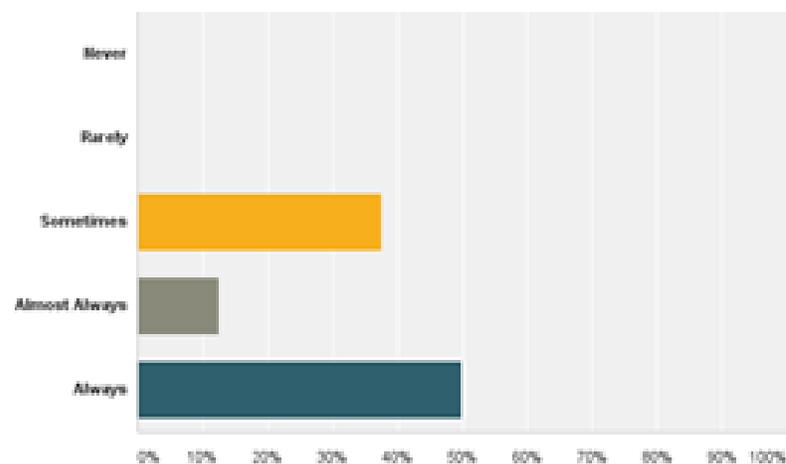
Q5: OPIP facilitators encouraged the active participation of all team members in learning sessions.

Answered: 8 Skipped: 0



Q8: Learning sessions created an opportunity to share experience and advice with colleagues from other practices.

Answered: 8 Skipped: 0



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Participants in the ORPRN-led Learning Collaborative were given training in the use of shared decision making (SDM) to improve patient experience of care. The participants made the following comments

about the value of SDM:

- It's important, but it can be a long process
- It's much more than handing out educational materials
- It's clear that it's critical to listen closely to the patients
- It's more of a formal process and is more structured these days
- Education and decision making are very inter-woven
- A big barrier is having the time and finding the tools

Overall Evaluation of ORPRN-led Learning Collaborative

The majority of the practices in the ORPRN Improving Patient Experience Collaborative found the learning session to be content appropriate and educational. The practices provided ratings across the board as always or almost always in relation to the learning session component of the collaborative. The practices almost universally reported that the ORPRN facilitators always encouraged the active participation of all team members during the sessions and that the facilitator allowed time for questions and answers. They also thought that content was applicable to the team and they were provided with clearly defined next steps.

The exception to the overwhelming positive feedback from the practices was that there was at least one practice that felt that some of the tools that ORPRN provided to them were not tools that their team could use right away. Perhaps this had more to do with the stage of implementation that the practice was in than the actual tools that ORPRN provided.

ORPRN practices also reported that ORPRN gave them ample networking opportunities where practices could share their experiences and advice with colleagues from other practices. This is an area that ORPRN excelled compared to the other Collaboratives.

The practices had an opportunity to comment on the ORPRN staff and facilitators on how well they followed up with the practices on the progress that they were making towards their goals and if they had the knowledge to coach and support the practices. All the practices answered *always* or *almost always* in relation to ORPRN staff support. Specifically the practices provided feedback indicating that ORPRN excelled at providing support and coaching aimed at establishing effective internal processes for quality improvement, such as goal setting, planning for small tests of change and overall project management.

The practices were also very satisfied with ORPRN's communication efforts. When the practices were asked overall how well ORPRN communicated with the practice team and then were given the answer options of *too much*, *just enough*, *not enough* and *not nearly enough*, the practices universally reported *just enough*, indicating that ORPRN has refined their support and communications skills in this area.

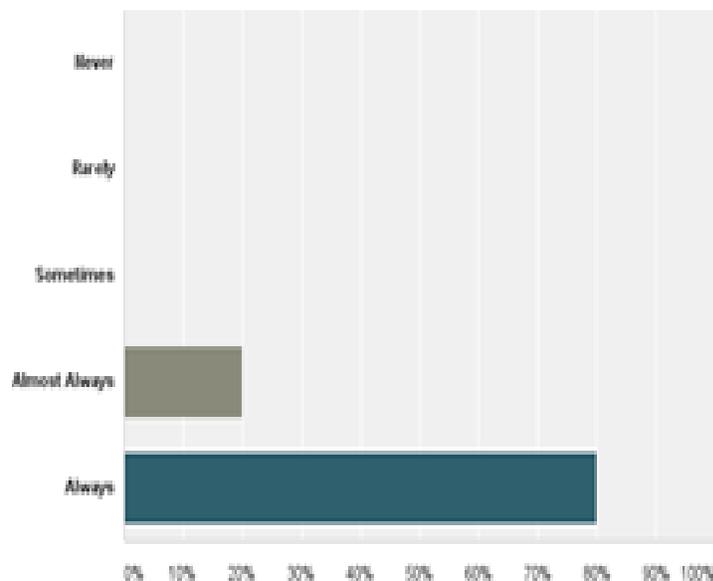
Overall, the majority of the practices reported feeling very involved in the learning collaborative as a whole, including the learning sessions and practice coaching which suggests that the efforts towards engagement of the practices on ORPRN's behalf was satisfactory. Most of them reported that there were not any specific challenges that they had that ORPRN overlooked and all of the practices reported that if they were given the opportunity to participate again, they definitely would.

Some of the practices have re-attested to be a PCPCH clinic, become a PCPCH clinic for the first time during the collaborative or are in the process of preparing to do so as participating in the collaborative has improved their understanding of the intent of the PCPCH program and how to implement Standards into their practice to improve care.

Ultimately, the practices reported that because of the Learning Collaborative, they have greatly improved the quality of care that they provide to their patients and that participating in the collaborative has greatly improved their practices' understanding and use of quality improvement skills.

Q5: ORPRN facilitators encouraged the active participation of all team members in learning sessions.

Answered: 5 Skipped: 0



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Project 2b: Behavioral Health Home Learning Collaborative (BHH LC)

At the January in-person Learning Session of the Behavioral Health Home Learning Collaborative, there was universal agreement that the practice coaches were the most valuable benefit of participation and an important element in the progress the agencies have made toward integration since May 2014. The practice coaches provided individualized assistance to the participating agencies, helping them conduct their self-assessments, design and conduct appropriate improvements projects, and interpret the results. But perhaps their most important contribution was serving as an impartial observer who was able to

identify barriers and mediate solutions with the different components of the team. In addition, participants noted that the regular visits imposed “homework” and an external accountability structure that created both a physical and metaphorical space to focus on the integration goal. They report that the practice coach helped to motivate the staff and leadership to set aside the time and resources for team building, project planning, data collection, and problem solving. The only complaint from the sites was that one visit/month was insufficient to get the most out of the coaching. For Year 2, therefore, we have increased the frequency of practice coach visits to twice/month.

We recently heard from one of the sites that was forced to drop out of the Learning Collaborative at the end of Year 1 because of massive staff turnover and organizational restructuring that they would like to return to Collaborative, specifically to benefit from the practice coaching. They noted that it has been extremely difficult to maintain their focus on the integration goal in the absence of regular meetings with the practice coach. Although we have only 4 months left in Year 2, we are working to accommodate this request and develop a modified plan of technical assistance that would be meaningful in the time available.

At the time of our last report, we noted that with the exception of a few sites that were familiar with quality improvement methods and relatively advanced in their integration efforts, most of the participants in the BHH LC had never before used PDSA cycles and found the approach too difficult and unhelpful. In recent months, however, we have heard from several of those agencies that they have become persuaded of the PDSA’s value and are trying to apply it as they develop new internal processes and workflows.

In June, we held the fourth in-person Learning Session. Based on feedback we had received during Year 1, we focused on providing structured opportunities for the sites to compare notes, ask for assistance on specific issues, and report on promising practices. The response to the revised format has been extremely positive and will inform our planning for the next Learning Session in October.

A more detailed analysis of promising practices for reverse integration will be available upon completion of our qualitative and quantitative evaluation of the BHH LC at the end of the grant period.

Which have been your least effective interventions? What steps, if any, have you taken to improve their effectiveness?

Project 2b: Behavioral Health Home Learning Collaborative (BHH LC)

Requiring participating sites to develop driver diagrams and employ PDSA cycles for their improvement projects proved to be both unpopular and relatively unhelpful for the most part. That said, we believe the exercise was an important developmental step for most of the agencies. At the end of Year 1, every participating agency reported and demonstrated dramatically greater clarity about their integration goal and what steps they need to take to achieve it.

In order to continue into Year 2, each site had to produce a description of the specific improvement project that was much more detailed than their original application and included an explanation of how it fits into their larger plans to achieve integration. It is worth noting that with perhaps one exception, the level of specificity in the design of the improvement projects for Year 2 would not have been possible last year. The participating sites have made huge progress in understanding the people they serve, their own organizations, the model of integration that they are pursuing, and what it will take to achieve it.

At the start of Year 1, we asked the sites to complete two sections of the Behavioral Health Integration Capacity Assessment (BHICA) to get a baseline assessment of their populations and some sense of organizational readiness. It was not a popular assignment, but yielded important information that helped the participants clarify both their current integration status and their ultimate goal. For Year 2, we

	<p>required that all sites complete the entire BHICA within the first month. This information has helped the practice coaches to provide technical assistance tailored to the needs and capacities of each site. We will administer the BHICA again at the end of the grant period in order to evaluate changes over time.</p>
<p>Planned Interventions</p>	<p>Describe interventions planned for expansion and/or implementation over the next six months (6/20/15-12/20/15) or until the end of your grant period with estimated implementation dates.</p> <p>Project 2a: Patient Experience of Care Learning Collaborative This project ended in June 2015.</p> <p>Project 2b: Behavioral Health Home Learning Collaborative (BHH LC) Thanks to the no cost extension, this Learning Collaborative will continue for the remainder of the grant period. Anticipated activities include the following:</p> <ul style="list-style-type: none"> • Ongoing practice coaching (2x/month through Dec. 20, 2015) • Fifth in-person Learning Session (October 2015) • Five webinars <ul style="list-style-type: none"> ○ Diabetes 101: (Aug. 5) intended to provide staff in behavioral health settings with a baseline of knowledge on diabetes to enable them to: <ul style="list-style-type: none"> ▪ understand and monitor the disease's progression and recognize warning signs of complications; ▪ understand how lifestyle choices and some psychotropic medications can increase the risk of developing diabetes or exacerbate its impact on overall health; ▪ empower clients to understand and manage this chronic condition ○ Hypertension 101: (Aug. 19) intended to provide staff in behavioral health settings with a baseline of knowledge on hypertension to enable them to: <ul style="list-style-type: none"> ▪ understand and monitor the disease's progression and recognize warning signs of complications; ▪ understand how lifestyle choices and some psychotropic medications can increase the risk of developing hypertension or exacerbate its impact on overall health; ▪ empower clients to understand and manage this chronic condition ○ 3 webinar series (Fall 2015) on information exchange, including compliance with 42CFR regulations • Additional specialized training opportunities (currently being organized) • Presentation of preliminary findings at conferences; preparation of articles for publication • Quantitative and Qualitative Evaluation of the BHH LC, including case studies and lessons learned <ul style="list-style-type: none"> ○ Focus groups (July-Aug 2015) ○ Exit interviews (Nov-Dec 2015) ○ Administration of BHICA (Dec 2015) ○ Compilation and analysis of data (Nov. 2015-Jan 2016)

V. Programmatic Goal: Data Stratification

Grantees must, over the duration of the grant, develop the capacity to stratify at a minimum three Medicaid Adult Core Set measures by at least two of the specified demographic categories to evaluate disparities.

Understanding this table was included in the Annual Progress Report, CMS asks that you provide updated information below.

Medicaid Adult Core Set Measure		Demographic Stratification Categories				
		Select <u>at least 2</u> demographic categories for each measure you have selected to stratify (mark with X)				
	Select <u>at least 3</u> of the measures listed below to stratify (mark with X)	Race/ Ethnicity	Gender	Language	Urban/ Rural	Disability Status
		Comprehensive Diabetes Care: Hemoglobin A1c Testing	X	X		
Prenatal & Postpartum Care: Postpartum Care Rate	X	X				
Controlling High Blood Pressure						
Cervical Cancer Screening	X	X				

- Provide a summary of the work conducted over the past 30 months related to this project activity:

As part of the development of a metrics dashboard, OHA and contractors are programming the ability to stratify measures by a number of filters, including race/ethnicity, gender, age, and geography. Eligibility categories are used as a proxy for disability status, and household language filters are under development.

- Describe any successes and/or challenges encountered in stratifying data.

When doing hybrid measures, there are challenges in stratifying by race and ethnicity because of the inconsistency and discrepancies of administrative data. While chart notes may indicate race, it is often incorporated into the history section of a chart, requiring a considerable labor to extract. Eligibility information at a state level has about 1/3 missing race and ethnicity. The State administrative data has been collected in various formats over time that may or may not allow for different degrees of granularity or coding for multiple races.

The definition of disability is inconsistent throughout the state agency and is based, at least in part, on program eligibility criteria, even using federal criteria, Social Security SSI or ADA thresholds differ.

We are unable at this time to stratify data by language, since our current data sources track only household language, not individual language designation.

- Provide a list of any additional measures that have been stratified in addition to the required measures and which demographic stratification categories were used.

FVA-AD	Flu Vaccinations, ages 18-64	Race/Ethnicity
MCS-AD	Medical Assistance with Smoking and Tobacco Use Cessation	Race/Ethnicity
PCR-AD	Plan All-Cause Readmission Rate	Race/Ethnicity
PQI01-AD	Diabetes, Short-Term Complications Admission Rate	Race/Ethnicity

PQI05-AD	COPD or Asthma in Older Adult Admission Rate	Race/Ethnicity
PQI08	Heart Failure Admission Rate	Race/Ethnicity
PQI15-AD	Asthma in Younger Adults Admission Rate	Race/Ethnicity
LDL-AD	Comprehensive Diabetes Care: LDL-C Screening	Race/Ethnicity
HA1C-AD	Comprehensive Diabetes Care: Hemoglobin A1c	Race/Ethnicity
IET-AD	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Race/Ethnicity

- Describe how the Grantee has used and/or plans to use this information to improve how care is delivered to adults enrolled in Medicaid.

The state adopted legislation that requires developing plans to improve race and ethnicity data at the point of collection and takes effect this year.

VI. Additional Questions

- **Budgetary Concerns:**

Provide *informal* feedback about any budgetary concerns you may have regarding the grant. *If none, leave blank.*

- **Technical Assistance:**

Describe any unmet technical assistance needs (i.e., as it relates to your ability to meet the programmatic goals of this project). *If none, leave blank.*

- **Highlighting Promising Practices:**

Describe grant activities that may be emerging as promising or best practices.

- **What lessons were learned over the past 30 months of the grant program:**

A year goes fast. For both learning collaboratives, the participants made good progress, but it was only at the end of the year that sites reported hitting their stride. Thanks to the 12-month no cost extension, the Behavioral Health Home Learning Collaborative (BHH LC) has been able to leverage the momentum built up over the first year and we are seeing some remarkable progress. In some sites, the difference in their engagement between Year 1 and Year 2 has been quite stunning, but all sites are showing huge growth in understanding their populations, recognizing their own organizations' strengths and weaknesses, and clarifying what integration could look like for them. We are very optimistic about the progress that the sites will be able to make in the next six months and look forward to documenting the lessons to be learned from their experiences.

In both Learning Collaboratives, practice coaching (or practice facilitation) has been shown to be a powerful intervention to support quality improvement.

- Participants in the BHH LC in particular have been very vocal in calling out their practice coach as a critical force for promoting change.
- As in any relationship-based method, there needs to be a good match between the site and the practice coach, not only in terms of skill sets, but also personality.
- Based on feedback, it appears that two on-site visits/month may be optimal: once/month is helpful, but a month is a long time to maintain focus when the world is pressing in. Two visits allows for more timely feedback and helps to keep the momentum of change going.

Technology continues to be a major barrier to integrated care. At the start of the BHH LC, most of the participating sites had few, if any, technological resources for record keeping, data collection, and care planning. The majority of behavioral sites now have some EHR capabilities, but have discovered that their systems typically do not play well with the EHRs of their medical partners. A common complaint now is that even after making a substantial financial commitment to enhancing IT systems, it is still difficult to exchange information, create shared care plans, and provide timely alerts.

Staff turnover is a major barrier to sustained transformation. In behavioral health settings, turnover is especially common and especially deleterious, since clients with SPMI and addictions have an even greater need for stable relationships than other populations. Leaders of several participating behavioral agencies have remarked that this is a very exciting time in behavioral health, but is also perhaps the most difficult for organizations to navigate in recent decades. They have expressed the hope that creating genuine behavioral health homes will improve outcomes for both clients and staff.

- **Key Lessons Learned & Our *Ah-ha!* Moments from this Period of Performance:**

Perhaps the most important realization from the Behavioral Health Home Learning Collaborative (BHH LC) over the last 6 months has been that the essence of all of the integration projects is cross-disciplinary coordination. In some sites, this is happening through internal care management; in others, it is being done through care coordination of referrals. But regardless of the specific model chosen, real integration has to be grounded in highly functional cross-disciplinary teams. Some of the pre-requisites that have been identified thus far are:

- There needs to be a clearly articulated vision for integration that is shared (or “owned”) by all members of the organization, from the highest leadership positions to the office staff and everything in between in order to provide the highest quality care for populations with the most complex needs.
 - This collaborative exercise may seem inefficient, but organizations that have not done this up-front work have encountered unexpected resistance and had to double-back later in the process
- Cross-disciplinary care teams need sufficient time and space to become cohesive working groups.
 - Regular and frequent meetings are essential (typically weekly huddles)
 - Both sides of the equation – medical personnel and behavioral practitioners – need to adapt their habitual work patterns to make this new model work.
- Cross-training is essential.
 - Medical practitioners are increasingly familiar with behavioral issues, but need more training in trauma-informed care. Medical personnel need to try to understand and respect the different pace of work and variety of roles in behavioral health care

- Behavioral practitioners are often uncomfortable with the medical side and need specialized training in chronic conditions, procedures, processes, and community resources to enable them to assume new roles
- Ideally, behavioral practitioners will work to the top of their license, allowing them to take on more functions

- **Sustainability and Spread**

Provide a list of meetings, conferences, and other ways you have shared information about your grant activities with a wider audience. Include date, title and location of event and information about the audience reached, if available.

Adult Core Measures

1. CMS conf. Dec. 2014 – 2 posters and a presentation
 - a. “A Hybrid Sampling Strategy, CAHPS Health Plan and Clinician and Groups - PCMH” (also shared during April monthly phone call with AMQ Grantees)
 - b. “Adding Shared Decision Making Questions to the CAHPS Clinician and Groups, PCMH”
 - c. Charles Gallia, presentation on “Patient’s Experience of Care and Shared Decision Making”
2. OHA has worked with 4 of the CCOs and they have shown improvements in their CAHPS scores. (See [Oregon's Health System Transformation: Final 2014 Report.](#))

Statewide PIP on improving diabetic monitoring in people with co-occurring diabetes and schizophrenia or bipolar disorder

1. To date, four plans (two in southern Oregon, one on the coast, and one in Portland) have spread the concepts from their interventions to additional provider offices in their delivery service areas (an urgent care clinic, a community help center, and two family practice/internal medicine offices). Additional detail will be available when the final report becomes available at the end of July 2015.

Patient Experience of Care Learning Collaborative

1. Webinar: “Engage, Collect, Partner: How to Use Patient Experience of Care Surveys in Your Practice,” May 22, 2014 (Pre-Learning Collaborative), 31 attendees, 12 video recording views
2. Blog post: Incorporating the Patient and Family Voice in Patient-Centered Medical Home Improvement Efforts, August 8, 2014, 63 views
3. Blog post: ORPRN Leads its First Improving Patient Experience of Care Learning Sessions, October 13, 2014, 26 views
4. OPIP hosted a CCO-wide learning session in April and inviting practices beyond those they are working with at WVP, and has engaged the CCO in thinking about patient experience data, through the project and how they might do so across the CCO, April 2015.

Behavioral Health Home Learning Collaborative

1. Poster, Coordinated Care Model Summit, Portland, OR Dec. 3-4, 2014
2. Rita Moore and Liz Waddell, contributed to webinar on care coordination, Eastern Oregon Coordinated Care Organization Learning Collaborative, attendees from 23 participating organizations, February 18, 2015
3. Pam Martin, presentation to panel on tobacco use and cancer in people with severe mental illness at the National Council for Behavioral Health, Orlando FL, April 17, 2015

4. Rita Moore, Liz Waddell, Dan Reece, Presentation and table discussion, Innovation Café, Portland, OR May 2015
5. Beth Sommers, “Moving Beyond the Job Description: Exploring How Practice Facilitators Support Primary Care,” workshop at the NAPCRG PBRN Conference 2015 (North American Primary Care Research Group) (Practice-based Research Network), Bethesda, MD, June 29, 2015 (20 people participated)
6. Poster, Coordinated Care Model Summit, Portland, OR (anticipated, November 2015)

- **Looking to the Future:**

Provide a one-to-two paragraph description of what you hope to report on in terms of progress in the next progress report (period of performance would be June 21, 2015 through the end of grantee’s No Cost Extension or December 20, 2015).

Two projects supported by this grant – the statewide PIP on diabetes monitoring for people with co-occurring diabetes and schizophrenia or bipolar disorder and the Patient Experience of Care Learning Collaborative – concluded only in June. The final reports of findings will be completed shortly and results will be available for inclusion in the close-out report in March 2016. At that time, we also anticipate being able to report on the adult core measures through mid-year 2015.

The Behavioral Health Home Learning Collaborative will continue through the end of the grant period in December 2015. A full evaluation of this project, including case studies and lessons learned, will be completed by January 31, 2016 and reported in the close-out report in March.

Appendix 6

Transformation Grants Report



OFFICE OF THE DIRECTOR

Kate Brown, Governor



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April 13, 2015

The Honorable Senator Richard Devlin, Co-Chair
The Honorable Representative Peter Buckley, Co-Chair
Joint Committee on Ways and Means
900 Court Street, NE
H-178 State Capitol
Salem, OR 97301

Re: Oregon Health Authority (OHA) update on Transformation Fund

Dear Co-Chairpersons:

NATURE OF THE REQUEST

The Oregon Health Authority (OHA) Transformation Center is responding to the HB 5030-A budget note, passed on June 28, 2013 (see Appendix A), related to the \$30 million General Fund Health System Transformation Fund. This report is an update from a letter submitted January 24, 2014.

Summary:

The Health System Transformation Fund provides a strategic investment in 16 coordinated care organizations (CCOs) to engage in innovative projects that support better health, better health care and lower costs in their communities. A portion of the fund also leverages 90 percent federal funding to invest in statewide health information technology (HIT) to share and aggregate electronic health information.

CCOs have indicated that these funds are supporting innovative projects that would not have been possible otherwise. The funding has led to 120 projects that have impacted health care utilization, care integration, provider capacity and patient outcomes. Preliminary results show that projects are leading to outcomes such as decreased emergency room visits and greater access to primary care or prenatal care.

As requested in the budget note, this report includes:

- Distribution process details;
- The dollar amounts distributed, to whom, and for what purpose;
- Expected outcomes and outcome measures, with some preliminary results; and
- Expected next steps.

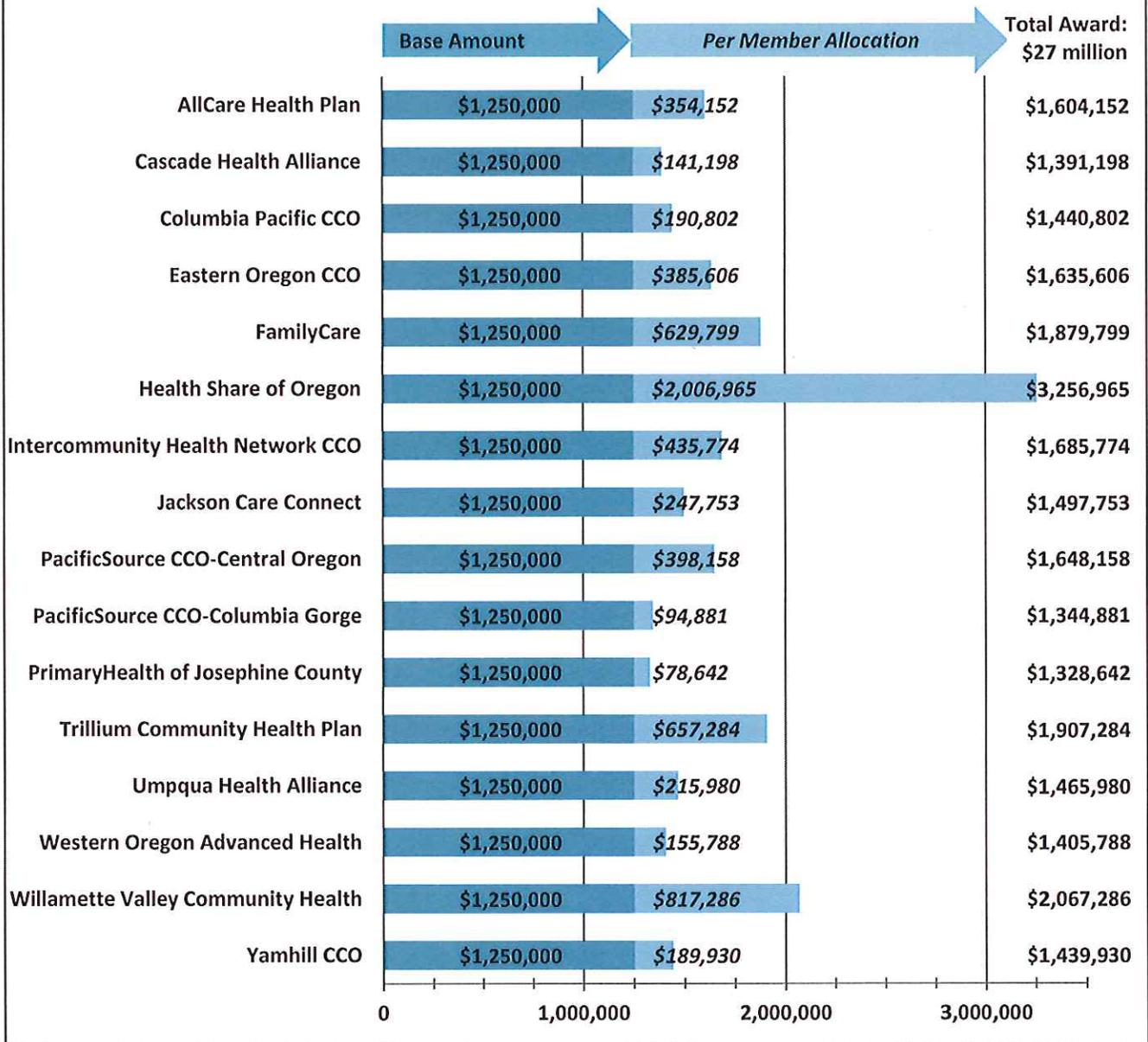
The report also includes:

- A high-level summary of Transformation Fund projects, including common project focus areas;
- OHA's role in building a culture of improvement and innovation among the CCOs;
- Challenges in Transformation Fund grant implementation;
- Information about a grant period extension for 13 CCOs that requested it; and
- An update on the HIT portion of the fund.

TRANSFORMATION FUND: AT-A-GLANCE

Health System Transformation Fund Total: **\$30,000,000**
 Amount allocated for shared statewide HIT investments: **\$3,000,000**
 Amount distributed to CCOs for Transformation Projects: **\$27,000,000**
 Total number of CCO Transformation Fund Projects: **120**

Figure 1: Total Transformation Funds by CCO



TRANSFORMATION FUND: OVERVIEW OF PROJECTS

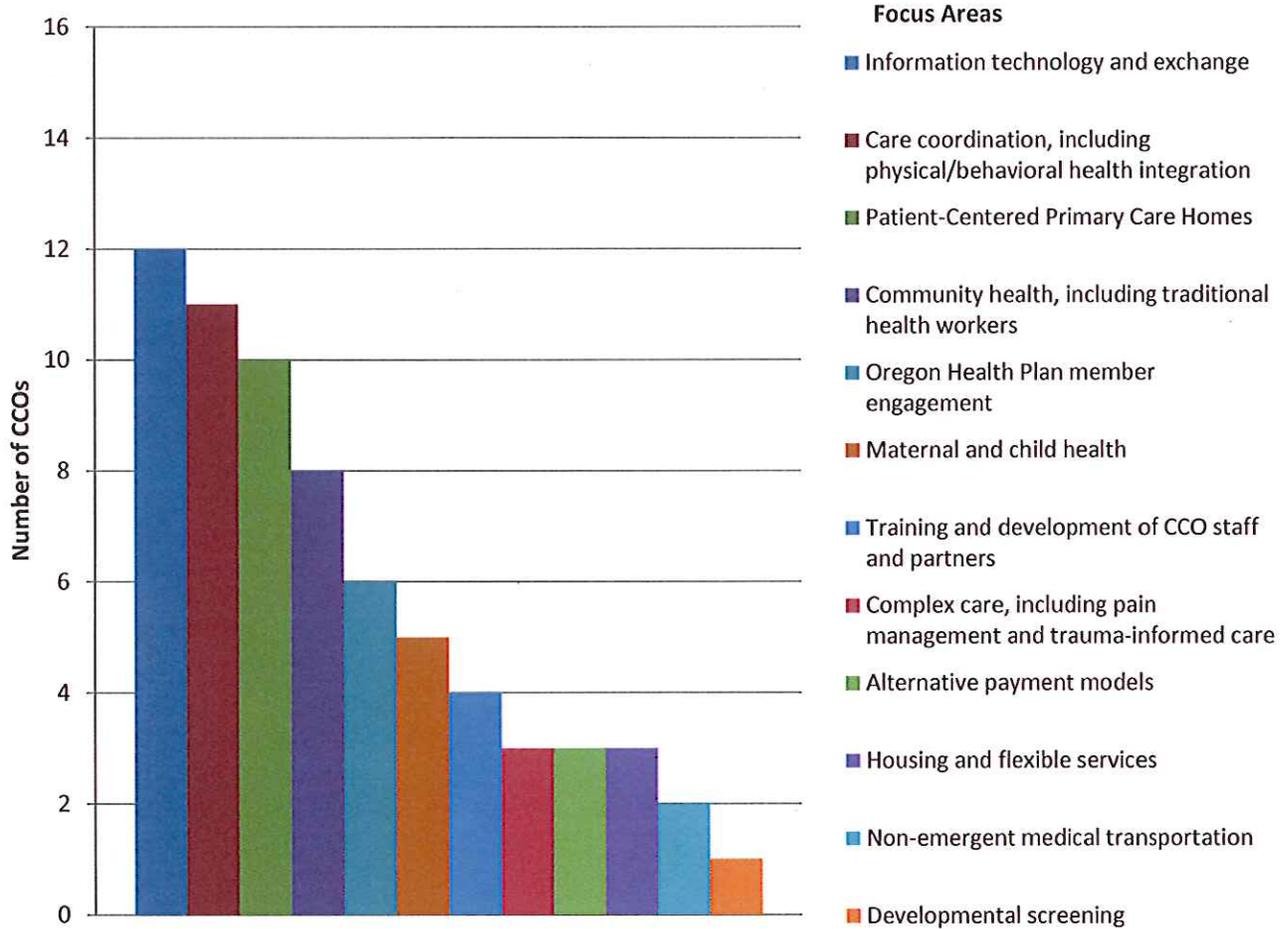
Process used for distribution to CCOs

The OHA Transformation Center collaborated with CCOs to develop an application process and timeline to distribute funds to CCOs. OHA also facilitated a discussion with the CCOs that resulted in all 16 CCOs agreeing that \$3 million of the fund should be used to maximize the opportunity to leverage 90 percent federal funding to invest in statewide HIT. The remaining funds (\$27 million) were distributed based on a budget note in HB 5030. Each CCO received a minimum award of \$1.25 million and the remainder was distributed based on the number of members in each CCO (based on average enrollment between January 2013 and April 2013) (see Figure 1). Total award amounts by CCO ranged from approximately \$1.3 to 3.2 million. All 16 CCOs had their project proposals approved. There are 120 individual projects; 15 of the 16 CCOs are funding multiple projects.

Summary of CCO Transformation Fund projects

Each project is designed to be innovative, scalable, transferable and related to CCO transformation plans. The wide array of types of projects across the 16 CCOs reflects the individual strengths and needs of each CCO community. Projects are categorized into the 12 focus areas listed in Figure 2.

Figure 2: Number of CCOs with Transformation Fund Projects by Focus Area



Processes CCOs used to develop projects and distribute funds locally

The majority of CCOs (13) used collaborative, internal processes involving the CCO governing boards, community advisory councils and CCO staff to develop project proposals. Three CCOs (Eastern Oregon CCO, PacificSource – Central Oregon and PacificSource – Columbia Gorge) used all of their Transformation Funds for a community grant program to support transformation. They developed community decision-making processes (which included community advisory councils) to determine how to allocate the funds. For example, Eastern Oregon CCO elicited ideas from a broad range of providers across its 12-county service area, resulting in 23 grant awards, with one to three grants in each of the 12 counties.

Preliminary results and outcome measures

In their January 2015 Transformation Fund progress reports submitted to OHA, CCOs indicated that these funds are supporting innovative projects that would not have been possible otherwise. The projects are building a foundation for future innovative projects funded by CCOs. Many are devising plans to sustain the projects beyond the grant period.

The projects are in various stages of implementation. Of the 120 projects:

- Thirty-one projects (26%) are in the early stage of implementation, meaning they have a defined metrics plan, the project team is formed, and activities are beginning to be implemented.
- Fifty-nine projects (49%) are in the mid-stage of implementation and early evaluation data has been collected.
- Thirty projects (25%) are in an advanced stage of implementation. These projects have enough data to inform next steps for spreading and sustaining them.

A detailed summary of the 120 projects, including aims, metrics, status and preliminary results, is provided in Appendix B: Transformation Fund Projects by Coordinated Care Organization. In addition, highlights of health and health system outcomes selected from the thirty projects in an advanced stage of implementation are provided in Appendix C: Preliminary Outcomes for Select Transformation Fund Projects.

Project highlights

The following section highlights one innovative project per CCO. Projects are grouped by the following goals:

- Decreased emergency room visits,
- Expanded provider capacity,
- Advanced care integration,
- Enhanced primary care,
- Improved health outcomes of patients with complex needs, and
- Decreased costs through changing payment models.

Projects designed to decrease emergency room visits: Many projects are diverting emergency room visits and facilitating access to primary care by meeting Oregon Health Plan (OHP) members where they are, such as in schools and service sites for the homeless. CCOs are strengthening multi-sector partnerships with housing, education, corrections and social services. Examples include:

- FamilyCare has used grant funds to connect 317 homeless youth to primary care. Forty-eight participants have received early childhood screenings and 158 were connected to permanent patient-centered primary care homes.
- Cascade Health Alliance developed the first-ever local short-term youth crisis respite program to improve services to youth with behavioral health disorders and keep families and other community supports more closely engaged with fewer transfers outside of the community. Pine View, a 12-bed respite residential program for boys and girls ages 12-18 experiencing a severe behavioral health episode, opened in September 2014 and began serving clients in October 2014.

Projects designed to expand provider capacity: Some projects are improving patient outcomes through increased coordination of care and expanding the capacity to provide care through the use of tele-mentoring and traditional health workers. Examples include:

- Health Share of Oregon is using an evidence-based tele-mentoring program with Oregon Health & Science University (OHSU) mental health specialists to increase primary care provider capacity for mental health care and decrease the need for specialty visits. Fifteen sessions have been held so far with approximately 15 community primary care providers attending each session. The CCO has committed to funding the program for one year after the Transformation Fund grant ends.
- PacificSource – Columbia Gorge has created a sustainable training center for building capacity of community health workers in the Gorge and integrating them into the Gorge’s health care system. The CCO secured a community grant of \$75,000 to sustain and expand the program, which has trained:
 - 8 certified trainers;
 - 26 community health workers, outreach workers, case managers and other providers (90 hours); and
 - 12 community health worker supervisors.

Projects designed to advance care integration: Projects are also advancing integration of care, including behavioral and oral health into primary care. Examples include:

- Eastern Oregon CCO is improving access to behavioral health services by co-locating a behavioral health clinician in the Yakima Valley Farm Workers Clinic in Umatilla County. A bilingual behavioral health consultant was hired and started seeing patients in September.
- PacificSource – Central Oregon is reducing dental care costs by implementing and evaluating a community-wide toothpaste distribution campaign enhanced by education and telephone support for OHP children and families in Central Oregon. The program has completed 450 interviews with parents of children under three years old. The program has mailed approximately 42,000 toothpaste kits; sent 71,000 phone messages; and mailed 65,000 informational mailers.
- Yamhill Community Care Organization is improving coordination between physical and behavioral health services by co-locating mental health providers at four practices.
- Trillium Community Health Plan launched a pilot program for integrating primary care and behavioral health care with eight participating clinics.
- Western Oregon Advanced Health is providing members who are concurrently diagnosed with certain persistent mental health conditions and diabetes with active medication therapy management services.
- Intercommunity Health Network is engaging mental and physical health providers to create an integrated, longitudinal medical record, including data from physical and behavioral health organizations.

Projects designed to enhance primary care: Projects are improving primary care delivery systems by increasing the availability of patient-centered primary care homes. Examples include:

- Willamette Valley Community Health is supporting the development of high-functioning patient-centered primary care homes through targeted learning collaboratives for three types of practices:
 - practices that are not yet recognized as patient-centered primary care homes;
 - practices focused on improving patient experience of care; and
 - more advanced practices.
- PrimaryHealth of Josephine County is improving birth outcomes by partnering with Women's Health Center of Southern Oregon to develop a maternal medical home engaged in education and outreach with care management focused on women at highest risk for poor birth outcomes. In the third quarter of 2014:
 - 75.6% of patients had an initial prenatal visit within 12 weeks;
 - 93% of patients received post-partum depression screening; and
 - The caesarean delivery rate decreased by 42%.

Projects designed to improve health outcomes of members with complex needs: Projects are improving the coordination of care for CCO members with complex health needs. Examples include:

- The Expanded Care Clinic at Umpqua Health Alliance has provided coordinated care for 76 high-needs patients through integrated physical health, mental health, addiction, dental and nurse case management services. Preliminary utilization findings in this population indicate a reduction in hospitalization and average length of hospital stay and an increase in number of primary care visits.
- Jackson Care Connect is improving care coordination for members with complex health needs by placing traditional health workers in clinics and the emergency department and implementing innovative initiatives to address opioid pain medication use and share chronic pain management best practices.
- The North Coast Pain Clinic at Columbia Pacific CCO provides integrated treatment for persistent pain, including movement therapy and behavioral health treatment. Twenty-seven people have graduated from the 10-week program.

Outcomes include:

- Fear of Movement: average decrease = 4.7%
- Depression (PHQ-9 screening): average decrease = 7.3% (decrease is a positive outcome)
- Patient Self-Efficacy Questionnaire: average increase = 17%
- Oswestry Disability Index: average decrease = 10% (decrease is positive)

Projects designed to decrease the cost of care by changing payment models: Projects are implementing alternative payment models, including paying for value instead of volume and incentivizing changes in primary care practice patterns.

- AllCare CCO is paying providers differently to improve the quality of care, population health and patient experience at a lower cost. Each alternative payment method being developed has a shared savings component that rewards providers who ensure access to care, manage utilization and perform well on quality metrics.

OHA strategies to support a culture of improvement and innovation

As a condition of receiving Transformation Funds, CCOs were required to designate a portfolio manager to oversee the projects. To help spread effective projects and innovative best practices to other CCOs, the OHA Transformation Center developed a learning collaborative to support the Transformation Fund portfolio managers in all CCOs. The first phase of the learning collaborative involved a three-day Improvement Science in Action training by the Institute for Healthcare Improvement held April 30 – May 2, 2014. More than 120 CCO portfolio managers, quality improvement managers and their project teams gained skills in quality improvement concepts, tools and techniques. All CCOs developed project charters and driver diagrams for at least one project. This framework was designed to assist CCOs and their partners in implementing improvement projects and spreading the change throughout the region. The majority of respondents to the participant evaluation reported that the three-day training was valuable in supporting their work (89.2%) and would improve their ability to lead change in their organization (92.1%). As one participant wrote, “I want more – this was life altering for me.” Another participant wrote, “Overall it was an amazing training with so much practical, useful information.”

As follow-up to the training, during the fall of 2014 Transformation Center staff visited all 16 CCOs to provide technical assistance on measurement plans for their projects. The third phase of the learning collaborative, launched in December 2014, involved convening the portfolio managers in a Quality Improvement Community of Practice. This group meets every other month to informally discuss lessons learned from project implementation. In addition, the portfolio managers are participating in the Institute for Healthcare Improvement’s Leading Quality Improvement for Managers course, a three-month, in-depth virtual program on improvement science, measurement, modeling, coaching and innovation. Finally, in early June, the Transformation Center is hosting the Oregon Innovation Café, which will allow the CCOs’ health system transformation champions and other stakeholders to present innovative projects and discuss lessons learned. Topics will include behavioral health integration and complex care, and the event will highlight successful Transformation Fund projects.

Challenges in Transformation Fund grant implementation

Many CCOs have reported challenges in implementing the Transformation Fund grants, especially given the relatively short time frame to disburse and spend the funds. As new organizations, CCOs are still building their organizational structures and operating in a start-up capacity. Hiring and onboarding new staff to manage the funds, and formulating new subcontracts, has taken a significant amount of time. In addition, CCOs have reported delays interfacing with contractors, particularly with HIT vendors, and with clinical delivery partners and community stakeholders who are at varying stages of readiness to implement these initiatives.

Grant period and request for extension

OHA is confident that all the Transformation Funds will be paid to CCOs on or before June 30, 2015. However, due to the delays mentioned above, many CCOs requested extensions from OHA to expend their grant funds through subrecipients and to complete projects. Thirteen CCOs have received OHA Director approval for an extension through December 31, 2015. (Three CCOs – FamilyCare, Intercommunity Health Network and Trillium Community Health Plan – did not request an extension and their grants will end June 30, 2015.) Extensions will allow time for CCOs to fully implement proposed projects, and gather meaningful evaluation data to inform the scalability and transferability of projects.

Health information technology update

In 2013, Oregon's 16 CCOs unanimously agreed that OHA would use \$3 million of the Transformation Funds to maximize the opportunity of leveraging a 90 percent federal match to invest in statewide health information technology services. CCOs supported leveraging funds to invest in statewide technology and technical assistance services that support Medicaid providers, CCOs and health system transformation in their efforts to share and aggregate electronic health information. The need for these resources was identified through extensive stakeholder engagement, including listening sessions with CCOs, health plans, providers and other key stakeholders, including Oregon's Health Information Technology Oversight Council.

In 2013, OHA established the Health Information Technology Advisory Group to serve as a governing body on HIT efforts, overseeing and guiding the investment of the \$3 million Transformation Funds. The advisory group is ongoing and includes representatives from half of the CCOs.

To date, OHA has leveraged its Transformation Funds to secure nearly \$27 million in federal Medicaid funding, launching some services and beginning development for others. Specifically:

- Transformation Funds are leveraging federal funding to support statewide basic health information exchange through Direct secure messaging. Funds are also supporting Oregon's Emergency Department Information Exchange, which provides critical information to emergency departments in real-time for treating high-utilizers. This service was launched in 2014 as a partnership with the Oregon Health Leadership Council, Oregon's hospitals, CCOs and others, and it is live in 55 of Oregon's 59 hospitals.
- Two additional services will be launched in 2015: statewide hospital notifications, which include sending a real-time notice to CCOs and other Medicaid care coordinators when their patient is having a hospital event; and technical assistance for Medicaid providers using their electronic health records and seeking federal incentive payments.

- Funding is secured, and development work has started, on a state-level provider directory and a statewide clinical quality data registry. OHA anticipates additional participants, beyond CCOs and Medicaid providers, will want to use some of these services as they are developed and will contribute to the financing of those services over time.

Next steps

OHA will continue to monitor the grants and provide support around project implementation. CCOs are required to submit final progress reports at the end of the grant period.

ACTION REQUESTED

Acknowledge receipt of report.

LEGISLATION AFFECTED

None

Sincerely,



Lynne Saxton
Director

CC: Linda Ames, Legislative Fiscal Office
Ken Rocco, Legislative Fiscal Office
Kate Nass, Chief Financial Office
Tamara Brickman, Chief Financial Office

Appendix A: Budget Notes on the Health System Transformation Fund
Appendix B: Transformation Fund Projects by Coordinated Care Organization
Appendix C: Preliminary Outcomes for Select Transformation Fund Projects

Appendix A: Budget Notes on the Health System Transformation Fund

HB 5030-A, 2013 Session, Passed June 28, 2013 by the Joint Committee on Ways and Means
http://www.oregon.gov/oha/2013_2015BudgetMaterials/Measure%20Summary%20of%20HB%205030-A.pdf (See Page 5)

The [Human Services] Subcommittee also approved \$30 million General Fund for the Health System Transformation Fund to support efforts of Coordinated Care Organizations (CCOs) to transform health care delivery systems. The following budget note was approved regarding the Health System Transformation Fund, to specify the distribution methodology and clarify that no one CCO would receive more than a total of \$5.25 million out of the \$30 million Fund:

Budget Note:

The Health System Transformation Fund provides a strategic investment in Coordinated Care Organizations to engage in projects that support better health, better health care and lower costs in their communities. Each CCO will be eligible for a minimum potential award of \$1.25 million with a possible additional allocation, not to exceed \$4 million for an individual CCO, based on the CCO's average monthly member count.

The Oregon Health Authority will establish a process for approving and awarding the Health System Transformation Funds to Coordinated Care Organizations. CCOs will be asked to submit a proposal for up to the total dollar allocation for which they are eligible, describing the project objective, purpose and goals. Projects under implementation or proposed projects should be innovative, scalable, transferable and related to CCO transformation plans and the overall goals of transformation with a focus on, but not limited to:

- Information technology systems and CCO infrastructure including additional investment in electronic medical records (EMR) and claims processing systems
- Population health management, case management, disease management, and achieving quality metrics
- Provider panel and clinic enhancements to provide extended primary care services to high risk Oregon Health Plan members.

The agency will report on the implementation of the program, based on the following budget note:

Budget Note:

The Oregon Health Authority shall report to the Legislature during the 2014 and 2015 legislative sessions on the implementation of a grant program using the Health System Transformation Fund. The reports should include details of the process used for distribution, the dollar amounts distributed, to whom, for what purpose, and expected outcomes. The reports should also describe any preliminary results available, including outcome measures, as well as expected next steps.

Appendix B: Transformation Fund Projects by Coordinated Care Organization

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
AllCare Health Plan				
Alternative payment models	Develop Alternative Payment Methods (APMs) Using a Shared Savings Payment Model	<ul style="list-style-type: none"> Adapt a payment model developed for AllCare's recognized patient-centered primary care home providers to address high-risk/high-cost populations using cost-effective providers such as traditional health workers and incorporating patients' social needs into care coordination Reward providers who ensure access to care, manage utilization and improve quality metrics Expand compensation for providers who accept larger Medicaid panels Generate savings by incentivizing reduction of emergency room visits; use of generic drugs; and prevention and referrals to lower cost settings 	<ul style="list-style-type: none"> Provider participation Screening for substance use disorder and depression Return on investment Emergency department utilization Readmissions Cost of care Relevant Incentive Metrics Patient experience 	<ul style="list-style-type: none"> Primary care APM completed first year, pediatric APM in place for 6 months. \$1M available to primary care providers in Josephine County. Average payout estimated at 68% of available funds. Primary care and pediatric APMs now available voluntarily in Jackson and Curry Counties Specialty care APM in pilot test; includes Educational Collaborative with primary care providers Training providers on coding and documentation All APMs include SBIRT (screening, brief intervention and referral to treatment) 11 funded positions across 3 counties 600 primary care/pediatric patients surveyed in Josephine County 93% of providers received satisfactory or very satisfactory rating
Cascade Health Alliance				
Community health, including traditional health workers	Non-Traditional Healthcare Worker and Non-Emergent Medical Transportation	Reduce high-use members' emergency department usage by establishing a health care worker cadre in Klamath County in conjunction with a system of Non-Emergent Medical Transportation (NEMT) separate from the traditional NEMT system	For the population enrolled in non-emergent medical transportation: <ul style="list-style-type: none"> Emergency department utilization Readmissions Primary care provider enrollment 	<ul style="list-style-type: none"> 3 community health workers hired Launched August 1, 2014. As of January 5, 2015, more than 100 members assigned to a health care worker and case manager if warranted. 150 referrals to non-emergent medical transportation
Care coordination, including integration of physical and behavioral health	Mobile Crisis Team	<ul style="list-style-type: none"> Develop a mobile therapeutic team to respond on-site to mental health crises Reduce number of emergency department admissions Divert individuals in crisis from penetrating into more intensive levels of care 	<ul style="list-style-type: none"> Emergency department utilization for mental health crises Mental health crisis calls to intervention team 	<ul style="list-style-type: none"> 265 total calls, 75 calls involving 61 members Responded to 8 in-home crises and 4 school crises 59% decrease in mental health crisis visits to emergency department for clients from August 2014 to November 2014.
Care coordination, including integration of physical and behavioral health	Youth Crisis Respite and Residential Program	<ul style="list-style-type: none"> Develop a local eight-bed, short-term respite program for youth in temporary psychiatric crisis Provide more effective and efficient crisis services to youth with behavioral health disorders Keep families and community supports more closely engaged with youth in crisis respite care Demonstrate significant savings by reducing referrals to out-of-area services and reallocate those funds to local outpatient care 	<ul style="list-style-type: none"> Youth served Youth sent out of area Youth transitioned from out-of-county treatment facilities to the local treatment facility 	<ul style="list-style-type: none"> First client was received in October 2014 Seeing clients from both Klamath Falls and out of area
Information technology and exchange	Health Information Exchange System Implementation: Connection to the Jefferson Health Information Exchange (JHIE)	<ul style="list-style-type: none"> Provide immediate, real-time notification of members' emergency room visits and hospital discharge to improve care coordination, identify high utilizers and reduce readmissions Reduce medical errors associated with the inaccurate and incomplete information available to providers Improve communication among health care providers and their patients to provide the right care at the right time based on the best available information Improve care coordination for behavioral health patients and bridge the information divide between primary care and behavioral health care 	<ul style="list-style-type: none"> Provider participation Mental health clinic participation 	<ul style="list-style-type: none"> 50 new practices enrolled (495 providers in 91 clinics) Users able to send and receive Direct Secure Messages with CareAccord

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Care coordination, including integration of physical and behavioral health	Care Coordination Program: Electronic Health Record Implementation	<ul style="list-style-type: none"> Implement an electronic health record to improve care coordination Coordinate services for health plan members to achieve positive individual-level health outcomes Connect members with the health care network and support them as they navigate through it 	<ul style="list-style-type: none"> Relevant Incentive Metrics Members assigned to case manager Members with care plan in place Patient experience Members per case manager 	Due to staff change over, program implementation was delayed. Currently looking at going live April or May 2015.
Columbia Pacific CCO				
Complex care, including pain management and trauma-informed care	Opiate Performance Improvement Project	<ul style="list-style-type: none"> Develop a comprehensive chronic pain treatment program to be piloted in Astoria and then spread to the rest of the CCO Reduce the number of opioids prescribed by adopting existing opiate prescribing guidelines and prescribing contraindications 	<ul style="list-style-type: none"> Providers trained Patients referred Patients completed program Opiate prescribing rate Improvement on Pain Self-Efficacy Questionnaire Improvement on mental health survey 	<ul style="list-style-type: none"> 297 patient referrals, orientation sessions for 149 patients, 27 patients graduated from the 10-week program at a pain management clinic Clinical Outcomes for the five completed groups: <ul style="list-style-type: none"> Fear of Movement: average decrease = 4.7 PHQ-9 depression screening: average decrease = 7.3 (decrease is a positive outcome) Patient Self Efficacy Questionnaire: average increase = 17.0 Oswestry Disability Index: average decrease = 10% (decrease is positive)
Care coordination, including integration of physical and behavioral health	Crisis Respite Capacity	<ul style="list-style-type: none"> Increase the number of crisis respite rooms/beds for secure short-term stays for individuals undergoing psychiatric crisis in Clatsop County Develop a mobile crisis unit and expand crisis capacity to other CCO counties 	<ul style="list-style-type: none"> Beds available Occupancy rate FTE of Behavioral Health Specialist available for mobile crisis intervention 	<ul style="list-style-type: none"> Strong partnerships developed and funding gathered GOBHI purchased a facility in Warrenton. Providence Seaside donated \$70,000, Care Oregon willing to donate for remodel and other community donations coming in Construction manager hired
Community health, including traditional health workers	Community Health Assessment and Community Health Improvement Plan	Conduct a Community Health Assessment and develop and implement a Community Health Improvement Plan	<ul style="list-style-type: none"> Priority strategies identified in the CHIP that are implemented 	<ul style="list-style-type: none"> Regional community health improvement plan completed and approved Community Wellness Investment Funds have sponsored local projects Using Transformation Fund technical assistance to support work of CAC CCO sponsoring The Way to Wellville in Clatsop County to spread community health improvement efforts
Care coordination, including integration of physical and behavioral health	SBIRT Training for Primary Care Providers and Support Team	Increase use of SBIRT (screening, brief intervention and referral to treatment) in primary care	<ul style="list-style-type: none"> Rate of SBIRT screening Providers completed training Referrals 	<ul style="list-style-type: none"> 2884 basic SBIRT screens across all insurance carriers More than 100 full SBIRT screens (DAST and AUDIT) completed for CCO members All positive screens are referred
Complex care, including pain management and trauma-informed care	Reducing Inappropriate Emergency Department Use in High-risk Patients	Reduce inappropriate emergency department use in the high risk patient population	<ul style="list-style-type: none"> Inappropriate Emergency Department utilization affecting total cost of care 	<ul style="list-style-type: none"> Developing clinical pharmacy capacity for 2 clinics in Clatsop County Develop the Health Resiliency Program in Columbia County at 2 clinics
Housing and flexible services	Healthy Homes Demonstration Project	Address unhealthy housing situations and the potential negative effects on member health	<ul style="list-style-type: none"> Members provided home screening and assessments Emergency medical costs 	<ul style="list-style-type: none"> 20 referrals, 3 projects completed, 1 near completion Reverse referrals from community action team to CCO primary care
Care coordination, including integration of physical and behavioral health	Detox Bed Capacity	Add local detox capacity for Medicaid patients (previously unavailable in CCO network)	<ul style="list-style-type: none"> Beds open Members receiving detox locally rather than out of area 	Projected opening date February 1, 2015, for facility with 6 beds for medical detox level of care
Care coordination, including integration of physical and behavioral health	Telehealth Interventions - CareMessage	Utilize automated text and voice messages, integrated with electronic medical records, to proactively manage chronic/persistent health conditions to help members improve health and avoid preventable health outcomes and inappropriate emergent care use	Under development	Partnership has been developed with CareMessage and volunteer clinics to pilot the text and voice messaging program
Maternal and child health	Prenatal Performance Improvement Project (PIP)	Design a prenatal care incentive program to increase timely, early access to prenatal care, especially for patients for whom English is a second language	Under development	<ul style="list-style-type: none"> Work group has been created and the human centered design process has been identified as the best method for creating the program Research conducted on the current state of prenatal care and access in the service area, existing programs and successes/failures

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Patient-Centered Primary Care Homes	Patient & Population Centered Primary Care Learning Collaborative (PC3)	Continue the Primary Care Learning Collaborative to support clinic and organization leaders in practice transformation to meet patient-centered primary care home requirements and move beyond to meet triple aim outcomes	<ul style="list-style-type: none"> Clinics certified as Tier 3 Patient Centered Primary Care Homes Clinics participating in PC3 Collaborative 	<ul style="list-style-type: none"> 7 clinics participating All participating clinics are PC3 recognized and have made significant progress towards practice transformation and having a greater impact on their clinic populations PC3 created venue for clinics to learn from each other's experiences
Complex care, including pain management and trauma-informed care	Resilience Trumps ACEs/Trauma Informed Care Project	Adapt and implement the Trauma Informed Care model of the National Council for Behavioral Health at the CCO level. This is the first time that this model is being applied to a CCO-type organization.	<ul style="list-style-type: none"> Clinics/hospitals trained Individuals trained 	<ul style="list-style-type: none"> Strategic plan developed to fit needs of CCO Identified two primary clinics for pilot training to take place by June 30, 2015
Eastern Oregon CCO				
Community health, including traditional health workers	South Gilliam County Health District: Wellness Facility	Decrease obesity rates, decrease disease burden and increase access to physical therapy through a wellness facility for patients and the public	<ul style="list-style-type: none"> Percent of past and current patients with BMI documented in chart Wellness program design completed 	<ul style="list-style-type: none"> Entered baseline BMIs on approximately 80% of patients Picked patients for a pilot program that would help design and define a wellness program Working on an evaluation form
Non-emergent medical transportation	Community Connection of Northeast Oregon Union County: Non-Emergent Medical Transportation	Reduce the rate of missed appointments due to lack of transportation and increase the rate of same day deliveries of medication to communities not served by a pharmacy	<ul style="list-style-type: none"> Providers in network Hours available for Call Center use by patients Same day medical access requests filled Public outreach ads placed Discovery of tools, methods and reports 	<ul style="list-style-type: none"> Same-day medical deliveries up dramatically relative to baseline Distributed reminder cards and outreach materials to medical care partners Call center near capacity goal
Care coordination, including integration of physical and behavioral health	Lake County Mental Health: Mental Health First Aid Training	Increase early referrals to mental health services and decrease crisis services by training community health providers	<ul style="list-style-type: none"> Percent of individuals trained per agency Total individuals at each training Referrals 	<ul style="list-style-type: none"> Trainings have begun and future ones are being scheduled Most trainees have requested the additional training targeting the population not addressed in the training they attended Trainees all report a better understanding of what to look for and how to appropriately refer to services
Community health, including traditional health workers	Malheur County Health Dept.: Community Health Worker Training and Support	Conduct community health worker training for 25 participants in Malheur County	<ul style="list-style-type: none"> Recruited trainees Participants certified 	Recruited over 25 interested trainees and confirmed 17
Community health, including traditional health workers	Good Shepherd Health Care System: Community Health Worker Workforce Development	Establish a community health worker program to reduce health disparities among low-income families, children, the elderly and racial/ethnic minorities	<ul style="list-style-type: none"> Emergency department utilization Improvement on patient health risk assessment tool Duplicated and missed services Patient experience 	<ul style="list-style-type: none"> Training and equipment in place Began serving clients at the end of October 2014 Held Motivational Interviewing training
Community health, including traditional health workers	Malheur County Lifeways, Inc.: School-based Adolescent Health	Hire and train a certified community health worker to coordinate integrated school-based care and develop culturally and linguistically competent service delivery, co-management and referral services for school age youth and Hispanic families	<ul style="list-style-type: none"> Students enrolled Contacts with community health worker per enrolled student Contact time per case Completed referrals Participants in outreach events Outreach events Ratio of health and social service providers to students 	<ul style="list-style-type: none"> Convened multidisciplinary advisory team: public health, primary care, education, child development, dental, pediatrics, social services, corrections Fielded parent and student survey on service/support barriers Hired community health worker
Community health, including traditional health workers	Wallowa County: Youth Fitness and Nutrition Programming (Fit Fridays)	Decrease the percentage of overweight children by increasing knowledge about nutrition and diet and increasing physical activity on Fridays when school is not in session (school is held only on Monday through Thursday)	<ul style="list-style-type: none"> Community partners Fit Friday classes Proportion of K-8th grade participating in Fit Fridays Self-reported increase in fitness level Self-reported percent of participants spending 1 or more hours outside recreating per day Other self-reported measures 	<ul style="list-style-type: none"> 20 5-8th graders enrolled in Wallowa Resources Exploration of Nature (WREN) 10 K-1st graders enrolled in SwimFit 9 community partners have contributed time or materials

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Maternal and child health	Morrow County CAC: Interdisciplinary Community Care Team	Develop an interdisciplinary care team to provide wraparound services and improve access to prenatal care, well-child checkups including behavioral health services, and developmental screening for underserved children age 0-18 and pregnant women	<ul style="list-style-type: none"> Referral packets distributed Resources identified Resource guides distributed Participant survey 	<ul style="list-style-type: none"> 17 referrals including applications for: Developmental Disability Services, Department of Human Services, HUD housing and Medicaid Care Packets created and distributed to schools and community agencies
Care coordination, including integration of physical and behavioral health	Gilliam County CAC: Mental health media campaign and services	<ul style="list-style-type: none"> Implement mental health media campaign Reduce mental illness stigma and discrimination Increase availability of counseling opportunities for school age kids and senior citizens 	<ul style="list-style-type: none"> Survey data measuring mental illness knowledge Mental health counseling service utilization 	<ul style="list-style-type: none"> Media campaign up and running School counselor started seeing students in September 2014 Senior citizens are being met with and referred if needed
Community health, including traditional health workers	Wheeler County CAC: Health Education and Outreach Campaign	Conduct a health education campaign to all 1,440 residents of Wheeler county to improve cancer screenings, early childhood screenings, exercise promotion, depression screening and treatment options for alcohol and drug abuse	<ul style="list-style-type: none"> Attendance at BMI reduction group meetings BMI metrics Scholarships awarded Phone survey 	<ul style="list-style-type: none"> Sent first quarterly mailing to 850 households in Wheeler County on weight, risk factors and availability of BMI reduction group and Living Well Both groups achieved capacity All but one member of BMI reduction group lost weight in first month
Community health, including traditional health workers	Grant County Community Counseling Solutions: Health Promotion on Obesity, Oral Health and Children's Health	Engage high-risk community members in developing personalized health plans and increase health awareness and education	<ul style="list-style-type: none"> Participants Improvement on awareness and education assessment Attendance Support workers 	<ul style="list-style-type: none"> Coordinator hired and first workshop is scheduled for December 8, 2014 Comprehensive invitation process including advertising, personal invites, social media and flyers to reach intended audience
Maternal and child health	Center for Human Development, Inc. Union County: Low Birth Weight Social Marketing Campaign	<ul style="list-style-type: none"> Implement a "point of sale/service" low birth weight social marketing campaign targeting individuals purchasing or receiving pregnancy tests or contraception Increase timeliness of prenatal care Increase availability and use of preconception and interconception health care services Increase access to health insurance and PCPCH medical homes Decrease tobacco use and periodontal disease by pregnant women 	<ul style="list-style-type: none"> Low birth weight babies Pregnant women using tobacco Women initiating prenatal care in first trimester 	<ul style="list-style-type: none"> Multidisciplinary work group established with broad representation from key community partners Partnering with Moda to mail about project to all EOCCO target clients in Union County
Care coordination, including integration of physical and behavioral health	Lake Health District: Home Health & Hospice Patient Navigation Team	Create and implement a patient navigation team to decrease inappropriate use of the emergency department and increase patient engagement in and accountability for members' own health	<ul style="list-style-type: none"> Self-assessment of mental health and physical health services Enrollment in physical activity program Referrals to health care and social services Completed appointments Health insurance enrollment 	<ul style="list-style-type: none"> 13 navigation referrals offered and accepted Collected 8 self-assessments 14 referrals without first meeting yet
Care coordination, including integration of physical and behavioral health	Lifeways, Inc. Umatilla: Behavioral Health Community Health Workers	<ul style="list-style-type: none"> Hire and train two new community health workers Reduce readmissions and effectively transition patients to outpatient behavioral health services, primary care and community supports Train the emergency department staff on Mental Health First Aid 	<ul style="list-style-type: none"> Milestones Referrals Patient experience Provider experience 	<ul style="list-style-type: none"> 2 behavioral health community health workers trained Universal referral system created with public health and hospital Referrals received from outside agencies, partner and self-referrals One community health worker works three days per week out of the St. Anthony clinic, and is often available to see patients immediately upon receiving referrals from their doctors

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Care coordination, including integration of physical and behavioral health	(Malheur County) Saint Alphonsus Medical Center Follow up After Hospitalization for Mental Health and Substance Use	<ul style="list-style-type: none"> Reduce emergency department readmissions among high-utilizers by effectively transitioning patients to outpatient behavioral health services, primary care and community supports Increase capacity of social work and patient navigation staff to respond effectively to patients with complex health needs by providing training and support 	<ul style="list-style-type: none"> Emergency department utilization for mental health and substance use Patients making and keeping referral appointments Patients receiving screens for depression and/or anxiety 	<ul style="list-style-type: none"> Staff are oriented and trained Hospital staff report satisfaction with resources for patients Emergency department staff report decreased "high utilizers" since project inceptions
Care coordination, including integration of physical and behavioral health	Umatilla County: Yakima Valley Farm Workers Clinic	Improve access to behavioral health services by co-locating behavioral health clinician in primary care clinic	<ul style="list-style-type: none"> Patients seen by Behavioral Health Consultant Improvement pre- and post- on mental health screening Patients screened Patients with billable behavioral health codes in electronic medical record Patient experience 	Hired a bilingual behavioral health consultant who has been seeing patients since September 2014
Care coordination, including integration of physical and behavioral health	Harney District Hospital: Embedded Behaviorist in Primary Care	Embed a behavioral health counselor in a primary care clinic to identify current gaps in mental health services and develop plans to address them with care coordination	<ul style="list-style-type: none"> Milestone Enrollment 	<ul style="list-style-type: none"> Talked with 3 licensed social workers about the position, but have not yet hired for the position Signed an agreement with a recruiting firm
Care coordination, including integration of physical and behavioral health	(Gilliam County) St. Alphonsus Medical Center: Nurse Navigators & Care Coordinators	Reduce emergency room visits, increase access to care and increase preventive screenings (depression, colorectal cancer, high blood pressure) through services provided by nurse navigators and care coordinators	<ul style="list-style-type: none"> Patients seen by behavioral health specialist Emergency Department utilization for depression diagnosis Medical home enrollment 	<ul style="list-style-type: none"> Hiring a liaison Added depression screening tool (PHQ-9)
Care coordination, including integration of physical and behavioral health	North Central Public Health District: Public Health Nursing and Care Coordination	Decrease emergency department visits and hospital readmission by doing home visits with high utilizers. Home visits will be provided by public health nurse home visitors.	<ul style="list-style-type: none"> Milestones Participants Patient Activation Measure 	<ul style="list-style-type: none"> Purchased patient disease self-management program Trained staff
Community health, including traditional health workers	Wallowa Memorial Hospital: Complete Health Improvement Program	Implement 12-week, evidence-based intensive lifestyle intervention program, "Complete Health Improvement Program (CHIP)," to support adults with chronic disease to adopt healthier lifestyle habits, improve cardiovascular health and decrease use of health care services	<ul style="list-style-type: none"> Attendance Blood glucose levels Cholesterol (total and LDL) BMI Medication usage 	<ul style="list-style-type: none"> 1 of 3 18-session series completed Second series beginning in January 2015 and third to begin in April 2015 Positive feedback from participants (feel better, motivated to continue healthy habits)
Information technology and exchange	Blue Mountain Home Health & Hospice: Improved Communication for Hospice and Home Health	Increase efficiency so workers can spend more time with each patient and patients have a shorter wait time to first visit	<ul style="list-style-type: none"> Milestones 	<ul style="list-style-type: none"> Electronic devices purchased and policies in development Intermediary data program is in place
Care coordination, including integration of physical and behavioral health	Blue Mountain Hospital District: EHR Enhancement and Patient Portal	<ul style="list-style-type: none"> Enhance electronic health records and patient portal Improve communication among providers Enable patients to access their health information and communicate with care team Enable reporting on usage and core measures 	<ul style="list-style-type: none"> Patients seen Nurse time spent charting Patient experience 	<ul style="list-style-type: none"> Provider-to-provider: Started implementation In clinic: Equipment and vendor in place to begin. Staff training scheduled In hospital: Implementation complete
Patient-Centered Primary Care Homes	Warner Mountain Medical Clinic Lake County: Patient Centered Primary Care Development	Obtain patient-centered primary care home (PCPCH) status to become the first PCPCH-recognized clinic in the county	<ul style="list-style-type: none"> Acute patient openings per day 12-18 year olds who had well care visit Children in first 36 months who have a developmental screening recorded and reviewed 	Clinic has implemented an electronic health record and completed several other steps necessary to obtain patient-centered primary care home status

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
FamilyCare, Inc.				
Community health, including traditional health workers	Community Health Education (Homeless Youth Care Team, Family Resource Coordination)	<ul style="list-style-type: none"> Develop community-based education programs for members and the community Coordinate care and community-based partnership of health-supporting social services for homeless youth (includes Outside In, New Avenues for Youth, and Janus Youth programs) Support a family resource coordinator at Gladstone Center for Children and Families 	<ul style="list-style-type: none"> Milestones 	<ul style="list-style-type: none"> Increased connection to Outside In's clinic for preventive care for youth Average clinic interactions per youth increased from 2.34 to 3.1 317 participants received direct services including 48 early childhood screenings and 158 connections to pediatricians and medical homes. Ninety percent of the participants followed through with the agreed upon referrals and recommendations. RFP issued for community health education programs; 32 proposals received; hiring a Community Health Improvement Plan Coordinator
Community health, including traditional health workers	Promoting Nutritional Emphasis	Establish nutritionist services to promote enhanced health and wellness to members and the broader community	<ul style="list-style-type: none"> Nutritionist visits to providers Nutritionist visits to classes in schools Collaboration with providers FamilyCare Care Management team 	Registered dietician nutritionist: <ul style="list-style-type: none"> Facilitated Cooking Matters program (nutrition and cooking classes) Visited FamilyCare providers to assess nutrition-related practices Provided trainings to three providers Dietetic interns placed at clinics
Oregon Health Plan member engagement	Re-Engineering Integrated Care	Implement patient/provider oriented resource teams (P ² ORTs) to achieve effective, timely and positive connections between providers and members	<ul style="list-style-type: none"> Milestones Provider satisfaction Patient satisfaction Emergency Department utilization Hospital readmissions 	<ul style="list-style-type: none"> 9 P²ORTs operational Asian Health Services Center community health workers provided welcome calls, redetermination calls and health risk assessments to newly assigned Asian members (3722 member contacts) Assigned all primary care physicians to a P²ORT (over 600 providers at over 160 clinics)
Care coordination, including integration of physical and behavioral health	Improving Health Information Technology Infrastructure	<ul style="list-style-type: none"> Identify and assess current provider use of electronic health records and other care management applications Identify barriers to provider use of electronic health records and health information exchange Implement tools to support provider panels 	<ul style="list-style-type: none"> Use of electronic health record Provider comments regarding resistance to electronic health record implementation Link to Patient/Provider Oriented Resource Teams 	<ul style="list-style-type: none"> Surveyed all contracted primary care providers (approximately 30% of providers in the FamilyCare network) about electronic health record systems used, plans for change, progression on the "Meaningful Use" continuum and data export capabilities Created the Year 1 Technology Plan Initiated implementation of a utilization analytics solution to help identify opportunities to improve care management and care integration Implementing the Pre-Manage function of the emergency department information exchange (EDIE) system to provide alerts to care management staff, providers and community health resources on specific emergency department and hospital admissions
Patient-Centered Primary Care Homes	Patient Centered Primary Care Home (PCPCH) Technical Assistance	Increase the number of practices in the provider network that are certified as an Oregon patient-centered primary care home	<ul style="list-style-type: none"> Members assigned to a Tier 2 or Tier 3 Patient Centered Primary Care Home Clinic certification renewal at a higher tier New clinics certified 	<ul style="list-style-type: none"> Provided one-on-one practice coaching technical assistance to 12 primary care provider groups in pursuit of Tier I-III PCPCH Certification Member assignment to Tier III clinics increased from 74% to 76%, even with doubling of membership through Medicaid expansion

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Health Share of Oregon				
Patient-Centered Primary Care Homes and information technology and exchange	Strengthening Primary Care Capacity: Telementoring (Project ECHO) and development of an Advanced Primary Care Model	<p>Expand Primary Care capacity with Project ECHO (Extension for Community Healthcare Outcomes), an evidence-based telementoring program with mental health specialists to increase primary care provider capacity for mental health care and decrease the need for specialty visits.</p> <p>Develop an Advanced Primary Care Practice Model. Create clinic-based multidisciplinary teams skilled to help manage patients with complex medical and non-medical socio-behavioral issues (focus: patients with avoidable ED/inpatient hospital use). This work builds upon the Health Resiliency Program, in which Health Resiliency Specialists engage highest acuity and costliest patient population in meaningful 'wellness' partnerships that are less medical and more sensitive to their needs. Services are offered where members are - in their homes, homeless shelters and community centers.</p>	<ul style="list-style-type: none"> ECHO clinics held Primary care providers participating via video per clinic Primary care providers self-report level of knowledge and skills for managing patients with psychiatric medication needs <p>Adventist – Resilience Center</p> <ul style="list-style-type: none"> Patient goals met Patient experience Hospital days and Emergency Department utilization Per member per month cost <p>Central City Concern - Old Town Clinic</p> <ul style="list-style-type: none"> Preventable hospital utilization Patient health outcomes Patient experience <p>Legacy - Good Samaritan</p> <ul style="list-style-type: none"> Emergency Department utilization Mental health screening Percent of population with a Patient Centered Care Plan <p>Multnomah County - Northeast</p> <ul style="list-style-type: none"> Clients engaged Hospital days and Emergency Department utilization Patient Activation Measure 	<ul style="list-style-type: none"> Held 15 ECHO clinic sessions (~15 providers each) Didactic presentations are posted online after each clinic session Health Share has committed to fund this project for one year after grant ends <p>All advanced primary care clinics have developed teams, finalized program descriptions and identified metrics</p> <ul style="list-style-type: none"> Held three learning sessions with all clinic teams together for three half days; topics included: defining your program, effective teams, program descriptions and metrics, role of the clinical champion, patient case studies, focus on additions, team accomplishments, Health Resilience Program, team learning systems and additions resource center
Community health, including traditional health workers	Enhancing Community Health Integration: Community Health Improvement Plan	Support community-based organizations to employ community health workers and peer support specialists to work with members with chronic disease and behavioral health issues	<p>North by Northeast Community Health Center</p> <ul style="list-style-type: none"> Patients assigned to community health worker "Clinical topics for community health workers" trainings held and # of attendees New primary care patients established through outreach efforts <p>Familias en Accion</p> <ul style="list-style-type: none"> Referrals and enrollments Trainings provided and participants Completion of programs <p>Northwest Family Services</p> <ul style="list-style-type: none"> Clients served Peer Support Specialists trained Trainings provided and participants Community presentations delivered <p>Center for Intercultural Organizing</p> <ul style="list-style-type: none"> Wellness Life Guides contracted with Members participating in intercultural group process work Group process workshops offered Community specific events held and participants 	<p>North by Northeast Community Health Center</p> <ul style="list-style-type: none"> Provided six-week, 24-hour training 14 patients assigned to community health worker <p>Familias en Accion</p> <ul style="list-style-type: none"> Received 49 referrals that became 30 new, low-income clients Helped with social services, food, insurance applications, medication reconciliation, medical referrals and chronic disease management <p>Northwest Family Services</p> <ul style="list-style-type: none"> 29 referrals for additional services 37 individuals receiving mental health support services Held peer support specialist and Mental Health First Aid training <p>Center for Intercultural Organizing</p> <ul style="list-style-type: none"> Hired 4 Life Guides Started monthly community wellness cohorts (Somali, Latino, Marshallese and Iraqi communities)

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Housing and flexible services	Enhancing Community Health Integration: Chronic Disease Management Programs in Supported Housing	Integrate chronic disease management supports in supportive housing environments	<ul style="list-style-type: none"> Residents who participate in Living Well with Chronic Conditions program Level of self-efficacy after participation Sustainability goals and strategies developed by partners 	<ul style="list-style-type: none"> Public health nurse has engaged 162 clients; top three self-reported chronic conditions include depression, diabetes and hypertension; two highest risk factors identified are obesity and tobacco use Public health nurse interventions include health teaching, referral and follow-up; counseling; advocacy; screening; and case management Held community events to introduce the "Nurse in the Neighborhood" Made improvements to community spaces as identified by residents
Housing and flexible services	Enhancing Community Health Integration: Expand Healthy Homes Asthma Program	Expand Multnomah County's Healthy Homes Asthma Program to Washington and Clackamas Counties to provide home visits to identify and remove asthma triggers for children in the home	<ul style="list-style-type: none"> Emergency department utilization by asthmatic children after the first nurse home visit for a period of 12 months Hospitalization of asthmatic children after the first nurse home visit for a period of 12 months Score of the Test for Asthma Control in Kids Score of the Environmental Assessment for all children 	<ul style="list-style-type: none"> Developed internal systems to manage and assign referrals Created program supply kits for public health nurse and community health worker (CHW) CHW and RN have contacted 38 families (23 total cases: 19 open) 9 initial nursing assessments 6 initial environmental assessments 9 initial track/act assessments
Maternal and child health	Enhancing Community Health Integration: Future Generations Collaborative	<ul style="list-style-type: none"> Improve the health of urban Native communities by identifying and addressing the causes of substance-exposed pregnancies among 15-24 year olds Implement a community-based participatory planning process to develop a community action plan for reducing the impact of substance use on pregnancy in local Native communities Empower elders and Natural Helpers to steer the project, ensuring trust and interaction between the Collaborative and community 	<ul style="list-style-type: none"> Reported increase in knowledge of effect of historical and intergenerational trauma on health inequities and health outcomes Satisfaction with collaborative process Stakeholder organizations committed to engage in mutually reinforcing activities that address priorities to reduce substance exposed pregnancies 	<ul style="list-style-type: none"> Awarded a \$200,000, 3-year Implementation Grant from Northwest Health Foundation Engaged 19 elders and natural helpers in winter self-care retreat facilitated by the Native Wellness Institute The elders and natural helpers were honored by the Native American Rehabilitation Association Survey shows high rates of satisfaction for capacity building and organizational partner work. Recruited, oriented and trained 3 new elders/natural helpers
Maternal and child health	(New) Project Nurture: Improve care for pregnant women with substance abuse	<ul style="list-style-type: none"> Pilot integration of prenatal services in an addictions treatment setting and integration of addictions treatment services in a midwifery clinic Improve outcomes for women with substance abuse Improve rate of substance use recovery Improve neonatal outcomes 	<ul style="list-style-type: none"> Enrollment in Project Nurture Engagement in substance use disorder services prenatal and postpartum Days in the Neonatal Intensive Care Unit 	<p>Pilot 1: CODA/OHSU Family Medicine</p> <ul style="list-style-type: none"> Two doulas added to team Held first clinic day <p>Pilot 2: Legacy Midwifery/Lifeworks</p> <ul style="list-style-type: none"> Created new peer mentor/doula position Hired case manager 3 patients scheduled to see certified alcohol and drug counselor Identified 31 women with substance use disorder (24 prenatal and 7 postpartum)
Oregon Health Plan member engagement	Engaging Members	Increase new member access by changing workflows so clinic staff are working at the top of their license (increase role of RN in patient visits) and develop and pilot a new Member Navigator role to assist members with complex needs	<ul style="list-style-type: none"> Hire Member Navigator <p>Neighborhood Health Center</p> <ul style="list-style-type: none"> Patients attended group new patient appointment Patients who establish care through progressive visit process Nurse triage visits provided Percentage of new CareOregon patients engaged in primary care <p>Virginia Garcia</p> <ul style="list-style-type: none"> New patients outreached to and patients successfully contacted New patients assessed and established through new nurse visit process 	<ul style="list-style-type: none"> Neighborhood Health Center doing patient orientation visits and progressive visits Close review of new patient process has led to updating forms Virginia Garcia implemented Swarm Family Nurse Practitioner concept at Beaverton clinic, adding team capacity Virginia Garcia has been successful in establishing new patients in primary care: Beaverton Clinic established 566 new patients, Hillsboro Clinic established 133 new patients, and Cornelius Wellness Center established 160 new patients.

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Care coordination, including integration of physical and behavioral health	Addictions Provider Education	Upskill primary care providers in basic knowledge of addictions medicine and treatment modalities as well as knowledge of local treatment resources	<ul style="list-style-type: none"> Milestones 	<ul style="list-style-type: none"> Curriculum under development Day-long CME conference for primary care and behavioral health providers planned with Northwest Addiction Technology Transfer Center 2 addiction education sessions delivered at grand rounds/trainings with 6 more confirmed
Care coordination, including integration of physical and behavioral health	Improving Community Care Coordination through Information Sharing	Convene partners to align existing efforts in order to optimize multi-system care coordination through the Emergency Department Exchange (EDIE) platform	Under development	<ul style="list-style-type: none"> Drafted EDIE Care Guideline template with regional partners
Care coordination, including integration of physical and behavioral health	Leveraging Health Information Technology	Improve Health Share's data aggregation, analysis and reporting solution that will inform transformation and strategic initiatives	<ul style="list-style-type: none"> Enhance reporting to include member engagement, geo mapping, etc. and improve data integrity 	Project completed; report changes made
Care coordination, including integration of physical and behavioral health	Behavioral Health Promotion/Prevention	Develop regional approach to community-level behavioral health promotion/prevention activities that promote positive behavioral health and well-being	<ul style="list-style-type: none"> Milestones Outreach to target population in each county Regional anti-stigma media campaign 	<ul style="list-style-type: none"> Hired regional coordinator, created regional planning team Developed website concept including registration, payment platform, data collection and links to resources. Clackamas County will host the website and be the fiduciary agent for the secure payment system. Helping counties to collaborate on trainer capacity
Intercommunity Health Network				
Information technology and exchange	Regional Health Information Collaborative	Create an integrated longitudinal medical record including alcohol and drug data with mental and physical health providers engaged	<ul style="list-style-type: none"> Milestones Partner organizations engaged Validation that longitudinal record includes data from health plan, electronic medical record, mental health, alcohol and drug Signed data share agreements Organizations contributing data Usage 	<ul style="list-style-type: none"> Contract completed with Inter-Systems to implement HealthShare product Samaritan test clinical data and payer data is currently being tested in the HealthShare product environment
Jackson Care Connect				
Information technology and exchange	Data Sharing and Health Information Technology: Jefferson Regional Health Information Exchange (JHIE)	<ul style="list-style-type: none"> Deepen connectivity to the Jefferson Health Information Exchange (JHIE), a collaborative HIE including shared electronic health records, for major addiction and mental health services providers across multiple counties and CCOs Support adoption of electronic records for the CCO's major addiction service providers Create a network of service providers committed to the "No Wrong Door" philosophy through Vistalogic (Community Connect Network). Note: Vistalogic is spearheaded by Jackson County Health and Human Services for their new comprehensive building, and will support the local Early Learning HUB work 	<ul style="list-style-type: none"> Milestones Addiction service providers using electronic health record Participating social service, education and health care organizations System available for production use for all critical participating partners 	<ul style="list-style-type: none"> System anticipated to be available for use for all partners, including 5 CCOs and 3 hospital systems, by July 31, 2015 Core clinical partners are being identified, engaged and enrolled in Phase 1, which includes referrals and direct secure messaging Four core clinical partners are connected Staff trained on the Community Health Record function JHIE has expanded HIE, entering into contracts with Mid-Columbia Medical Center, Providence Hood River Hospital and PacificSource Community Solutions CCO One service provider is completing testing One provider is working with a consultant on process mapping Created physical space for the new systems; training employees Both Jackson County A&D providers have adopted the same electronic health record, as has a service provider in Josephine County

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Complex care, including pain management and trauma-informed care	Care Coordination: Pain Management and Opiate Prescribing Guidelines; Traditional Health Workers; and Case Management Program	<ul style="list-style-type: none"> Address chronic pain management and develop standards of coordinated care through comprehensive provider collaboration to reduce opiate misuse and death Initiate and support programs that improve coordination of care for members with complex health needs Create and nurture partnerships to improve quality, decrease overall costs and enhance member care. Partnership formed with Jackson Care Connect, AllCare and Jackson County Mental Health (Birch Grove) to support access to primary care services for patients with high alcohol and drug treatment needs and mental health needs. 	<ul style="list-style-type: none"> Chronic pain treatment best practices implemented Settings with Traditional Health Worker in place In partnership with AllCare and Jackson County Mental Health, provide primary care services to patients with high alcohol and drug treatment needs and high mental health needs by including screening and educational components 	<ul style="list-style-type: none"> Implementation of 120mg Morphine Equivalent Dosage policy and provision of alternative pain management options in Jackson County to lower the number of opiates prescribed. Planning for The Pain Resiliency Program is near completion Jackson Care Connect/Care Oregon opioid assessment and support team regularly reviews appeals, makes decisions and supports providers Placed three traditional health workers Hired nurse case manager; working with CareOregon to develop case management program Contracted with Cambridge Management Group to work on community linkage mapping and communitywide quality improvement projects Financial model for the behavioral health clinic in development, one year pilot to implement case rate reimbursement methodology with fee-for-service components Emergency department visits for patients at one alcohol treatment center have been reduced by > 40%
Patient-Centered Primary Care Homes	PCPCH Capacity Building and Learning	<p>Establish patient-centered primary care home (PCPCH) learning collaborative to build new capacity in primary care clinics</p> <p>Provide support to partners recognized as PCPCH who are committed to deeper dive into this work</p>	<ul style="list-style-type: none"> New clinics certified as PCPCH Percent of members receiving care at a PCPCH Engage clinical partners on projects related to access, team-based care, and/or integration of behavioral health Pay for Performance incentives will be offered to PCPCH clinics incentivizing quality measures 	<ul style="list-style-type: none"> 3 clinic systems enrolled in Pay for Performance incentives to PCPCH clinics incentivizing quality metrics (OHA and others) Began conversations at 4 of the 6 identified core PCPCH partner clinics to work on self-identified projects related to incentive metrics, access and addressing high risk populations. 3 additional clinic systems at 9 sites have achieved recognition as PCPCH Moved from 50% to 70% of members receiving care at PCPCH clinics
Training and development of CCO staff and partners	Systems Management	Ensure resourcing for CCO partners, providers and staff to successfully implement transformation projects	<ul style="list-style-type: none"> Relevant training opportunities provided 	<ul style="list-style-type: none"> Provided training on motivational interviewing Sponsored staff, board, community advisory council and clinical advisory panel members to attend the Coordinated Care Model Summit (over half of CAC members participated)
PacificSource Community Solutions – Central Oregon				
Care coordination, including integration of physical and behavioral health	Community Paramedicine Project & Medical Transportation System Optimization	<ul style="list-style-type: none"> Optimize the medical transportation system for improved quality, cost containment and outcomes Implement a pilot community paramedicine initiative designed to reduce non-emergent ambulance rides Contract with transportation systems experts to identify gaps in services and opportunities to improve cost, access and quality of medical transportation options 	<ul style="list-style-type: none"> Time spent with patient Access to integrated in-home preventive care Re-admission rates to ER or hospital in the past year + post intervention; at 30, 60, 90, 120 days. Medication adherence rates Number of non-emergent medical transports 	<p>Community Paramedicine Project</p> <ul style="list-style-type: none"> 26 referrals to community paramedic from providers; 26 patients seen (22 of them more than once) Simplified intake forms and referral process Anecdotes from patients and providers show increased patient satisfaction due to program <p>Medical Transportation System Optimization</p> <ul style="list-style-type: none"> Commute Options consultant met with 8 partner agencies Updated "current conditions" list regarding access to medical services Commute Options portion of project in holding pattern until further notice from Central Oregon Health Council
Oregon Health Plan member engagement	Member Engagement	<ul style="list-style-type: none"> Optimize Oregon Health Plan member utilization, experience and continuity of care within the CCO system by engaging and orienting members with events and social media Produce 3-part video series and print materials 	Members who successfully renewed coverage before their termination date/number of members due to renew	<ul style="list-style-type: none"> Held two community events (reached 600 people) Hired member engagement coordinator and member engagement specialist Developed materials Attempted 21,349 member outreach calls (through interactive voice response reminders) about OHP renewal Finalized evaluation plan

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Community health, including traditional health workers	Bending the OHP Dentistry Cost Curve in Central Oregon by Reducing the Burden of Oral Disease	Implement and evaluate a community-wide toothpaste distribution campaign enhanced by education and telephone support for OHP children and families in Central Oregon	<ul style="list-style-type: none"> Families using the tooth brushing kits by intervention group Families reporting the telephone support as positive among the enhanced intervention group Families reporting that the SMS messages were helpful Cost of dental services Rate of hospitalizations for oral health issues 	<ul style="list-style-type: none"> Completed 450 pre-program interviews with parents of children under 36 months Collected baseline data 42,387 kits mailed 70,724 Televox automated voice messages sent 64,782 informational mailers sent
Care coordination, including integration of physical and behavioral health	Pediatric Health Engagement Team	Deploy the Health Engagement Team model to advance coordinated service delivery and improve health for up to 60 of the highest cost Medicaid/CHIP children in the St. Charles and Central Oregon Pediatric Associates networks, specifically those with multiple inpatient stays and emergency department visits related to poorly managed diabetes	<ul style="list-style-type: none"> Patient health outcomes (EHR) HbA1c levels Patient compliance Inpatient admissions ED admissions Patient and caregiver's disease-related anxiety and depression level Patient school attendance Caregiver work attendance 	<ul style="list-style-type: none"> Terminated original contract; new vendor identified One participant had 4 hospitalizations in 2013 (20 inpatient days). Since enrollment (June 12, 2014), he has had zero emergency department and inpatient admissions. Developed Bluetooth capability for participants to test their blood sugar, which is sent to their care teams Patient portal is available to participants, family and care team
Maternal and child health	Public Health/Primary Care Partnership: Maternal, Infant, and Child Health (through 12/2014)	Continue systems work with public health and primary care to enhance integration, increase communication and enable new and more efficient processes to serve high-risk pregnant women, infants and children	<ul style="list-style-type: none"> Members served Referrals 	<ul style="list-style-type: none"> Established new partnerships with primary care by embedding public health maternal health educator (8 hours/week) 48 clients served 144 referrals (avg. 3/client) Services included OHP application support, WIC certifications, and referrals to home visiting, dental, primary care and behavioral health, social and community outreach agencies
Maternal and child health	Pediatric Hospitalist Program	Develop a pediatric hospitalist program to provide greater continuity of care, care coordination, increased access to care and to bring new inpatient care options to the region	<ul style="list-style-type: none"> Patient satisfaction Length of hospital stays Patient access to care Hospital re-admission rates 	<ul style="list-style-type: none"> Weekly collaborative meetings of providers Program administrator/medical director hired Half-time hospitalist hired Positive reviews from all areas, especially emergency department and pediatric nurses Providing care continuity not available previously
Alternative payment models	Global payments for practices that integrate behavioral health into primary care	The project identifies integrated practices, prepares practices to collect data that will inform integration efforts and builds infrastructure to evaluate a global payment model. The global payment model aims to improve quality and reduce costs by facilitating the coordination of behavioral and physical health care.	Integrated practices identified, completing a comprehensive work flow documenting their model, using a cost tool	<ul style="list-style-type: none"> Completed site visits and initial assessments for two practices Team will select 2-4 more practices to participate
Housing and flexible services	Flexible Services Fund	Determine if funding items/services not currently covered by Medicaid will enhance patient experience and quality of life, and reduce overall health care costs within the target population	<ul style="list-style-type: none"> Patients receiving documented flexible items/services Provider satisfaction with process Engagement of patient with primary care provider, related to flexible services 	<ul style="list-style-type: none"> Project implementation complete Providers selected and invited to participate Evaluation in process with Central Oregon Research Coalition
Care coordination, including integration of physical and behavioral health	Central Oregon Clinical Pharmacy Services (CPS)	Demonstrate a reduction in medical and prescriptions costs for patients with chronic conditions via an ambulatory clinical pharmacist embedded in primary care practices	<ul style="list-style-type: none"> Rate of adverse Rx events due to polypharmacy and non-adherence Patients enrolled Provider satisfaction Inpatient and Emergency Department utilization 	<ul style="list-style-type: none"> Pharmacist hired 71 patients have received a comprehensive medication review Identified 228 medication related problems (average 3/patient). Pharmacist connected to prescription claims data and communicates medication adherence problems to provider Decreased workload for providers
Information technology and exchange	Telemedicine: Bridging Specialty Care Barriers for Mosaic Medical Patients	Improve access to specialty care through telemedicine services, thus removing geographic, economic, social and cultural barriers	<ul style="list-style-type: none"> No show/show rate for scheduled appointments Process time; length of time from primary care provider referral to telemedicine consult completion 	<ul style="list-style-type: none"> Launched with first patients October 21, 2014 Purchased and installed hardware and software Trained staff Scheduling two patients every other week Included RN to explain tests Positive feedback from patients

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PacificSource Community Solutions – Columbia Gorge				
Community health, including traditional health workers	Meals on Wheels for post-surgical patients	Prevents avoidable rehospitalization and minimizes adverse outcomes following surgery or hospitalization through delivery of meals	<ul style="list-style-type: none"> • Clients enrolled • Meals delivered • Food insecurity • Risk of malnutrition 	<ul style="list-style-type: none"> • Served 243 meals • Outreach to discharge planners, outpatient clinics, same-day surgery staff and surgical specialist offices • Gaining interest from community • No re-hospitalizations or infections • All clients reported satisfaction with services, reports of alleviated stress • Created meaningful measures, analysis plan and reporting tools
Community health, including traditional health workers	Community health worker training center	Builds workforce capacity through a sustainable training center for community health workers	<ul style="list-style-type: none"> • CHWs trained • Supervisors trained • CHWs certified • CHWs trained to teach 	<ul style="list-style-type: none"> • Implemented Train the Trainers program, certified 8 trainers • Trained 26 CHWs, outreach workers, case managers and other providers (90 hours) • Trained 12 CHW supervisors • Developing advanced CHW certification • Secured additional \$75,000 funding to sustain and expand program
Community health, including traditional health workers	Community Action Plan for Reducing Childhood Obesity	Develop a community coalition that agrees to a collective impact plan to lower the percent of overweight and obese elementary school children in Wasco County	<ul style="list-style-type: none"> • Children measured • Percent overweight • Percent obese • Process measures: partners engaged, meetings held, participant feedback, Declaration of Cooperation 	<ul style="list-style-type: none"> • Change of scope from short-term solutions to consortium building and long-range planning; approved by clinical advisory panel • Produced an educational video on the obesity epidemic (http://youtu.be/ZAdz2pkW4f0) • Produced exhaustive report to analyze childhood obesity and related factors in The Dalles (in North Wasco County elementary schools, 38% overweight, 22% obese -- compared to 30%/15% in Oregon)
Community health, including traditional health workers	Intentional Peer Support (IPS) Training	Contribute toward a stronger, healthier, inter-connected community by supporting training for at least 20 persons in the region in the Intentional Peer Support model	<ul style="list-style-type: none"> • Participants 	<ul style="list-style-type: none"> • One-week course held • 21 participants representing 6 agencies • Participants said class increased their skills and was personally enriching
Care coordination, including integration of physical and behavioral health	Network Coordination "Hub"	Develop, coordinate and connect a region-wide network of staff embedded in multiple agencies and sectors in our region and positioned to find community members in need of specific services, across which multiple health outcomes related to those services can be pursued in a Pathways Community Hub model	Process steps: Declaration of Cooperation, program manager hired, CGHC-PacificSource agreement, steering group formed	<ul style="list-style-type: none"> • 501(c)3 application accepted • Project manager hired • Commitments from over 20 regional agencies across health care, housing, social services and education (including early learning)
Complex care, including pain management and trauma-informed care	Community Health Team Phase II	Improve the activation and health behaviors and reduce the costs of at least 120 OHP members predicted to be "high cost" in the Columbia Gorge	<ul style="list-style-type: none"> • People enrolled 6 months pre & post enrollment: • Emergency Department utilization • Activation of enrollees • Total allowed costs of enrollees 	<ul style="list-style-type: none"> • 36 patients currently or previously enrolled (28 current, 8 graduated) • Use agreement signed with Central Oregon Independent Practice Association for Patient Activation Measures • Received 77 referrals
Complex care, including pain management and trauma-informed care	Chronic Pain Strategic Education for Providers	Develop a regional strategy for managing chronic pain patients with the goals of improving quality, reducing risk for patients and community, reducing cost and improving health	<ul style="list-style-type: none"> • Presentations • Providers trained • Population claims data 	<ul style="list-style-type: none"> • Provided 11 presentations to 190 primary care providers and allied health workers • Implemented opiate utilization management strategies on Dec. 1
Oregon Health Plan member engagement	Proactive Health Screening & Orientation	Proactively identify and engage OHP members new since January 1, 2014, who have been identified as high risk by collaborating with medical homes and contacting members to understand their needs, to facilitate their establishment of care and coverage and to provide information on health plan benefits	<ul style="list-style-type: none"> • Identified members • Identified members reached • Established care with primary care provider • Videos produced 	<ul style="list-style-type: none"> • Member engagement coordinator hired • 3 videos produced • Identified 70 new members and 59 previous members as high utilizers • Secured 200 licenses for Patient Activation Measure
Patient-Centered Primary Care Homes	Care Management Training	Using a "train the trainer" model, disseminate high-quality training about chronic disease management and care coordination within and between PCPCHs and the CHW Hub, to Develop Nurse Care Managers at all 5 Primary Care Clinics in the Mid-Columbia Outpatient Clinic system	<ul style="list-style-type: none"> • People trained • Emergency department visits • Rate of SBIRT (screening, brief intervention and referral to treatment) for alcohol and drug use • Rate of developmental screenings 	<ul style="list-style-type: none"> • Two RNs certified in OHSU's Care Management+ program • These certified RNs trained 7 other RNs, 6 have completed certification • Increased 6-month average monthly emergency department visits (491, compared to target of 404) • Increased percentage of SBIRT screenings (31%) • Increased percentage of developmental screenings (33%)

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Care coordination, including integration of physical and behavioral health	Clinical Pharmacy Services Project, Phase I	Improve health status and clinical outcomes, and reduce medication-related problems and/or overall health care costs through the use of a clinical pharmacist embedded in primary care and working directly with patients in a collaborative, inter-agency effort	<ul style="list-style-type: none"> • Patients enrolled • Provider satisfaction • Inpatient hospital utilization • HbA1C (blood sugar average) • LDL cholesterol • Adverse pharmacy events 	<ul style="list-style-type: none"> • 108 patients seen by clinical pharmacist (28 had second visit, 5 had third visit) • Identified 441 medication-related problems (avg. 4/patient) • Of problems needing provider approval, 94% of recommendations were accepted
Care coordination, including integration of physical and behavioral health	Clinical Pharmacy Services Phase II	Improve health status and clinical outcomes, and reduce medication-related problems and/or overall health care costs through the use of a clinical pharmacist embedded in primary care and working directly with patients in a collaborative, inter-agency effort	<ul style="list-style-type: none"> • Patients enrolled • Provider satisfaction • Inpatient hospital utilization • HbA1C (blood sugar average) • LDL cholesterol • Adverse pharmacy events 	<ul style="list-style-type: none"> • 6 of 27 referred patients have agreed to medication therapy management services and met at least once with pharmacist • Average of 6 clinical interventions per patient seen • 85% of interventions accepted by patient or provider • Barrier of transferring information between hospital and clinic electronic medical records has been resolved
Care coordination, including integration of physical and behavioral health	Practice Facilitation support with Behavioral and Physical Health Integration Modeling	Assist primary care practices and a community mental health center to develop capacity for integrating behavioral health and primary care	<ul style="list-style-type: none"> • Clinics participating • Minimum data set • Agency for Healthcare Research and Quality (AHRQ) lexicon • Use of CoACH cost tool 	<ul style="list-style-type: none"> • Memoranda of understanding with five practices • All-provider meetings with two of the participating clinics • CoACH cost tool piloted, introduced to five practices • AHRQ replaced by Comprehensive Primary Care Monitor • Behavioral health agency therapists now able to view electronic health records at community health clinic
Information technology and exchange	Community-wide Health Information Exchange	Leverage and enhance existing technology and information solutions to support robust point-to-point and virtual coordinated care secure messaging plus health information exchange and data aggregation across the primary institutions of health care and social service delivery for OHP clients	<ul style="list-style-type: none"> • Licensed users for secure messaging • Referrals tracked • Agencies using referral tracking • Providers using secure messaging/ providers with access to secure messaging 	<ul style="list-style-type: none"> • 9 organizations on first wave of registration process • Hood River County Health Dept. go live on Ahlers electronic health record November 19, 2014
Maternal and child health	Emotional Literacy Training	Increase parents' awareness and understanding of children's social/emotional needs	<ul style="list-style-type: none"> • Parents trained • Children completing • Parental self-report • Engagement of physicians 	<ul style="list-style-type: none"> • 200 posters produced • Over 10,000 direct mail cards sent • Project coordinator trained • Presented at Making the Connection Conference • Began contract to track participant engagement
Oregon Health Plan member engagement	Enrollment Continuity	Increase the rate of continuous enrollment in the Oregon Health Plan for those members who continue to qualify	Successfully renew coverage/ due to renew coverage	<ul style="list-style-type: none"> • Implemented interactive voice response reminders to members nearing redetermination deadlines • Connected with Columbia Gorge enrollment assisters • Contracted with high-performing enrollment assister not funded by OHP
Complex care, including pain management and trauma-informed care	Persistent Pain Education Program for Patients	Correct maladaptive pain cognitions amongst program participants and instruct them in self-directed lifestyle changes to improve overall health and function while decreasing pain perception through an 8 session curriculum, using expert presenters	<ul style="list-style-type: none"> • Participants • Provider survey At entrance/exit: <ul style="list-style-type: none"> • Reported pain • Locus of control • Patient activation • Opioid use 	<ul style="list-style-type: none"> • Completed 5 cycles of the 8-week program • 100 people completed some or all classes • Videos posted: http://mcmc.net/News/1193/persistent-pain-education • 26.3% of participants had clinically significant improvement in pain score with activities of daily living (ADLs) • 31.3% of participants had clinically significant improvement in depression score • Average 5.61 point improvement for the Chronic Pain Acceptance Questionnaire • Multidimensional Health Locus of Control: Largest change in score was in the "Internal" locus of control category (considered the most beneficial)

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
PrimaryHealth of Josephine County				
Maternal and child health	Maternal Medical Home	Maternal medical home engages in education and outreach with care management focused on women at highest risk for poor birth outcomes	<ul style="list-style-type: none"> • Timeliness to prenatal care • Prenatal screening for clinical depression • Prenatal substance abuse screening • Elective delivery before 39 weeks 	<ul style="list-style-type: none"> • PrimaryHealth and Women's Health Center of Southern Oregon launched pilot project for the Maternal Medical Home in August 2013 • An alternative payment method for the pilot was transitioned under the Transformation Grant in October 2013 • Providing PrimaryHealth with a risk stratified monthly roster of pregnant patients under their care • Increased access to first prenatal visit (in the third quarter of 2014, 75.6% of patients had initial visit within 12 weeks representing an 18% increase over first quarter); increased screening (93% of patients received postpartum depression screening representing a 365% increase over first quarter); and decreased caesarean delivery rate (decreased by 42%).
Training and development of CCO staff and partners	Transformation Training Programs	Staff, clinics, and community partners participate in educational activities that support the development of an enhanced delivery system	<ul style="list-style-type: none"> • Primary care clinics, staff and ancillary providers who have participated in educational programs • Trainings and attendees 	<ul style="list-style-type: none"> • The Quality Improvement Director took on the role of Portfolio Manager • An experienced RN/CPHQ within the CCO has taken on the role of CCO Transformation Guide to implement grant related activities and evaluate and collect data • Hired and trained two new outreach workers
Care coordination, including integration of physical and behavioral health	Information Technology	Implement software and enhanced reports to guide transformational efforts and create enhanced CCO utilization reports and/or dashboards for CCO staff and clinics to guide improvements	Primary care clinics having access to data/dashboards	<ul style="list-style-type: none"> • PrimaryHealth secured a licensing agreement with a software vendor, Architrave. The Inteligenz software was implemented May 1, 2014, and identifies at-risk and high-utilizer populations. • Assisted Choices Counseling Center in implementing electronic medical records to improve communications between alcohol and drug treatment providers and other providers
Care coordination, including integration of physical and behavioral health	Enhanced Care Delivery System Pilot	Make improvements on quality and outcome measures, total cost of care, and patient satisfaction with care through enhancements in the delivery system	<ul style="list-style-type: none"> • Individuals who receive a behavioral health assessment following referral • Adolescent well visits 	<ul style="list-style-type: none"> • Developed and implemented Behavioral Health Therapist, Alcohol and Drug Counselor, Medical Home Assistant, Community Outreach Worker, and Education to Support Transformation positions • Only 43% received a behavioral health assessment following a referral (target 60%), but potential data calculation discrepancy. Exceeded behavioral health target to increase referral 15% over baseline. Screenings conducted increased from 50% to 80%, and 100% of behavioral health encounter treatment plans shared with primary care provider. • SBIRT (screening, brief intervention and referral to treatment) encounters are increasing rapidly and alcohol and drug treatment referrals engaging individuals unable to engage prior • Original pre-visit screening process for Medical Home Assistants was piloted and not successful • Two Community Health Workers manage a caseload of 30-40 high utilizers. Per member per month costs for these members has decreased 46% from the pre-engagement median of \$1826 to the post-engagement a median of \$989. • Hired nurse case manager
Information technology and exchange	Network Health Information	Increase participation in a regional platform to allow community providers to coordinate care effectively and may connect to other regional platforms in the future	Primary care clinics able to securely share a portion of health information in real time	<ul style="list-style-type: none"> • The Jefferson Health Information Exchange (JHIE) currently has 250+ providers enrolled in Josephine, Jackson and Klamath Counties. Jackson Care Connect, Cascade Health Alliance and AllCare are also members and financial supporters of JHIE. • Public health is actively involved on the following JHIE committees: Finance, Policy and Procedures, Behavioral Health • Encouraging providers to enroll, prioritizing contact with larger clinics to impact the largest number of providers and assigned CCO members • The IT staff hired has been instrumental in implementation of the Inteligenz software and ECHO implementation for Choices Counseling Center

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Patient-Centered Primary Care Homes	Patient Centered Primary Care Home Development Support	Increase the number of clinics certified as patient-centered primary care homes (PCPCHs)	Members assigned to PCPCHs certified in Tier 2 or 3	<ul style="list-style-type: none"> >99% of members receiving care at a certified patient-centered primary home clinic (increase from 95%) One clinic certified as a Tier 3 PCPCH in May 2014 Two remaining sites are not certified with 100 (of 10,564) members assigned to sites' primary care providers. One plans to apply for PCPCH soon and another is still considering an application. Primary care is embedded into the Community Mental Health Program. Conducted 7 learning sessions and 4 collaborative learning lunches for PC3 learning community, with 3 additional trainings related to quality improvement. Funding a 0.5 FTE alcohol and drug counselor to work on site at an FQHC
Training and development of CCO staff and partners	CCO Staff Transformation Development	Ensure this work is prioritized by adding staff FTEs in transformational roles and/or with time dedicated to project facilitation and transformational work	Community health worker costs per member per month	<ul style="list-style-type: none"> Supported staff at trainings: Medical Home Practice Coach, IHI Improvement Leader, SBIRT, End of Life, Compliance, ACEs and Trauma Informed Care Supported multiple staff and CAC member attendance at 8 local and national conferences Supported multiple staff attendance at local complex care management meetings, leadership retreats, learning collaboratives and policy meetings
Trillium Community Health Plan				
Information technology and exchange	Shared Care Plan: Enhance and facilitate Health Information Exchange	At the core of the Shared Care Plan project is a web-based platform, Care Team Connect © (CTC), a secure, web-based integrated care management tool that brings together disparate care team members across the health delivery network to coordinate care within a shared, patient-centric care plan	<ul style="list-style-type: none"> Milestones Providers utilize health information exchange Provider satisfaction using health information exchange 	<ul style="list-style-type: none"> Technology plan updated IT designed workflows and developed configurations Proof of concept approved by OHA Environmental scan of primary care offices' electronic health records Retained TransforMED to assist 8 medical practices with redesigns needed before Crimson Care Management could be developed and configured
Care coordination, including integration of physical and behavioral health	Shared Care Plan: Integration of Physical and Mental Health and Development of PCPCH	A CCO pilot project in which behavioral health is integrated into four primary care clinics and physical health is integrated into four behavioral health clinics. Sites have the capacity to serve 14,603 CCO members in the primary care clinics and 2,300 in the behavioral health clinics.	Under development	<ul style="list-style-type: none"> Launched pilot program for integrating primary care into behavioral health care with eight clinics participating A full-time Transformation Plan Project Coordinator is coordinating the administrative transformation to support the project TransforMED was retained to consult with 14 clinics in 2014 to assist with rapid cycle change for the development of care coordination, access, practice-based team care and population health management Hired a Performance Metrics Coordinator to assist PCPCHs with improving quality rates. This individual runs monthly Metrics Learning Collaboratives and visits clinics to provide direct support of business processes. In the process of hiring and training 12 Clinic Performance Assistants to be embedded in clinics to assist with workflow that affects performance
Care coordination, including integration of physical and behavioral health	Shared Care Plan: Improve Care Coordination and Disease Management	Improve care coordination and disease management to ensure improved outcomes for quality measures	<ul style="list-style-type: none"> Calls after emergency department use Follow-up visits after mental health assessment Mental health and physical health visits for DHS kids Relevant quality and incentive metrics Provider satisfaction 	<ul style="list-style-type: none"> Second Crimson Care Management training for Lane County Perinatal staff completed. Information exchange active All Trillium Physical Health / Behavioral Health Care Coordinators and community health workers are using care management system Implemented complex case management Shared care plan functioning for Medicare and Medicaid members Hired Health Integrated to perform health risk assessments and manage disease management programs

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Oregon Health Plan member engagement	Shared Care Plan: Engage Members in Their Care and Well-Being	Engage members in their care and well-being by assigning them to a community health worker and engaging them in writing a care plan	<ul style="list-style-type: none"> Members assigned a community health worker or engaged in goals for a care plan accessed Crimson Care Management Patient satisfaction with shared care plan Outcomes for members engaged in shared plan vs. those who did not 	<ul style="list-style-type: none"> Smoking cessation program launched The clinic performance assistant program will incorporate a patient engagement component and connect with members Developed a member incentive program that provides members with a \$15 gift card for certain services (up to \$45/member) Working with Health Integrated to perform member health risk assessments and engage members in disease management programs Community health worker program overall savings-to-cost ratio is 2.71
Umpqua Health Alliance				
Care coordination, including integration of physical and behavioral health	Expanded Care Clinic	This specialized clinic for patients with complex conditions provides coordinated care through integrated physical and mental health, addiction, dental and nurse case management services. Serves as a "hot spot" and provides high staff-to-patient ratios, much improved access and other co-located services.	<ul style="list-style-type: none"> Emergency department utilization Hospital utilization Pharmacy reviews Patient satisfaction 	<ul style="list-style-type: none"> Assigned 76 members to expanded care clinic Preliminary results: 1% fewer inpatient hospitalizations; 19% decrease in average length of hospital stay; 1% average monthly decrease in emergency department visits; and 50% increase in number of primary care visits.
Community health, including traditional health workers	Implementation of Community Wellness Services	Offer wellness services for members, using Community Health Improvement Plan as a guide	<ul style="list-style-type: none"> Wellness events offered during grant period Community partners involved in program offerings 	<ul style="list-style-type: none"> Launched pilot project for a physician-referred 12-week outcome based health and wellness program Members >21-years referred by primary care provider to Healthy Living Challenge program receive comprehensive health assessment, exercise and nutrition logs, weekly weigh-ins, pedometers, BMI and body-fat analysis, fitness classes, nutrition and motivational workshops, and incentives for participation Initial observations demonstrate active participation and some very engaged participants
Non-emergent medical transportation	Non-Emergent Medical Transportation Services	Develop and implement a plan to best serve the transportation needs of members and maintain non-emergent medical transportation as a community endeavor	Transportation services provided by the CCO	<ul style="list-style-type: none"> Non-emergent medical transportation services to be transferred to CCO on July 1, 2015 Met with consultant Proceeding with option to improve existing brokerage model Preliminary contract in development
Patient-Centered Primary Care Homes	Expansion of Patient Centered Primary Care Homes	Expand the patient-centered primary care home (PCPCH) to smaller and more rural practices	<ul style="list-style-type: none"> Members served in Tier 2 clinics Members served in Tier 3 clinics Clinics certified as patient-centered primary care homes at any level Clinics certified at increased tier level 	<ul style="list-style-type: none"> New PCPCH coordinator hired Coordinator conducted visits with network providers about methods to assist with initial and increased-level PCPCH attestation Coordinator developed tools to assist with preparing for PCPCH site visits 89% of CCO members are served in Tier 2 or Tier 3 recognized PCPCH (1.5% Tier 2 and 87.5% Tier 3)
Care coordination, including integration of physical and behavioral health	Co-location of Addiction and Primary Care Services	Increase the number of patients who see addiction counselors by co-location of services	Patients referred to addiction services who attend first visit	<ul style="list-style-type: none"> Co-location of Addiction and Domestic Violence Advocacy Agency well established in an office sharing a campus with large primary care clinic Two agencies providing routine service delivery in co-location office Gradual increase over prior 6-months for member referrals to the two agencies Exceptional appointment follow-through rate for referred members
Care coordination, including integration of physical and behavioral health	IT Population Metrics Solutions	Use patient-centered electronic health record to make it easy for providers to know who needs the services and prompt them to perform the service	<ul style="list-style-type: none"> Population health staff meetings with provider clinics Providers engaged in population health metrics Providers who receive reports regularly Providers using population health staff outreach 	<ul style="list-style-type: none"> Population health staff continue to conduct outreach visits with primary care provider clinics and share provider performance Implemented new provider portal; gives providers access to individual performance for applicable CCO and state performance measures Primary care providers actively using CCO and State performance measures to support member panel health management

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Western Oregon Advanced Health				
Care coordination, including integration of physical and behavioral health	Advanced analytics to identify needs of patients requiring complex care	Allows ambulatory care providers to access patient information which risk stratifies those with high needs. Data informs development of cost-effective coordinated care plans. The provider at the point-of-care, with full access to risk analytics, is quickly able to discern the patient's: risk factors for multiple health conditions; overall risk score; total potential cost; risk acuity level; early morbidity potential; and whether or not the patient's medical condition is trending in an improving or deteriorating direction and how rapidly.	<ul style="list-style-type: none"> • CCO physicians able to access advanced analytics • CCO Medicaid members whose medical information may be accessed through advanced analytics system • Ambulatory Care Sensitive ratios • Cost avoidance values 	<ul style="list-style-type: none"> • The project has identified baseline Ambulatory Care Sensitive Ratios, by zip code, for the general population, based on calendar year 2011-2012 data • Risk stratification tool is operational at multiple pilot physician practices • Hired a data analyst dedicated to the advanced analytics program • Contractor will be working with Bay Area Hospital to develop systems for populating recent and real-time data to hospital admissions, discharges, and emergency department visits
Care coordination, including integration of physical and behavioral health	Medication Therapy Management	Provide CCO members who are concurrently diagnosed with certain persistent mental health conditions and diabetes with active Medication Therapy Management services	CCO Medicaid members diagnosed with bipolar or psychotic conditions and diabetes who receive Medication Therapy Management services	<ul style="list-style-type: none"> • At least 40 percent of all CCO members who are concurrently diagnosed with certain persistent mental health conditions and diabetes are receiving active Medication Therapy Management services • Using three strategies: 1) Medication Therapy Management, 2) Medication Reconciliation, and 3) 340b Pharmacy Pricing • Currently conducting PDSAs for hospital readmissions • Medication Reconciliation has commenced at Waterfall Community Health Center for patients discharged from Bay Area Hospital. Anecdotal feedback from patients and providers has been positive.
Information technology and exchange	Planning and Implementation for Analytics and Shared Community Health Information	Advance the planning, development and implementation of a community health information exchange	Milestones	<ul style="list-style-type: none"> • Planning phase completed • Established free-standing legal entity and governance structure
Training and development of CCO staff and partners	Strategic Transformation Planning and Portfolio Management	Establish transformation charters for all aspects of the organization's undertakings through a consolidated strategic and transformation plan	Portfolio projects brought to completion, resolution or appropriate development level	<ul style="list-style-type: none"> • Multiple projects brought to completion: Spanish Language Health Interpreter Training, onboarding the Child and Adolescent Needs and Strengths (CANS) assessment, further integration of addiction and primary care services through the retention of a health psychologist who works in multiple settings, and advocacy for the local delivery of accredited training for traditional health workers • Review of operating systems informed the strategic decision to retain the services of a Chief Operating Officer and a Customer Service Manager
Willamette Valley Community Health				
Developmental screening	Early Learning Developmental Screening	<p>Increase community-wide documentation of developmental screens</p> <p>Enhance the coordination of developmental screens across the health care and early learning education system</p> <p>Increase CCO developmental screening rate</p>	Screens administered in the community	<ul style="list-style-type: none"> • Distributed a community survey to identify the frequency of developmental screens administered in the community • Partnering with the Early Learning Hub to upgrade software systems to enable documentation of developmental screens outside medical system • Will be coordinating with the Early Learning Hub's new Screening and Care Systems Coordinator to promote use of the Ages and Stages Questionnaire (ASQ) developmental screening tool • Held ASQ train-the-trainer sessions • Developing a strategy for electronic transition of developmental screens
Care coordination, including integration of physical and behavioral health	Care Coordination for Children with Complex Medical Needs	Develop a centralized care coordination system that supports the provision of services across physical, mental and children's health services	Families served	<ul style="list-style-type: none"> • Held kickoff meeting with care coordination stakeholders • Trained Family Support Coordinators in wrap-around care models • Participating clinics held information sessions about the program

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Information technology and exchange	Community Health Information Sharing	Pilot software solution for data aggregation, analytics, and population health management	Members served	<ul style="list-style-type: none"> Finalized agreement with Arcadia Health Solutions Shared claims information with Arcadia for the pilot
Patient-Centered Primary Care Homes	Patient Centered Primary Care Home Development	Develop high-functioning medical homes by hosting learning collaboratives	<ul style="list-style-type: none"> Clinics certified as patient-centered primary care homes Learning collaborative attendance 	<ul style="list-style-type: none"> Hosted first of three PCPCH Basics Learning Collaborative sessions, partnering six primary care providers with the Oregon Rural Practice-based Research Network Contracted with the Oregon Pediatric Improvement Partnership (OPIP) to lead a Patient Engagement Learning Community. OPIP has completed clinic site visits and held a kick-off meeting with all participating clinics.
Yamhill Community Care Organization				
Oregon Health Plan member engagement	Population Health Management Clinical Initiatives	<p>Assist members gain access to appropriate settings of care and decrease costs by facilitating efficient use of network services:</p> <p>Provoking Hope</p> <ul style="list-style-type: none"> Connect at-risk expecting mothers to OHP, primary care and community support programs <p>Community-based EMS Model Program</p> <ul style="list-style-type: none"> Provide routine primary care services outside the clinic or hospital to members in rural areas with limited transportation <p>SNACK Program</p> <ul style="list-style-type: none"> Improve health and wellness by providing nutrition education and physical activity services to adolescents and families <p>Newborn Tool Kit</p> <ul style="list-style-type: none"> Reduce emergency department use in the first year of life in the newborn population born at Willamette Valley Medical Center 	<p>Provoking Hope</p> <ul style="list-style-type: none"> Expectant mothers referred Expectant mothers engaged with their patient-centered primary care home Addicted and/or recovering mothers served <p>Community-based EMS Model Program</p> <ul style="list-style-type: none"> Members served per quarter Types of services provided Follow-up care post hospital discharge Treatment and education of high-frequency users <p>SNACK Program</p> <ul style="list-style-type: none"> Nutrition classes held Children/families in nutrition classes <p>Newborn Tool Kit</p> <ul style="list-style-type: none"> Tool kits given out Newborn visits to emergency department 	<ul style="list-style-type: none"> Engaged 57 moms through the Provoking Hope project Referred three members to primary care services through the Community Based Emergency Medical Service Model Program Provided nutrition education to 24 children, ages 11-17, through the Student Nutrition and Activity Clinic for Kids (SNACK) Program Created the Newborn Tool Kit, which aims to reduce emergency department use in the first year of life of newborns born at Willamette Valley Medical Center
Complex care, including pain management and trauma-informed care	Chronic Pain Management Solution	Implement a systemwide program to address member's needs facing chronic pain and to provide a place of referral for these individuals	<ul style="list-style-type: none"> Opioid prescriptions written Patients referred to pain clinic Patients who attended orientation Patients who started pain school; completed Cost per patient per year for pain school Percentage of patients diagnosed with chronic pain enrolled in chronic pain management program Providers trained in chronic pain management Providers who adopt Community Prescribing Guidelines 	<ul style="list-style-type: none"> Developed Community Prescribing Guidelines Developed a model of care Identified a behaviorist Held a pain summit Will soon launch the Persistent Pain and Wellness Center
Alternative payment models	Value-based payments in a maternal medical home	Coordinate value-based payments for behavioral and physical health services at a maternal medical home. Rewards providers for value, not volume.	<ul style="list-style-type: none"> Alternative payment models developed for patient-centered primary care home and maternal medical home Providers who apply for alternative payment method Providers receiving alternative payment method 	A consultant is working on a Maternal Medical Home alternative payment model

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Care coordination, including integration of physical and behavioral health	Embedded Behaviorist Program Expansion	Expanded delivery of behavioral health services in physical health settings to allow for better coordination and delivery of patient-centric care in a single setting	<ul style="list-style-type: none"> • Expectant moms who saw behavioral health provider • Expectant moms entering care in first trimester • Expectant moms screened for depression • Expectant moms receiving SBIRT screening (alcohol and drug misuse) 	<ul style="list-style-type: none"> • A behaviorist was hired and is beginning to see patients • Conducted site visits as part of the Villa Medical Behavioral Health Expansion project • Site visits for women's clinic behavioral health expansion projects and Psy D program are scheduled
Care coordination, including integration of physical and behavioral health	Primary Care Provider Team Expansion and Bilateral Integration Support	Increase access to primary care services as well as streamline and better coordinate the delivery of physical and behavioral health services in a single physical location to provide timely care	<ul style="list-style-type: none"> • Patients assigned to each clinic • New patients engaged in care 	<ul style="list-style-type: none"> • Approximately 500 members were assigned to Willamette Heart Clinic • 130 members were assigned to Villa Medical Clinic • Approximately 800 members were assigned to Virginia Garcia Memorial Health Clinic
Information technology and exchange	Local Health Information Exchange Tool Implementation/Support	Efficiently use and coordinate health care resources through electronic exchange and analysis of health information	<ul style="list-style-type: none"> • Milestones • Yamhill CCO providers enrolled in health information exchange tool 	PreManage has been chosen as the health information exchange tool. It includes a flexible notification system and care coordination platform.
Care coordination, including integration of physical and behavioral health	Data Coordination & Health Strategy Support	Manage and analyze multiple data feeds consisting of utilization, cost, quality and performance information to support clinic level activities	<ul style="list-style-type: none"> • Agencies represented in work group • Milestones 	<ul style="list-style-type: none"> • Onboarded staff to work on program development, program management and data analytics • Quality Program work group meets regularly
Patient-Centered Primary Care Homes	Medical Home Model Development	Help advance all providers to the tier 3 medical home level as well as develop maternal medical homes for all OB/Gyn providers	<p>Patient-centered Primary Care Home (PCPCH) Collaborative</p> <ul style="list-style-type: none"> • Clinics in service area at least tier 2 • Clinics involved in learning collaborative <p>Member Engagement Specialist</p> <ul style="list-style-type: none"> • Expectant moms contacted • Expectant moms engaged in PCPCH • Expectant moms provided assistance connecting to their PCPCH 	<ul style="list-style-type: none"> • A PCPCH learning collaborative, supporting providers/clinics in obtaining Tier 3 status, will launch in February 2015 • Hired and trained a member engagement specialist • Developed a Maternal Medical Home model

Appendix C: Preliminary Outcomes for Select Transformation Fund Projects

CCO	Project	Preliminary Outcomes (January 2015 Report)
Cascade Health Alliance	Mobile Crisis Team	<ul style="list-style-type: none"> 59% decrease in emergency room mental health crisis visits
Columbia Pacific CCO	Opiate Performance Improvement Project	<ul style="list-style-type: none"> 17% increase in self-efficacy and 7.3% decrease in depression for 27 pain-clinic clients
FamilyCare, Inc.	Community Health Education	<ul style="list-style-type: none"> 317 homeless youth gained access to a medical home
Health Share of Oregon	Project ECHO	<ul style="list-style-type: none"> 15 primary care clinicians expanded their capacity to serve patients with behavioral and mental health issues
Jackson Care Connect	Care Coordination: Pain Management and Opiate Prescribing Guidelines; Traditional Health Workers; and Case Management Program	<ul style="list-style-type: none"> 40% decrease in emergency department visits for patients at one alcohol treatment center
PacificSource Community Solutions – Central Oregon	Central Oregon Clinical Pharmacy Services	<ul style="list-style-type: none"> 228 medication problems identified for 71 patients
PacificSource Community Solutions – Central Oregon	Bending the OHP Dentistry Cost Curve in Central Oregon by Reducing the Burden of Oral Disease	<ul style="list-style-type: none"> 42,387 dental tool kits in English and Spanish mailed to the homes of all OHP members
PacificSource Community Solutions – Columbia Gorge	Meals on Wheels for Post-surgical Patients	<ul style="list-style-type: none"> 243 meals served; no re-hospitalizations or infections occurred
PacificSource Community Solutions – Columbia Gorge	Persistent Pain Education Program for Patients	<ul style="list-style-type: none"> 26.3% pain-score improvement and 31.3% depression score improvement for 100 people
PacificSource Community Solutions – Columbia Gorge	Care Management Training	<ul style="list-style-type: none"> 31% increase in SBIRT screenings and 33% increase in developmental screenings at partner clinics
PrimaryHealth of Josephine County	Maternal Medical Home	<ul style="list-style-type: none"> 18% increase in access to first prenatal visit, 365% increase in post-partum depression screening and 42% decrease in caesarean delivery rate
PrimaryHealth of Josephine County	Enhanced Care Delivery System Pilot	<ul style="list-style-type: none"> 46% decrease in monthly costs for over 30 high-need patients

Appendix 7

Task Force on Individual Responsibility and Health Engagement



Office of the Director

John A. Kitzhaber, M.D., Governor



November 1, 2013

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Senate Interim Committee on Health Care and Human Services
House Interim Committee on Health Care
Oregon Legislative Assembly

Dear Senator Laurie Monnes Anderson and Representative Mitch Greenlick,

The Oregon Health Authority (OHA) recognizes that achieving the Triple Aim of improving health, health care, and lowering costs by transforming health care delivery relies on the full engagement of individuals, their families and caregivers, and communities. As OHA continues to be a partner in transformation and the spread of innovation through its Transformation Center, a concerted effort to foster engagement among members of the Oregon Health Plan (OHP) is a key priority.

The Task Force on Individual Responsibility and Health Engagement was created by House Bill 2859 (2013) and chartered to develop recommendations to the legislature to establish mechanisms that meaningfully engage members of the Oregon Health Plan (OHP) in their health and health care. The task force met in the fall of 2013. Under the direction of the Governor and guided by principles in support of the Triple Aim, the task force extensively reviewed evidence-based and person- and family-centered approaches to patient engagement, including:

- Roles that incentives and disincentives play in patient engagement including cost-sharing in Medicaid,
- Health behavior change science as it relates to patient engagement, and
- Patient-engagement strategies effective in but not limited to Medicaid populations.

The task force's recommendations support coordinated care organizations (CCOs) and members of the Oregon Health Plan. The recommendations aim to further realize OHP members' full potential for improving and maintaining their health and for serving as active partners in a transformed health system. The recommendations put forward in this report, when implemented and supported by OHA, will help further health system transformation in support of all Oregonians.

Enclosed are the task force's recommendations.

Sincerely,

Bruce Goldberg, M.D.
Director



HB 2859
**Task Force on Individual Responsibility
and Health Engagement**

**Recommendations to Engage Members of the
Oregon Health Plan**

November 2013

**Prepared by
Oregon Health Authority**

**Prepared for
The Oregon State Legislature
Per House Bill 2859**

**This report is available online at:
<http://www.oregon.gov/OHA/OHPR/Pages/irhe.aspx>**



HB 2859 TASK FORCE REPORT

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Roster
Task Force on Individual Responsibility
and Health Engagement

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Individual Responsibility and Health Engagement Task Force Summary Report to the Oregon Legislature

Introduction

In 2013, the Oregon Legislature passed House Bill 2859 that established the Task Force on Individual Responsibility and Health Engagement. The task force was chartered to develop recommendations for the legislature to establish mechanisms that meaningfully engage members of the Oregon Health Plan (OHP) in their health and health care. Under the direction of the Governor and guided by principles in support of the Triple Aim, the task force convened on four occasions over two months during the fall of 2013 to review evidence-based and person- and family-centered approaches to patient engagement. The task force consisted of 11 members, including bi-partisan representation from the Oregon State House of Representatives and the Oregon State Senate, two OHP members, a patient health navigator, and four health care professionals, with representation from both urban and rural communities. This document describes the task force, the process used, and rationale for the final recommendations. This document should be used to inform specific next actions that may include additional stakeholder input and review as detailed action plans are developed.

Task Force Process

Staff with the Oregon Health Authority (OHA) provided the task force with an overview of Oregon's Medicaid delivery system, information on the OHP, and data on expenditures and utilization in Oregon's state Medicaid program (i.e. OHP). The task force thoroughly considered federal and state policy that governs Medicaid cost-sharing, including expanding options for cost-sharing in OHP. A national expert on patient engagement, Dr. Susan Butterworth, provided background and evidence on a broad array of patient engagement strategies, including how incentives and disincentives can affect patient engagement and health behavior change. She also presented on a range of other evidence-based strategies that seek to engage patients in their health and promote appropriate use of health care services.

Task Force Recommendations

The task force concluded that health engagement is not achieved solely through use of financial incentives or cost-sharing. Evidence shows that financial incentives work for simple health behavior change; however, complex behavior change requires a more comprehensive approach. The task force's recommendations seek to leverage existing health reform efforts and align with Oregon's commitment to local accountability and flexibility among coordinated care organizations (CCOs) and their community partners. Furthermore, the task force decided that imposing further legislative requirements on CCOs was not appropriate at this time. As an alternative approach, the task force recommends OHA adopt the recommendations below in an effort to provide targeted resources and technical assistance to CCOs, which will allow them to further support OHP members as active participants in their own health.

Expand Options for Member Cost-sharing in the Oregon Health Plan. As part of comprehensive health reform, recent federal rules provide state Medicaid programs greater flexibility to vary enrollee cost-sharing. The task force identified an opportunity to expand options for cost-sharing in OHP through a Value-based Benefit Design (VBBD) model. VBBD aligns consumer incentives by reducing barriers (through no or low cost-sharing) to high-value health services such as preventive care, and discouraging (through higher cost-sharing) the use of low-value health services. These can include non-emergent use of the emergency department when an alternative for care is available, or the discouraged tests and procedures outlined in the evidence-based Choosing Wisely Campaign.

Recommendation—OHA request federal approval to expand options for cost-sharing in OHP at the service level to promote the use of appropriate and cost-effective care modeled after a Value-based Benefit Design, in alignment with Oregon’s approved 1115 Medicaid Demonstration Waiver.

Provide Resources and Support for CCOs. To foster innovative local solutions for CCOs to best serve their patient population and support individual members in meeting their needs and health goals, the task force recommends that evidence-based resources and technical assistance be made available to CCOs to facilitate the implementation of patient engagement strategies.

Recommendation—by the end of 2014, the OHA Transformation Center shall work with other OHA partners, as appropriate, to:

- Develop a resource guide for CCOs for adoption, implementation, and measurement of evidence-based member engagement strategies that target the use of appropriate and high-value health services, prevention, self-management, and individual empowerment.
- Work with CCOs to incorporate in their Transformation Plans a plan for member engagement, including identifying indicators for success, and foster information sharing of best practices across CCOs.
- Promote the use of the Choosing Wisely campaign as a shared decision-making tool to facilitate engagement among OHP members, providers and CCOs.
- Identify a list of standardized and validated health appraisal tools that CCOs may use with their members as part of their strategy to prevent disease, promote health and self-management, target interventions, and evaluate success in managing and improving health over time.
- Conduct a formal assessment to identify barriers to CCOs’ use of traditional health workers to foster engagement, and take steps to address these barriers.

Foster Statewide Strategies to Engage and Support OHP Members. The task force recommends that OHA leverage resources and activities statewide to disseminate best practices for health engagement that are appropriate for OHP members and their families, and are sensitive to and account for the needs of diverse communities.

Recommendation—by the end of 2014, the OHA Transformation Center shall:

- Work with traditional health workers, community-based organizations, and CCOs to identify strategies to support partnerships between these groups to foster health engagement.
- Work with professional health licensing boards to make available a list of evidence-based patient engagement training materials for use as part of their licensing or continuing education requirements.
- Ensure health engagement strategies are integrated within other OHA initiatives, such as health information technology.

Charter: Task Force on Individual Responsibility and Health Engagement

Authority	
<p>HB 2859 (2013) established the Task Force on Individual Responsibility and Health Engagement. Under the direction of the Governor, the task force shall develop recommendations for legislation to establish mechanisms that meaningfully engage members of the Oregon Health Plan (OHP).</p>	
Guiding Principles	
<p>The following principles will guide the Task Force to prioritize recommendations that:</p> <ul style="list-style-type: none"> • Align with Oregon’s Triple Aim and leverage existing efforts underway by Coordinated Care Organizations (CCOs). • Represent best practices, are evidence-based, and support person- and family-centered engagement and appropriate utilization of health services among OHP members including prevention, wellness and disease management. • Empower individuals on OHP and their families/caregivers to engage in their care in ways that are meaningful to them, that offer actual and perceived benefits, and allow participation as fully informed partners in health system transformation. • Are appropriate to the characteristics of OHP members—including their cultural, geographic and economic circumstance—to improve health equity, reduce health disparities, and avoid creating barriers to care for OHP members. • Leverage available community resources and align with community-based priorities. • Can be implemented rapidly upon receipt of any necessary federal approval. 	
Scope	
<p>This task force is responsible for developing recommendations for legislation that will establish mechanisms to meaningfully engage OHP members in their own health, disease prevention and wellness activities. Key areas of focus for the task force may include, but are not limited to: types/uses of incentives/disincentives to encourage healthy behavior(s); effective utilization of health care services; evidence-based patient-engagement strategies effective in but not limited to Medicaid populations; and other innovative approaches to encourage individual responsibility and health engagement. The task force will take into consideration the health status of Oregon Health Plan members, their needs, and potential policy impacts on the health care delivery system.</p>	
Membership, Roles & Responsibilities	
<p>Executive Sponsors: Mike Bonetto, Governor’s Office Tina Edlund, Chief of Policy, Oregon Health Authority</p> <p>Staff: Chris DeMars, OHA Oliver Droppers, OHA Jeannette Nguyen-Johnson, OHA</p>	<p>Task Force Members: Senator Brian Boquist Senator Betsy Johnson Representative Alissa Keny-Guyer Representative Jim Thompson Melinda J. Muller, MD (Chair) Kay Dickerson E. Maurice Evans Melissa T. Lu Joyce Powell Morin, MSN Janet E. Patin, MD Evelyn P. Whitlock, MD, MPH</p>

Major Deliverables

Recommendations for legislation in the form of an executive summary that will establish mechanisms to meaningfully engage medical assistance recipients in their own health, disease prevention and wellness activities.

Exclusions or Boundaries

Recommendations are to be submitted by the task force in the manner provided in ORS 192.245, to the appropriate interim committees of the Legislative Assembly no later than November 1, 2013. Policy implementation will not be carried out by the Task Force.

Schedule

The taskforce will meet on four separate occasions. The frequency of meetings may be altered to fit legislative timelines and/or other needs that arise. The task force charter will end by November 2013.

- **9/10/13 – First Task Force meeting:** Appoint chair; adopt charter; overview of the Oregon Health Plan and health reform; overview of Medicaid Advisory Committee report on Person- and Family Centered Care and Engagement; introduce background and conceptual framework on patient engagement.
- **9/27/13 – Second Task Force meeting:** Review menu of options; rate each option based on guiding principles.
- **10/8/13 – Third Task Force meeting:** Review straw proposal for recommendation(s); develop draft recommendations.
- **10/22/13 – Fourth & Final Task Force meeting:** Revise and adopt final recommendations/executive summary.
- **11/1/12 – Recommendations due:** Submit recommendations to the appropriate interim committees of the Legislative Assembly no later than November 1, 2013.

Cost Sharing in Medicaid

This brief provides an overview of cost sharing in Medicaid (can include premium, deductibles, copayments, and coinsurance) including a summary of the federal guidelines and recent changes, describes Oregon's Medicaid program, the Oregon Health Plan (OHP), and outlines states' experiences with cost sharing in Medicaid.

Federal Guidelines on Cost Sharing in Medicaid

The Centers for Medicare and Medicaid Services (CMS) regulates cost sharing in Medicaid. Federal law limits the amounts that states can charge Medicaid beneficiaries for premiums, deductibles, copayments, and coinsurance (see page 7 for descriptions of terms). States have flexibility to impose cost sharing on certain children and adults with incomes between 100% and 150% of the Federal Poverty Level (FPL) and to impose higher cost sharing for beneficiaries with incomes above 150% FPL. Cost sharing for individuals below 100% FPL is generally limited to nominal amounts established in federal regulations (see Table 1 for federal cost sharing guidelines). Federal regulations on cost sharing include exemptions of a number of vulnerable groups and certain types of services. In addition, states must ensure that the total cost sharing for all family members does not exceed 5 percent of a family's income on a quarterly or monthly basis (see Table 2 for examples of allowed cost sharing by income level).¹

Over the years, states have opted to use cost sharing to control costs in Medicaid, expand coverage by modifying income eligibility standards, encourage more personal responsibility for health care choices, and to better align public coverage with private coverage, particularly where states have expanded coverage.² The Deficit Reduction Act of 2005 provided states new flexibility to implement cost sharing in Medicaid beyond existing authority, by allowing states to vary their cost sharing by eligibility group and to make cost sharing enforceable, i.e. a provider could deny services if the cost-sharing is not paid. The Affordable Care Act (ACA) streamlines Medicaid cost sharing regulations and gives states additional flexibility (see Table 1). If a state opts to create a cost sharing structure beyond the federal limits, they need to meet the following requirements through a demonstration waiver approved by CMS³:

- Test a unique and previously untested use of copayments
- Limited to a period of not more than 2 years
- Provide benefits to the recipients reasonably expected to be equivalent to the their risks
- Based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area
- Voluntary, or make provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation

¹ Robin Rudowitz and Laura Synder of the Kaiser Commission on Medicaid and the Uninsured. Premiums and Cost-Sharing in Medicaid. February 2013.

² Ibid.

³ Section 1916(f) of the Social Security Act

Oregon Health Plan

Oregon's Medicaid program, the Oregon Health Plan (OHP), provides health care coverage to low-income Oregonians and is administered by the Oregon Health Authority (OHA). Today, the OHP has two main benefit packages. OHP *Plus* is a full benefit package that primarily serves Oregon's mandatory Medicaid populations, including low-income seniors, people with disabilities, low-income families, children, and pregnant women. OHP *Standard* is a limited benefit package that provides health coverage to low-income uninsured adult Oregon residents who are ages 19 and older. Federal authority to offer Standard will expire at the end of 2013 due to the Affordable Care Act's (ACA) Medicaid Essential Health Benefits (EHB) provision that requires states to offer a comprehensive package of services.⁴

The ACA allows states to expand their Medicaid programs in 2014, to adults under age 65, up to 138 percent of the Federal Poverty Level (FPL).⁵ For the first three years (2014 through 2016), federal funds will pay 100 percent of the costs for people who are eligible under the increased income limit. Federal funding will gradually decline to 90 percent in 2020, where it will remain. In 2013, Governor Kitzhaber and the State Legislature approved opening OHP to more low-income Oregonians as allowed under the ACA. In 2014, a projected 240,000 newly eligible low-income Oregonians who are currently uninsured could be covered through OHP by 2016. Many of these adults are uninsured and work part-time or in low-wage jobs without access to health insurance.⁶

Starting in January, all members in the OHP will receive one benefit package, OHP *Plus*. Oregon's current OHP Standard population will become part of the newly eligible Medicaid expansion population and receive the same health benefits package as current OHP *Plus* members. The OHP *Plus* benefit package for adults includes access to preventive care, access to primary care doctors, check-ups and mental health treatment. In addition, members will receive management of chronic conditions like diabetes, heart disease and cancer. It also includes some vision and dental and benefits. Pregnant women and children in OHP *Plus* receive fuller vision and dental benefits.

⁴ 10 federal EHB Categories: (1) ambulatory patient services; (2) emergency services;(3) hospitalization; (4) maternity and newborn care;(5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices;(8) laboratory services;(9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

⁵ The ACA establishes 133% FPL as the income eligibility threshold for the Medicaid expansion population, but because it also provides that the first 5% of income is automatically disregarded, the effective income eligibility threshold is 138% FPL.

⁶ Michael Perry and Naomi Mulligan with Lake Research Partners and Samantha Artiga and Jessica Stephens with the Kaiser Commission on Medicaid and the Uninsured. Faces of the Medicaid Expansion: Experiences of Uninsured Adults who Could Gain Coverage. November 2012.

Cost Sharing for the Oregon Health Plan

Currently, the OHP does not impose premiums or deductibles, but does require nominal copayments (\$1-\$3) for a range of covered services that include:

- Office and home visits
- Certain prescription drugs
- Hospital emergency services where there is no emergency
- Outpatient hospital services and outpatient surgery
- Outpatient treatment for mental health and chemical dependency
- Occupational, physical and speech therapy
- Restorative dental work and vision exams

In compliance with federal regulations, certain populations and services in OHP are exempt from cost sharing, and include the following groups⁷:

- Children under 19, including preventive services provided to children, regardless of income
- Foster children (through age 20)
- Pregnant women (all services related to pregnancy or a medical condition that might complicate pregnancy, e.g. smoking cessation)⁸
- Services to terminally ill beneficiaries receiving hospice care
- Services to institutionalized individuals (inpatients in a hospital, nursing facility, intermediate care facility, or other medical institute for individuals with developmental disabilities) who are required to spend most of their income for medical care costs
- Emergency services in an emergency situation as defined by law
- Family planning services and supplies
- Individuals receiving services under a federal home- and community-based CMS waiver
- American Indian/Alaska native populations in a federally recognized Indian tribe or receiving services through a tribal clinic
- Individuals receiving Medicaid coverage through the federal Breast and Cervical Cancer Treatment program (BCCTP)
- Each service may only be subject to one type of cost sharing

Today, the CMS 5 percent cap on cost sharing must be calculated individually for each member and taken into account by the Oregon Health Authority (OHA) and Coordinated Care Organizations (CCOs), creating administrative difficulties for clients in OHP and as incomes changes. As of July 2013, the majority of individuals in OHP are now enrolled in one of the 15 Coordinated Care Organizations (CCOs); most of which have elected not to collect copayments as of September 2012.⁹ Only one of the fifteen OHA approved CCOs elected to collect copayments.¹⁰

⁷ Section 1916A of the Social Security Act

⁸ All services provided to pregnant women will be considered as pregnancy-related unless excluded in State Plan.

⁹ <http://www.oregon.gov/oha/healthplan/pages/managed-care/plans.aspx#choose>

¹⁰ Ibid.

States Experiences with Cost Sharing in Medicaid

Applying cost sharing in Medicaid creates administrative complexities at multiple levels—for the state agency administering the program, health plans, and providers—and can create unintended barriers to accessing care for Medicaid enrollees. For example, collecting copayments may be difficult because at the time of service a provider may not know the Medicaid reimbursement rate, or whether the individual has met the 5 percent family cap specified in the federal cost sharing rules. For states, the expense of administering cost-sharing may exceed anticipated state savings. For example, Arizona's state Medicaid agency concluded that the state would incur almost \$16 million in administrative costs to collect just \$5.6 million in copayments and other cost sharing measures. The Arizona study also noted that the administrative costs of collecting the copayments do not take into account increased healthcare costs that result from reduced use of medications by patients in need.¹¹

Out-of-pockets expenses for a service can affect a patient's access to care on account that low-income individuals are particularly sensitive to such costs. Research shows cost sharing can act as a barrier in obtaining, maintaining, and accessing health coverage and health care services, particularly for individuals with low incomes and significant health care needs.¹² These barriers can result in unintentional consequences such as increased emergency care utilization, unmet health care needs, and adverse, avoidable health outcomes.¹³ As individuals are unable to afford copayments and forego care, they often become sicker and eventually visit costly sites such as emergency rooms, increasing the state's overall health care expenses.¹⁴ Although cost sharing can be appealing for states looking to reduce Medicaid expenditures, such cost sharing mechanisms may actually cost states more.

Oregon's Experience

In 2003, Oregon increased premiums and imposed copayments for federally allowable adults in OHP. As a result, approximately 50 percent of these enrollees lost coverage. Of those who lost coverage, two thirds became uninsured. An additional 24 percent reported not having the ability to pay the copayment, and 17 percent reported being unable to receive needed health care because they owed their provider money. Increased premiums and copayments had the potential to generate revenue for the state. However, the amount the state received actually decreased due to lowered enrollment. A 2008 study conducted by Oregon researchers concluded that applying copayments to OHP Standard clients in 2003-2004 shifted treatment patterns but did not provide expected savings.¹⁵ The study suggested that if copayments are to be applied successfully in Medicaid programs, there is a clear need for a greater understanding of how they work in this context and greater attention paid to the details of co-pay policies.

¹¹ Fiscal Impact of Implementing Cost Sharing and Benchmark Benefit Provisions of the Federal Deficit Reduction Act of 2005. Arizona Health Care Cost Containment System. December 13, 2006.

¹² Laura Snyder Robin Rudowitz of the Kaiser Commission on Medicaid and the Uninsured. Premiums and Cost sharing in Medicaid: A Review of Research Findings. February 2013.

¹³ Ibid.

¹⁴ Basini, Leigha O.; *What a Difference a Dollar Makes: Affordability Lessons from Children's Coverage Programs that can Inform State Policymaking under the Affordable Care Act*; NASHP; April 2011

¹⁵ Wallace, Neal T, McConnell, John, Gallia, Charles A., and Smith, Jeanene A.; *How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan*; Health Serv Res. 2008 April; 43(2): 515–530; © 2008 Health Research and Educational Trust.

Table 1: Federal Cost Sharing Requirements Compared to OHP Cost Sharing Policy

	Federal Cost sharing Requirements			Oregon Policy All FPL levels
	< 100 percent FPL**	101-150 percent FPL**	>150 percent FPL	
Aggregate Cap	5% of family income on monthly or quarterly basis (cap on total premium and cost sharing charges for all family members)			
Premiums	Not allowed	Not allowed	Allowed, with exemptions and limitations	None
Cost sharing (may include deductibles, copayments, or coinsurance)				
Most services	\$4 maximum	Up to 10 percent of cost the agency pays	Up to 20 percent of cost the agency pays	\$3 for non-diagnostic outpatient services; \$0 co-pay for other services
Prescription drugs (all)	\$4 or \$8 maximum depending on the drug			\$0, \$1 or \$3 depending on the drug
Inpatient stay	\$75 maximum	10 percent of total cost the agency pays for entire stay	20 percent of total cost agency pays for entire stay	\$0
Non-Emergency Use of the ER	\$8 maximum	\$8 maximum	No limit	\$3
May service be denied for nonpayment of cost sharing?	No	Yes, state option	Yes, state option	No
Provider option to reduce or waive cost sharing?	Yes, on case-by-case basis			Yes
Tracking Requirements	If the state adopts premiums or cost sharing rules that could place beneficiaries at risk of reaching the aggregate family limit, the state plan must indicate a process to track each family's incurred premiums and cost sharing through an effective mechanism that does not rely on beneficiary documentation.			State's cost sharing rules do not place beneficiaries at risk of reaching the aggregate family limit

*"Maximum Nominal Out-of-Pocket Costs" are \$2.65 deductible, \$3.90 copayment, or 5% coinsurance. The maximum copayment that Medicaid may charge is based on what the state pays for that service. Source: [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Cost sharing/Cost sharing-Out-of-Pocket-Costs.html](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Cost%20sharing/Cost%20sharing-Out-of-Pocket-Costs.html)

**To be increased each year, beginning October 1, 2015, by the percentage increase in the medical care component of the CPI-U

*** May be imposed on individuals otherwise exempt from cost sharing. Due to additional information requirements under the ACA for non-emergency ED visits, Oregon may wish to reconsider this particular co-pay.

Table 2: OHP Individual and Family of Four, Income and Monthly Aggregate Cap on Cost Sharing

FPL Level	Individual Consumer		Family of Four	
	Annual Income	5% of Monthly Income	Annual Income	5% of Monthly Income
100%	\$11,490	\$48	\$23,550	\$98
138%	\$15,856	\$66	\$32,499	\$135
150%	\$17,235	\$72	\$35,325	\$147

Terminology

Co-insurance: A defined percentage of total charges for a service.
Co-payment: Payment made for a health care service or product by an individual who has health insurance coverage. The payment is usually made (or billed) at the time a service is received. Copayments are charged to offset some of the cost of care and to control unnecessary utilization of services. The amount can vary by the type of covered health care service.
Cost sharing: Patient exposure to out-of-pocket costs associated with health services delivery. This term generally includes deductibles, coinsurance and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.
Deductibles: Flat dollar amounts for medical services that have to be paid by the patient before the insurer or health plan picks up all or part of the remainder of the prices for services.
Out-of-Pocket Costs: An individual's expense for medical care that aren't reimbursed by their insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.
Out-of-pocket limit: The total amount of cost sharing allowed to be charged to a family or individual for health care services provided over a specified period of time.
Premium: The amount that must be paid for an individual's or family's health insurance or health plan coverage, usually paid monthly, quarterly or yearly.

Additional Resources

- Artiga, S. (2005, May). *Increasing premiums and cost sharing in Medicaid and SCHIP: Recent state experiences*. Retrieved from <http://www.kff.org/medicaid/upload/Increasing-Premiums-and-Cost-sharing-in-Medicaid-and-SCHIP-Recent-State-Experiences-Issue-Paper.pdf>
- Carlson, M. and B. Wright (2005). *The Impact of Program Changes on Enrollment, Access, and Utilization in the Oregon Health Plan Standard Population*. The Office for Health Policy and Research. Retrieved from: http://www.oregon.gov/oha/OHPR/OHREC/docs/OHREC_cohortflwup_0305.rpt.pdf
- Gardner, M. and J. Varon (2004, May). *Moving Immigrants from a Medicaid Look-Alike Program to Basic Health in Washington State: Early Observations*. Kaiser Commission on Medicaid and the Uninsured. Retrieve from: <http://www.kff.org/medicaid/7079a.cfm>
- Guyer, J. (2010, August). *Explaining health reform: Benefits and cost sharing for adult Medicaid beneficiaries*. Retrieved from <http://www.kff.org/healthreform/upload/8092.pdf>
- Hines, P., et al., (2003, December). *Assessing the Early Impacts of OHP2: A Pilot Study of Federally Qualified Health Centers Impacts in Multnomah and Washington Counties*. The Office for Oregon Health Policy and Research. Retrieved from: http://www.oregon.gov/oha/OHPR/OHREC/docs/presentations/assesimpohp211_01_ppt.pdf
- Hudman and O'Malley, (2003, March). *Health Insurance Premiums and Cost sharing: Findings from the Research on Low-Income Populations*, Kaiser Commission on Medicaid and the Uninsured. <http://www.kff.org/medicaid/upload/Health-Insurance-Premiums-and-Cost-sharing-Findings-from-the-Research-on-Low-Income-Populations-Policy-Brief.pdf>
- LeCouteur, G., Perry, M., Artiga, S., and D. Rousseau (2004, December). *The Impact of Medicaid Reductions in Oregon: Focus Group Insights*. Kaiser Commission on Medicaid and the Uninsured. <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=50058>

Value-based Benefit Design

Introduction

In the commercial market, health plans have been working to address behavior, lifestyle, and person engagement through new and innovative health insurance benefit designs. In an effort to promote personal responsibility, and quality- and cost-conscious decision-making, health plan are encouraging individuals to take ownership of their health and health care. Several of these consumer-directed approaches use mechanisms that focus on benefit design and the use of financial levers to urge individuals to make more cost-sensitive decisions. The underlying premise of many of these new benefit designs is to place the consumer in more control of his or her health care costs; and thus be better engaged, and make more appropriate health and health care utilization decisions.¹⁶ While such approaches originated mainly in the commercial and Medicare markets, state Medicaid programs have started to experiment with consumer-directed approaches as well.

A relatively new approach, value-based benefits places a priority on preventive care and other effective (or high-value) health services. The intent is to restructure cost-sharing in a way that provides incentives for individuals around the use of appropriate and cost-effective care. This benefit structure also uses financial disincentives for less effective services or ones that have little impact on health. Traditional cost-sharing can reduce the use of appropriate and inappropriate care in “almost equal measure.”^{17,18} The valued-based benefit model, however, aims to increase health care quality and decrease costs by using financial incentives to promote cost efficient health services and consumer choices.

What is Value-based Benefit Design?

The value-based benefit model is intended to incentivize individuals to use low-cost, evidence-based services (i.e. value-based services). The model ties cost-sharing to high-value services, which are evidence-based, using financial incentives to reduce demand for certain kinds of medical care.¹⁹ Value-based benefit design often eliminates cost-sharing for preventive services,²⁰ such as periodic screenings; vaccinations; screening for breast, cervical, colon, and prostate cancer; use of preferred providers; and participation in wellness programs.^{21,22} The model may also offer full coverage for

¹⁶ Dixon, A., Greene, J., and Hibbard, J. Do Consumer-Directed Health Plans Drive Change In Enrollees’ Health Care Behavior? *Health Affairs*, Vol. 27, No. 4 (2009): 1120-1131.

¹⁷ Lohr, K. Brook, R., Kamberg, C., Goldberg, G., Leibowitz, A., Keeseey, J, et al. (1986). Effect of cost sharing on use of medically effective and less effective care. *Medical Care*, 24(9), 531-8.

¹⁸ Thompson, S., Schang, L., & Chernew, M. (2013). Value-based cost sharing in the United States and Elsewhere can Increase Patients Use of High-value Good and Services. *Health Affairs*, 32(4), 704.

¹⁹ Shah, N., Naessens, J., Wood, D., Stroebel, R., Litchy, W., Wagie, A., et al. (2011). Mayo Clinic Employees Responded to New Requirements for Cost Sharing by Reducing Possibly Unneeded Health Services Use. *Health Affairs*, 30(11), 2134-2141.

²⁰ The Affordable Care Act (ACA) eliminates cost-sharing for preventive services.

²¹ See Thompson (2013).

tobacco and weight management and require coverage of generic drugs for chronic conditions such as to control blood pressure or diabetes at no cost. The approach can include incentives to encourage healthy behaviors, chronic illness management, and use of ambulatory clinics, rather than emergency departments, for non-emergency care. The intentional design feature is to create incentives by reducing or eliminating copays for valued-based services. The model uses disincentives as well, such as cost-sharing for health choices that may be unnecessary or repetitive (i.e. low value), or when the same outcome can be achieved at a lower cost, while not impeding access to essential care or making treatment unaffordable.

Value-based Benefit Design in Oregon

Oregon has been nationally recognized in its efforts to develop innovative ways to deal with increasing health care costs in an environment of limited resources while working to improve health. In 1991, Oregon pioneered an early form of value-based benefit design by adopted the Prioritized List of Health Services, which ranks health services from the most important to the least important. The List is used to specify covered benefits for OHP enrollees. Two decades later, the Oregon Health Fund Board (2008)²³ and the Oregon Health Policy Board (2010)²⁴ identified the concept of value-based services as a potential way to further Oregon’s Triple Aim:

- Improves health without increasing overall costs
- Improves quality by encouraging most effective services
- Controls costs by discouraging less effective services

In 2010, Oregon adopted the use of value-based insurance design by implementing it in its public employee health plans. The Oregon Educators Benefit Board (OEBB) and Public Employees Benefit Board (PEBB), with a combined total of approximately 265,000 Oregonians have both incorporated value-based insurance design in their health plans. The goal of Oregon’s use of value-based services in PEBB and OEBB is to remove the barriers to proven effective and preventive care. In other words, promote positive health choices and create financial disincentives for poor health choices by applying minimal out-of-pocket costs for individuals.

Cost-sharing is used on a tiered basis for preventive care, medication for treating chronic disease, and emergency services. For example, in PEBB²⁵ copays are waived for provider visits at a recognized patient-centered primary care home (PCPCH), and for chronic conditions and use of generic drugs. Alternatively, cost-sharing through the use of copays are applied for overused or preference-sensitive services of low relative value. Preference-sensitive services are treatments that involve significant trade-offs for individuals. An example of a preference-sensitive service is back surgery for pain that could be treated by physical therapy or emergency room visits for minor illnesses. PEBB has increased copays for some of the these types of procedures such as some knee and hip surgeries to avoid over-utilization and encourage education and consideration of other potential treatments that might

²² Ibid.

²³ Oregon Health Fund Board (2008). Benefits Committee – Final Recommendations.
<http://www.oregon.gov/oha/OHPR/HFB/benefits/finalrecommendation.pdf>

²⁴ Oregon Health Policy Board (2010). Comparative Pricing of Value-based Essential Health Benefit.
<http://www.oregon.gov/oha/OHPB/meetings/2010/agenda-pk-1010.pdf>

²⁵ Varies among individual plans offered in PEBB.

improve health and quality of life before proceeding with a surgical procedure. These could be further connected to requirements of using shared decision-making tools as part of a pre-authorization process. Key to this benefit design is to remove barriers around the use of effective services and treatments. Services eligible for reduction or elimination of cost-sharing include:

- Ambulatory services (i.e. outpatient), and include medications, diagnostic tests, procedures, and some office visits
- Primarily offered in the medical home
- Primarily focused on chronic illness management, preventive care, and/or maternity care
- Of clear benefit, strongly supported by evidence
- Cost-effective
- Reduce hospitalizations or Emergency Department visits, reduce future exacerbations or illness progression, or improve quality of life
- Low cost up front
- High utilization desired
- Low risk of inappropriate utilization

The Health Services Commission, the predecessor to the current Health Evidence Review Commission identified 20 services that have over-whelming evidence that there should be no barriers to care. See Appendix A for the full list of Value Based Services.

A key objective in value-based benefit design is to empower individuals to understand and make choices based on the risks, costs, and potential outcomes of treatment options (HA 2010, p. 2032). In order for this model of benefit design to be effective, consumer education is critical. Individuals need clear, understandable and trusted information about what is covered and what their costs would be for a given service. Some techniques, which might be used, include promotional and educational materials and shared decision-making tools to facilitate conversations between individuals and their providers or care teams. In order to make good choices, individuals need access to accurate cost information as well as an adequate understanding of the benefits and risks of various treatment options. In the best case, this information will come from a source that is independent and trusted.

As part of comprehensive health reform, the concept of value-based services could be further explored as a possible model to redesign cost-sharing in the Oregon Health Plan (OHP) for federally allowable population groups. To better motivate desired behavior, cost-sharing could be placed strategically rather than across the board. Whether the concept could have a similar effect in OHP—complimenting the use of the Prioritized List of Health Services as it has in the commercial health insurance market is unknown. Value-based benefit design is a potential option to align individual and provider incentives, as well as align benefit design among public and commercial insurance plans to foster the delivery of “high-value” care.

Appendix A: Value-Based Services

Proposed “Barrier-Free” services for use within a value-based benefit package

Diagnosis	Medications	Labs	Imaging/Ancillary	Other
Asthma	Medications according to NICE 2008 stepwise treatment protocol	None	Diagnostic spirometry	None
Bipolar Disorder	Lithium, valproate	Lithium – lithium level (q3 months); creatinine and TSH (q6 months) Valproate -LFTs and CBC (q6 months)	None	Medication management
Cancer Screening	None	Pap smears Fecal occult blood testing	Mammography Colonoscopy/Flexible sigmoidoscopy	Per USPSTF recommendations, “A” and “B” recommendations only
Chemical Dependency Treatment	Buprenorphine for opioid dependence Acamprosate for alcohol dependence	None	None	Brief behavioral intervention to reduce hazardous drinking (SBIRT) Methadone maintenance treatment
Chronic Obstructive Pulmonary Disease(COPD)	Short-acting inhaled bronchodilator	None	None	None
Congestive Heart Failure (CHF)	Beta-blockers, ACE inhibitors, diuretics	CBC, CMP, lipid profile, urinalysis (annually) TSH once	EKG, Diagnostic echocardiogram	Nurse case management
Coronary Artery Disease (CAD)	Aspirin, statins, beta blockers	Lipid profile (annually)	EKG	Cardiac rehabilitation for post-myocardial infarction (MI) patients
Dental Care, Preventive	Fluoride supplements (age 6 months to age 16), if indicated Professionally applied fluoride varnish (twice	None	Pit and fissure sealants in permanent molars of children and adolescents	None

Appendix A: Value-Based Services

Diagnosis	Medications	Labs	Imaging/Ancillary	Other
	yearly in children aged 12 months to 16 years old who are at high risk), if indicated			
Depression, Major in Adults (Severe Only)	SSRIs	None	None	Cognitive Behavioral Therapy (CBT) or Interpersonal Therapy (subject to limit, e.g. 10 per year) in conjunction with an antidepressant Medication management
Depression, Major in Children and Adolescents (Moderate to Severe)	None	None	None	Psychotherapy (CBT, interpersonal, or shorter term family therapy)
Diabetes – Type I	Insulin (NPH and regular only), insulin supplies, ace inhibitors	HgA1c (annually)	None	Diabetic retinal exam for adults (annually)
Diabetes – Type II	Metformin, sulfonyureas, ACE inhibitors, insulin (NPH and regular only), insulin supplies	HgA1c, lipid profile (annually)	None	Diabetic retinal exam for adults (annually)
Hypertension	Diuretics, ACE inhibitors, Calcium channel blockers, Beta blockers	Fasting glucose, fasting lipids (annually)	None	None
Immunizations	Routine childhood and adult vaccinations	None	None	Follow ACIP recommendations for non-travel vaccinations
Maternity Care	Folic acid, Rh immunoglobulin (when indicated)	Screening for hepatitis B, Rh status, syphilis, chlamydia, HIV, iron deficiency anemia, asymptomatic bacteriuria,	None	None

Appendix A: Value-Based Services

Diagnosis	Medications	Labs	Imaging/Ancillary	Other
		rubella immunity, screening for genetic disorders		
Newborn Care	Ophthalmologic gonococcal prophylaxis, Vitamin K prophylaxis	Sickle cell, congenital hypothyroidism, PKU (cost borne by the state)	None	None
Reproductive Services	Condoms, combined oral contraceptives, intrauterine devices, vaginal rings, Implanon, progesterone injections, female sterilization, male sterilization	See STI screening and maternity care	None	None
Sexually Transmitted Infections	Syphilis – Penicillin IM or doxycycline Chlamydia – azithromycin or doxycycline Gonorrhea – ceftriaxone IM or cefixime po	In certain populations: chlamydia, gonorrhea, HIV, syphilis	None	According to USPSTF guidelines for appropriate populations to screen (A and B recommendations only)
Tobacco Dependence	Nicotine replacement therapy, nortryptiline, and bupropion	None	None	None
Tuberculosis (TB)	Per CDC guidelines – standard drug treatment for latent and active TB	Screening and diagnostic algorithm according to CDC guidelines	Chest x-ray per CDC guidelines	None

Guidelines based on empirical evidence (systematic reviews and health technology assessments), from trusted sources such as: ACIP, AHRQ, Cochrane Collaboration, CDC, OHSU Center for Evidence-Based Policy, NICE, NIH, Ontario, SIGN, USPSTF, WHO

General principles

For medications

- 1) Generics unless no equivalent available
- 2) Medications for ≤ \$4 per month are preferred to more expensive medications

Appendix A: Value-Based Services

Glossary

ACE: angiotension converting enzyme

ACIP: Advisory Committee on Immunization Practices

AHRQ: Agency for Healthcare Research and Quality

CBC: complete blood count

CDC: Centers for Disease Control and Prevention

CMP: complete metabolic panel

EKG: electrocardiogram

HgA1c: hemoglobin A1c

HIV: human immunodeficiency virus

IM: intramuscularly

LFTs: liver function tests

NICE: National Institute for Health and Clinical Excellent
(England)

NIH: National Institutes of Health

OHSU: Oregon Health & Science University

PKU: phenoketonia

SIGN: Scottish Intercollegiate Guidelines Network

SBIRT: screening, brief intervention, and referral to treatment

SSRIs: serotonin specific reuptake inhibitors

STI: sexually transmitted infection

TSH: thyroid stimulating hormone

USPSTF: US Preventive Services Taskforce

WHO: World Health Organization



**Office for
Oregon Health Policy and Research**

**Person- and Family-Centered Care and Engagement
Medicaid Advisory Committee
Full Report and Recommendations**

July 2013

**Oregon
Health
Authority**



July 2, 2013

Chairs, Oregon Health Policy Board
Oregon Health Authority

Dear Chairs Parsons and Shirley and members of the Board:

The Medicaid Advisory Committee strongly believes that person- and family- centered engagement in health and health care serves as the most direct route to achieving Oregon's three-part aim for individuals served by the Oregon Health Plan (OHP). This conviction is reinforced by an increasing body of evidence that indicates individuals who are more engaged in their own health and health care experience better health outcomes, better experience of care, and incur lower medical costs. This is particularly the case when services and supports are tailored to their individual needs, goals, preferences, and circumstances with the input of the member and their families, in partnership with their health care team.

Recognizing the importance of OHP members' willingness and ability to engage in and manage their own health and health care, the Committee spent six months exploring a range of strategies to support this goal. The process comprised an extensive review of research and testimony from a diverse range of stakeholders and national experts on approaches and experiences from both commercial and state Medicaid programs. The Committee determined that strategies focused on cost-sharing, or the use of financial disincentives could have negative and unintended effects for OHP members. Furthermore, there is limited evidence that supports the use of financial incentives/disincentives in Medicaid, and is restricted by federal law.

The Committee opted to focus on a set of strategies and actions designed to coordinate, align and promote person- and family-centered activities statewide aimed at engaging OHP members in their health and health care. The goal is to further realize OHP members' full potential for improving and maintaining their health and for serving as active partners in a transformed health system that spans the Oregon Health Authority (OHA), Coordinated Care Organizations (CCOs), Patient-Centered Primary Care Homes (PCPCHs), other health care settings, and members' homes and communities.

Anchoring the Committee’s work is the recognition that in order to think about health and health care differently policy makers, legislators, health care executives, providers, community leaders, and other key stakeholders participating in Oregon’s historic Health System Transformation need to both think and talk about it differently. This entails continuing to shift away from the conventional medical model focused on disease treatment to thinking about, and caring for, the whole person, focusing on prevention and promoting health and wellness. For this reason, the Committee adopted preferred language, using the terms person (or individual) and family when talking about those who engage or are engaged in their health and health care.

The Committee also explicitly acknowledges that the prevailing nomenclature used in health care too often refers to individuals as patients instead of persons (i.e. individuals by categories as dual eligibles, patients, and consumers, rather than person). Examples include patient-engagement, patient-activation, and patient-centered care. In opting to move away from using the term “patient” and toward “person-centered” when possible, the Committee is also conscious of the undesirable and unintended connotations associated with the term patient. This subtle distinction recognizes that the term “patient” may connote passivity, as well as the historical patient-provider relationship, wherein a patient is one who relies on his or her providers to make health related decisions on his or her behalf. The Committee believes the preferred terminology, “person and family,” transcends the varying roles and responsibilities individuals, their families, and representatives/advocates have regarding their health and well-being, and the characterization of those roles, which are often heavily influenced by their audience and context, are of particular importance for OHP members. This is an intentional effort to both encompass and respect an individual’s needs, values, ability to engage, cultural traditions and family situation.

In closing, while concepts and strategies discussed in this report are applicable to a variety of populations, the Committee is charged with developing strategies for individuals enrolled as members in the Oregon Health Plan. The Committee believes the strategies put forward in this report, if implemented, will help further health system transformation in support of all Oregonians.

Sincerely,



Janet E. Patin, MD
Co-Chair, Medicaid Advisory Committee



Karen Gaffney, MS
Co-Chair, Medicaid Advisory Committee



Office for Oregon Health Policy and Research

John A. Kitzhaber, MD, Governor

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August 6, 2013

Chairs, Oregon Health Policy Board
Oregon Health Authority

Dear Chairs Parsons and Shirley and members of the Board:

The Medicaid Advisory Committee thanks the Oregon Health Policy Board for the opportunity to share its work on Person- and Family-Centered Care and Engagement, and appreciates the Board's support in its efforts to develop a framework for enhancing policies that support this work. Based on the Board's feedback and request, the Committee narrowed the initial set of strategies and actions to two recommendations, which serve as the desired starting point for this work over the next 6-12 months. The full list of strategies and actions¹ provide a broader framework as the Oregon Health Authority (OHA) works to align and spread models of coordinated and integrated care across the agency's health care programs, including Oregon's commercial marketplace.

The Committee prioritized its final recommendations in accordance with the Board's guidance summarized below:

- Consider the roles of all actors in the system and how responsibility can be appropriately assigned across the different parts of the health system.
- Leverage existing infrastructure and health system transformation efforts already underway, specifically the OHA Transformation Center and the Patient-Centered Primary Care Institute.
- Assure expectations placed on providers, practices, and the health care system is balanced with similar expectations and notions of accountability for local and state officials, communities, individuals, and their families/representatives.

¹ For the complete list of strategies and actions, please see the July 2013 MAC Report on Person- and Family-Centered Care and Engagement.

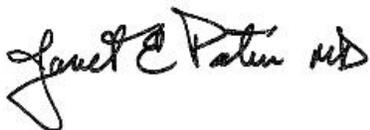
Recommendation #1: Each CCO and their delivery system partners empower individuals by providing education and support in how to navigate the delivery system and manage their own health by providing timely, complete, unbiased and understandable information in accessible and appropriate formats on health conditions and treatment options, taking into account cultural, linguistic, and age appropriate factors.

Recommendation #2: OHA partners with CCOs through the Transformation Center to achieve economies of scale to make the use of the Patient Activation Measure (PAM), shared decision-making tools, and health literacy tools more affordable to all practices and works with the Patient Centered Primary Care Institute to train and educate practices on the implementation of such tools.

With the upcoming expansion of Medicaid to low income adults up to 138% of the Federal Poverty Level, approximately 240,000 newly eligible low-income Oregonians are projected to enroll in the Oregon Health Plan (OHP) by the end of 2016. This is in addition to the 660,000 individuals currently eligible for the OHP that are projected to enroll within the same timeframe. This presents a historic opportunity to redefine the relationship, expectations, and roles of individuals on the OHP as active participants in Oregon's reformed health system. The overarching goal is to promote deeper engagement across all levels of the health system, and simultaneously encourage individual responsibility for managing one's own health and health care. The recommendations are intended to support individuals as equal partners in and accountable for their own health.

The Committee believes its report and recommendations should serve as a foundation for the Task Force on Individual Responsibility and Health Engagement, whose work will occur over the Fall of 2013. We appreciate the opportunity to create a new understanding of the roles and responsibilities of CCOs, health care professionals, local and state officials, communities, and individuals and families/representatives in support of person- and family-centered care.

Sincerely,



Janet E. Patin, MD

Co-Chair, Medicaid Advisory Committee



Karen Gaffney, MS

Co-Chair, Medicaid Advisory Committee

Medicaid Advisory Committee Report

Submitted to Oregon Health Policy Board

July, 2013

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If you would like additional copies of this report, or if you need this material in an alternate format, please call Lori Elliott at (503) 373-2275.

Executive Summary

The Oregon Medicaid Advisory Committee (MAC) believes that engaging a person and their family in their own health and health care is a critical aspect of achieving Oregon's three-part aim of:

- Improving the lifelong health of Oregonians;
- Increasing the quality, reliability, and availability of care for all Oregonians; and
- Lowering or containing the cost of care so it's affordable to everyone.

In an effort to build on the foundation of Oregon's health reform efforts, the Committee developed a set of strategies and key actions that will support Oregon Health Plan (OHP) members to become more engaged and informed decision-makers, enhance their ability to manage their health and health care, and support individuals in becoming more active participants in Oregon's health system.[†] The strategies, critical to improving health outcomes among less advantaged Oregonians, are presented as a framework for enhancing policies and interventions aimed at supporting person and family engagement at all levels of Oregon's Health System Transformation.¹ The actions are designed specifically to address the diverse backgrounds and complex needs of current and future OHP members.

In developing the strategies, the Committee carefully reviewed and identified gaps as well as opportunities to build on existing activities already supported by OHA's Patient Centered Primary Care Home (PCPCH) Program, Coordinated Care Organizations (CCOs), and other key reform efforts. The Committee's full report includes background information, an overview of the committee process, key policy considerations, and supporting evidence for the proposed set of strategies and actions. The executive summary provides a synopsis of the key recommended strategies, rationale and actions for each strategy, and is intended to inform and guide Oregon's transformation to a high-performance health system.

Committee Process

The Committee began its work by examining strategies designed to encourage individuals to take ownership of their health and health care by promoting personal responsibility and quality- and cost-conscious decision-making. Starting with the commercial market, the Committee reviewed consumer-directed approaches that use mechanisms focused on benefit design and the use of financial levers to urge individuals to make more cost-sensitive decisions. A common form of this approach is a health savings account linked with a high

[†] Broadly inclusive of groups such as Oregon Health Plan members, their families and/or representatives, providers, practices, community clinics, hospitals, local health departments, the Oregon Health Authority and Department of Human Services, other culturally and linguistically diverse community members (such as race/ethnicity, Limited English Proficient individuals, people with disabilities, across the life-span, people with mental health and/or addictions issues, social services organizations, consumer advocacy groups, the community-at-large, etc.).

deductible health plan. Proponents of this approach believe that a consumer in control of, and at greater risk for, his or her health care costs will be better engaged, and may make more appropriate health and health care utilization decisions.²

Early in the Committee's work, however, the MAC recognized that even nominal cost-sharing including premiums and co-pays, can serve as a barrier to accessing necessary preventive and primary care services for low-income and other vulnerable populations. Cost-sharing can also result in unintended consequences such as increased use of the emergency department after delaying care.^{3,4} Furthermore, past experience in Oregon and in other states demonstrates that implementing cost-sharing in Medicaid is complex and administratively burdensome, wherein costs often outweigh anticipated state savings.⁵ Finally, federal law imposes strict cost-sharing limitations and benefit design requirements for all Medicaid populations. Thus, federal requirements currently restrict the use of such approaches in Oregon's current health care environment.⁶

Subsequently, the Committee reviewed available research and information from state Medicaid incentive programs that use a variety of approaches, including financial and non-financial incentives, to promote healthy behavior and appropriate utilization of health care among their members. Examples include Florida's Enhanced Benefits Reward\$ Program and Idaho's Preventive Health Assistance program. Early findings from these states indicate that program effectiveness would be improved by better addressing the *challenges* Medicaid members face to participating in such programs, such as lack of awareness and understanding of the program, and *barriers* to adopting healthy behaviors, such as limited transportation options to access both health care services and healthy activities. To date, there is limited evidence on the efficacy and cost-effectiveness of such approaches within state Medicaid programs.⁷

The Committee considered a growing body of evidence that shows individuals who are more engaged in their own health and health care, experience better health outcomes and incur lower medical costs.^{8,9} Individuals that are more highly engaged and activated are less likely to have unmet medical needs; more likely to have regular check-ups, including screenings and immunizations; adhere to treatment and obtain regular chronic care services; and, engage in health behaviors such as eating a healthy diet, regular exercise, and avoid adverse behaviors such as smoking and illegal drug use.^{10,11,12} This is particularly the case when services and supports are tailored to their individual needs, goals, preferences, and circumstances.¹³ The Committee believes that innovative approaches, designed to improve individual engagement and accountability for one's own health in a person-and family-centered health system, will ultimately support the achievement of Oregon's three-part aim for all OHP members.

Recommendations

The recommended policy strategies seek to enhance alignment, coordination and create synergy among person- and family-centered efforts already underway through Oregon's Health System Transformation. The key is to effectively and equitably engage individuals and their families across all levels of the health system. Paramount to this is addressing the unique barriers and challenges experienced among OHP members. The continuum of person- and family-centered engagement in care is characterized across three levels: (1) direct patient care and partnership(s), (2) integration of patients' values in the design and governance of health care organizations, and (3) shared leadership and policy making that's responsive to patients' perspectives.¹⁴

The MAC envisions a number of key actors to help adopt and implement these strategies. Key partners include members of the OHP and their families and/or representatives; providers and practices, especially those in recognized, patient-centered primary care homes; the Patient-Centered Primary Care Institute (PCPCI); Coordinated Care Organizations (CCOs) and their community partners; the Oregon Health Authority and its Transformation Center, in addition partners such as Cover Oregon, health professional associations, and other stakeholders.

Strategy #1: OHP members provide information to providers and the OHA about how to effectively address barriers to individual and family engagement and improve the health system.

Rationale: To better understand how best to support individuals' efforts to participate in their health, there is a need to systematically and regularly collect information from OHP members on their level of engagement in their health and health care, their experience of care and satisfaction. This will identify specific opportunities, facilitators, and barriers for individuals to improve and maintain their health. The goal is to solicit information and understand members' barriers to accessing care, ability for self-management, and fostering shared responsibility for health.

- Action: Providers routinely and consistently engage OHP members and their families as key partners and participants in the health care process by providing timely, complete, unbiased and understandable information in accessible and appropriate formats on health conditions and treatment options, taking into account cultural, linguistic, and age appropriate factors.
- Action: Practices recognize and utilize members' experiences through outreach efforts including surveys, focus and advisory groups, and social media to guide practice level improvement.
- Action: OHP members and families directly partner with care teams, non-traditional health care workers, and community-based organizations to access and engage in community-based self-management programs.

- **Action:** OHA coordinates and aligns use of patient satisfaction and experience of care surveys statewide to address such things as purchasing strategies to assist practices and CCOs, preferred survey types (e.g. Picker, Press Ganey; HCAHPS, CG, & PCMH), use of benchmarks, survey timelines and redundancies with administration, and public reporting of information.

Strategy #2: Ensure ongoing education and training on evidence-based best practices for person- and family-centered engagement in health and health care.

Rationale: To fully support OHP members and their families in their own health and health care, practices and health care professionals, including community-based organizations, require education and sustained training in this arena. Such efforts should focus on effective use of techniques and best practices that create opportunities for individuals to make informed decisions and support health improvement of OHP members in their communities across Oregon.

- **Action:** Practices and providers receive regular and ongoing education and training from technical experts such as the Patient-Centered Primary Care Institute (PCPCI) and other learning forums on approaches to support person- and family-centered care. Examples include use of the Patient Activation Measure (PAM), shared decision-making and the use of decision aids, how to address low literacy and health literacy skills, and support for community-based self-management and wellness programs.
- **Action:** CCOs receive ongoing training and technical assistance from the OHA Transformation Center on how to work with practices to implement use of patient level data to inform practice and system level improvements.

Strategy #3: Leverage resources that support evidence-based best practices for person- and family-centered engagement and activation in health and health care.

Rationale: The Committee concluded that several evidence-based tools that would be helpful to sustain practice-level engagement efforts might not be affordable, individually, particularly for resource-limited small or rural practices.

- **Action:** PCPCI develop and disseminate practice-level tools for providers to routinely ask members and their families about their values, needs, knowledge, preferences and circumstances in culturally and linguistically appropriate ways. This will allow greater member feedback to be integrated into individually tailored and appropriate care plans.
- **Action:** OHA should work with CCOs and their delivery system partners to achieve economies of scale in order to make evidence-based tools more affordable and available to practices of all sizes throughout the state such as:
 - Patient Activation Measure (PAM)[‡] or other evidence-based activation measurement tool(s), to assess the skills and readiness of the individuals for

[‡] The Patient Activation Measure® (PAM®) assessment gauges the knowledge, skills and confidence essential to managing one's own health and health care.

engagement. Results can be used to determine the appropriate levels of intervention and allocation of resources. For example, a patient with complex and chronic health needs and low activation level may need the most intense interventions and resources versus someone with low acuity and a high level of activation.

- Shared Decision Making tools that are evidenced based, to engage individuals and their families about discrete health conditions and support medical decisions by providing information, helpful strategies, and other supports.
- Action: OHA works with community stakeholders to develop a sustainable system for evidence-based self-management program delivery and financing to ensure broader availability of community-based programs, such as Living Well with Chronic Conditions, across the state. The work should ensure linkages with PCPCHs and CCOs to the extent possible, working with the PCPCI and through the OHA Transformation Center to coordinate and align resources, provide targeted technical assistance and learning collaboratives.

Strategy #4: Create opportunities across all levels of the health system to support OHP members as integral partners in Oregon’s Health System Transformation.

Rationale: A comprehensive person- and family-centered transformed health system will need to encompass patients, families, their representatives, health professionals, and community partners working in active partnership at various levels across the system—direct care, organizational design and governance, and policy making—to improve members’ health and health care.

- Action: CCOs systematically and meaningfully engage representatives of diverse populations (including but not limited to cultural, language and age considerations) and community stakeholders to develop their community health assessments (CHAs) and community health improvement plans (CHIPs). For example, OHA should work closely with CCOs and their Community Advisory Councils to ensure the resources and support of person- and family-centered care strategies are available to foster the needs and primary goals of the members and community served by their CCO.
- Action: OHP members and their families serve as “equal and active partners” by fostering meaningfully and sustained participation in CCO advisory panels, provider/practice level advisory groups, and in local and state committees, councils, and boards, as OHP member advocates.

Strategy #5: Coordinate the adoption and spread of evidence-based best practices for person- and family-centered engagement in health and health care.

Rationale: Critical to this effort will be the promotion and alignment of multi-payer approaches to increase spread across provider practices and communities. OHA should work to ensure coordination and alignment of person- and family-centered models of care across the OHA, including CCOs, Public Employees’ Benefit Board (PEBB), Oregon Educators Benefit

Board (OEBC), the PCPCH Program, Cover Oregon and other payers. The goal is for OHA to leverage resources and activities statewide to disseminate best practices appropriate for OHP members and their families.

- Action: OHA should incentivize and disseminate the use of evidence-based best-practices for person- and family-care models of care that are sensitive to and account for the needs of diverse communities. This may be accomplished through the OHA Transformation Center coordinating with Innovator Agents, CCOs, regional learning collaboratives, and recognized PCPCHs to incentivize and disseminate the use of evidence-based best-practices for person- and family-centered models of care that are sensitive to and account for the needs of diverse communities.
- Action: OHA works with CCOs to increase the number of recognized PCPCH practices; modify existing PCPCH Standards to support of more robust person- and family-centered care and engagement models; and consider alternative payment methodologies to incentivize practices with resources to adopt and sustain patient engagement activities.

[FULL REPORT]



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Introduction

As state policymakers, legislators, and health care leaders endeavor to improve a key determinant of health—the delivery system—individuals, families and communities must serve as key partners in reforming the system. By placing individuals, families and their communities at the center of health reform, efforts to increase access and quality, and to ensure that the health care system is held accountable, will be optimized. In Oregon, as new and innovative models of health care emerge, it will

“The most direct route to the Triple Aim is through implementation of patient and family-centered care in its fullest form.”

Don Berwick, former administrator for CMS

be important to design and test policy interventions that also influence factors beyond the delivery system, thus leveraging the critical work already led by CCOs. New policy approaches are needed to modify other determinants of health as an extension of broader health reform efforts, specifically addressing behavior and lifestyle determinants.¹⁵

Dozens of states are earnestly working to implement broad health reforms—addressing the financing, payment and delivery of health care services, both in Medicaid and the commercial marketplace—many of which are directly supported by the federal Affordable Care Act (ACA). Paramount to these reform efforts is the recognition by policy makers that an individual’s health status and well-being are determined to a large extent by factors outside of insurance coverage and access to high-quality health care services.

Increasingly understood is that the health of a community and its residents is determined by a number of factors including access to, and use of primary and preventive health care services. Altogether, health care accounts for approximately 10 percent of an individual’s health.^{16,17,18} Therefore, comprehensive health reform efforts must also target broader social determinants of health such as education, housing and social cohesion, and personal behaviors such as diet, physical activity, tobacco use, substance abuse and addictions, approaches to safety, and coping strategies to stress. Combined, behavior and lifestyle account for over half the factors that influence one’s health status, including premature mortality.¹⁹

In the commercial market, health plans have begun to fold in efforts to address behavior, lifestyle, and person engagement through new wellness programs, such as Oregon’s Public Employee Benefit Board’s (PEBB) Health Engagement Model. Many such efforts tie financial penalties to non-participation in such programs. However, due to federal restrictions, these types of approaches cannot be fully replicated in state Medicaid programs. Nevertheless, opportunity remains in directing limited federal and state resources for Medicaid to support the design of new programs that target preventable and

healthy behaviors through novel interventions aimed at increasing individual responsibility and engagement of the individual in their own health and health care.

As Oregon works to transform its health system, an important factor in achieving the three-part aim is supporting providers along with individuals and their families to engage in improving and maintaining their health. The desired outcome is for individuals and families to adopt preventive and healthy behaviors, such as reducing tobacco use, modifying poor diet by increasing intake of nutritious foods, increasing physical activity, and reducing substance abuse. Oregon's transformed health system can benefit by encouraging and empowering individuals to take ownership of their health, particularly outside the clinical setting.

"Person-centeredness is needed if we are really going to improve health and if we want a partnership with the person whose health we are trying to improve."

Gary Christopherson, former CMS Senior Adviser

This report includes key background information, an overview of the committee process, review of the literature and evidence, key policy considerations, as well as the rationale and supporting evidence for the set of recommended strategies and actions.

Background

Oregon, along with other states can benefit by experimenting with interventions that seek to address behavioral and social circumstances by influencing and increasing participation of Medicaid beneficiaries in their own health care, make informed decisions as a member of their care team, increase efforts and support in disease management and wellness programs, and take part in preventive health behaviors. Over the long-term, these efforts may contribute to improved population health and curb the growth rate of health care expenditures.

States have begun to explore new opportunities to provide individuals with low-income and other vulnerable populations, access to resources and coverage of community-based services and supports. A good example in Oregon includes the use of non-traditional health workers (NTHWs), who are experts in providing culturally competent care and are uniquely placed to work with community members to identify and resolve their own most pressing health issues by addressing the social determinants of health; thus, contributing to reducing health inequities in Oregon. Accordingly, NTHWs can assist individuals in overcoming barriers to engaging and sustaining in preventive and healthy behaviors.

Among the more than 65 million individuals served by Medicaid, the notion of individual responsibility and the use of penalties or incentives to encourage healthy behaviors is

complex and not well understood.²⁰ There are several key policy considerations in trying to foster approaches designed to encourage individuals to take ownership of their health care by promoting personal responsibility and quality- and cost-conscious decision-making. Such considerations are of particular importance for those insured through Medicaid. For example, the use of incentive programs aimed at promoting healthy behavior and controlling costs must be designed so that the proposed interventions do not result in unintended consequences and inadvertently discriminate those covered by Medicaid. States have a responsibility to ensure and protect against policy interventions that insufficiently account for community-based and socioeconomic factors associated among low-income and other vulnerable population groups that affect an individual's ability to engage in healthy behaviors and disease management.

To learn from and build on the foundation of recent health reform efforts the Oregon Medicaid Advisory Committee (MAC) examined evidence and best practices around person- and family-centered care and engagement. The Committee spoke with experts both in Oregon and in other states to develop a set of strategies and key actions that will support OHP members to become informed decision-makers, enhance their ability to manage their health and health care, and support individuals in becoming more active participants in Oregon's health care system (*Please see *Appendix A* on page 18 for complete list of invited speakers).

What's the Issue?

The landmark Institute of Medicine report (2001), *Crossing the Quality Chasm: A New Health Systems for the 21st Century*, called for reforms to achieve a patient-centered health care system. The report described a future state in which the U.S. health care delivery system "is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions."²¹ The "new chasm" is bridging the loci of health care services for individuals through person- and family-centered care by linking the delivery system to the community. The next major step in federal and state health reform is transitioning to a system of person- and family-centered care.

For decades, Oregon has been working towards comprehensive reform of its financing, payment, and delivery system, with notable accomplishments in its Medicaid program. From the creation of the Prioritized List of Health Services in 1988; expansion of the OHP to adults up to 100% of the federal poverty level (FPL) in 1994; the creation of the Oregon Health Authority, the Health Policy Board, and the Patient-Centered Primary Care Home Program in 2009; and most recently, Coordinated Care Organizations (CCOs)—Oregon is now committed to its three-part aim:

- Improving the lifelong health of Oregonians;
- Increasing the quality, reliability, and availability of care for all Oregonians; and
- Lowering or containing the cost of care so it's affordable to everyone.

Historically, individuals have not served as equal partners in health care or been involved in systems-level reforms.²² A key challenge is to redesign Oregon’s health care system, including Medicaid, with the individual as the nucleus in a transformed system. Fundamental to this is recognizing and valuing individuals not as patients, or recipients of care, but rather as “partners” across all levels of the health care system. This includes interactions with providers and care teams, at the practice-level, in hospitals, community-based organizations, in local and state directed programs, CCOs, and by public bodies that engage in regional and state directed policy development and oversight functions (i.e. governance). The new model must move beyond any restrictions or nominal representation in these redesigned structures and processes. In other words, individuals and families need opportunities for meaningful engagement and for their input to be encouraged and valued across the continuum.

“Recognize that we are the most important part of the care team, and that we are ultimately responsible for our overall health and wellness.”

Oregon Patient Centered Primary Care Home (PCPCH) Program
Core Attribute

Fortunately, Oregon is well positioned to identify additional opportunities to build on what has already been accomplished and continue to work towards the ultimate goal of better health, better care and lower costs for Oregonians. It will be important to leverage efforts already underway including:

- Health System Transformation Center: provision of technical assistance and other support to CCO and their provider networks to help them meet their incentive measures, that include patient satisfaction and contract requirements that must demonstrate progress in provider- and patient-engagement, in addition to other critical patient-and family-centered care areas.
- Patient-Centered Primary Care Institute (PCPCI): fostering medical home transformation. The Institute has hosted several webinars relating to person- and family-centered care and engagement, as well as the tremendous work being led CCOs and PCPCHs across the state.

The next building block of health reform can be achieved—person- and family-centered care—for members of by Oregon Health Plan (OHP). The redesign of Oregon’s health system emphasizes local accountability for health care and allocation of resources by each CCO. The next step is to address personal responsibility and engagement of the individual and their family. First, there are important challenges experienced by low-income populations, often covered by Medicaid that must be addressed prior to proposing policy recommendations.

Challenges Faced by Low-income, Vulnerable Populations

As states and policy makers consider policies aimed at improving individual engagement and influencing behavior modification, it is critical to account for the unique challenges low-income and other vulnerable populations experience with accessing, improving and maintaining their health and health care. Given limited financial resources, often poorer health status, complex health needs, and other barriers such as education and physical environment—strategies to engage low-income vulnerable populations including those in Medicaid in their health and health care—must take into careful consideration the unique challenges and barriers experienced by these populations.²³

Frequently experienced challenges Medicaid beneficiaries encounter, include but are not limited to:²⁴

- Limited education
- Limited literacy and health literacy
- Lack of resources
- Access to child care services
- Appropriate transportation
- Unhealthy physical environment
- Chronic stress
- Social exclusion/isolation
- Survival mentality
- Physical and mental capacity
- Health care professionals lack of cultural sensitivity toward low-income, diverse populations

Framework for Observations and Recommendations

The lexicon that encompasses person- and family-centered care is multidimensional, multi-layered, and expands across a continuum of engagement.²⁵ The term is also used synonymously with *patient engagement* and *patient activation*, which are related concepts but do not have an identical meaning. To help clarify the committee’s work, these concepts first need to be defined to avoid confusion and increase comprehension.

Person- and Family-Centered Care

Person- and family-centered care^D is an approach to the planning, delivery and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, individuals, families and communities. It redefines the relationships in health care by placing an emphasis on collaboration with individuals and families of all ages, at all levels of care, and in all settings—shifting from the traditional approach of “*doing to and for*” them to partnering “*with*” them.²⁶ It acknowledges that individuals and families are essential allies for quality and safety within any health care setting. Person-and family-centered care also acknowledges that emotional, social, and developmental supports are integral components of health care. It

^D The Committee adapted the term “patient- and family-centered care” to use the word “person” or in lieu of “patient,” in keeping with our approach of using person first language when possible and appropriate. The definition is from the Institute for Patient- and Family-Centered Care.

promotes the health and well-being of individuals and families and restores dignity and control to them.

Person and family-centered care offers a new framework for bringing about transformational change to health care by shaping policies, programs, facility design, provider and organizational culture, and staff day-to-day interactions.²⁷ It leads to better health outcomes, improved patient satisfaction, quality of care, improved allocation of resources, while reducing health care costs and disparities in health care.²⁸

“Research has shown that patient- and family-centered care that incorporates shared decision-making can reap potential healthcare savings of \$9 billion over 10 years.”

Commonwealth Fund 2013

The core concepts of person- and family-centered care are:

- *Respect and Dignity*: Health care providers invite, listen to and honor individual and family perspectives and choices. Individual and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
- *Information Sharing*: Health care providers communicate and share complete and unbiased information with individuals and families in ways that are affirming and useful. Individuals and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
- *Participation*: Individuals and families are encouraged and supported in participating in care and decision-making at the level they choose.
- *Collaboration*: Individuals and families are also included on an institution-wide basis. Health care leaders collaborate with individuals and families in policy and program development, implementation, and evaluation; in health care facility design; and in professional education, as well as in the delivery of care.

Person- and family-centered care and cultural competence are inextricably linked. Respect for the beliefs, values, practices, preferences, needs and approaches to decision-making for individuals and families from diverse cultures and backgrounds are an essential aspect of person- and family-centered practice.²⁹

Individual Engagement and Activation

The term “patient engagement” encompasses patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system—direct care, organizational design and governance, and policy-making—to improve health and health care.³⁰ Furthermore, engagement activities range along a continuum, from consultation to partnership with the willingness and ability of patients to engage being affected by multiple factors.³¹

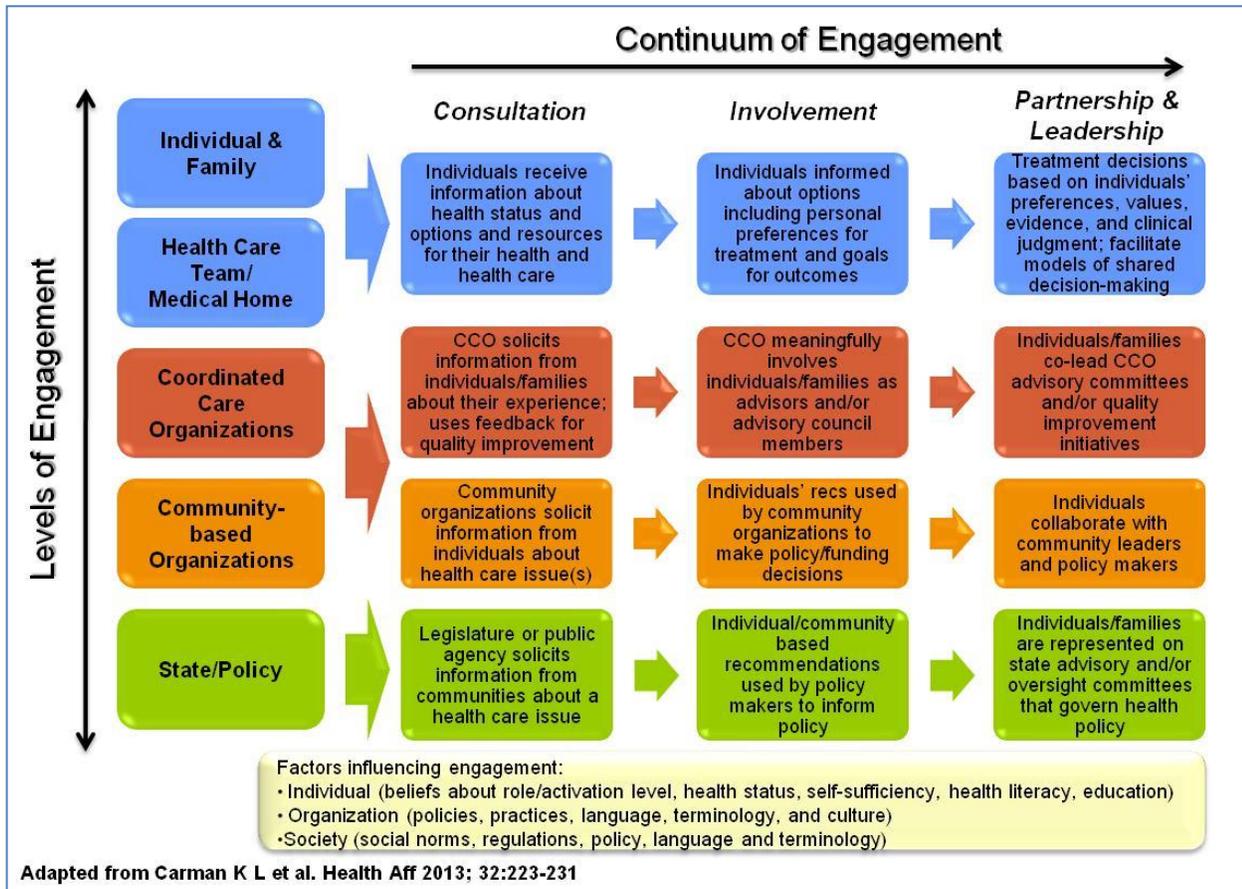
There is a growing body of research that indicates individuals who are more engaged, experience better health outcomes and help control health care costs.³² This is particularly the case when services and supports are person- and family-centered. Meaning they are respectful of and responsive to individual and family preferences, needs, and values, and ensuring that individual values guide all clinical decisions. Research consistently finds that those who are more activated are more likely to:³³

- Engage in preventive behaviors
- Engage in healthy behaviors
- Avoid health damaging-behaviors
- Engage in more disease specific self-management behaviors
- Engage in more health information seeking behaviors

Another important concept is patient activation, which refers to an individual's knowledge, skills, ability and willingness to manage his or her own health and health care.³⁴ Activation differs from compliance, where the emphasis is on getting individuals to follow medical advice. Individuals who are more activated have better health outcomes and experience of care. Activation is one aspect of an individual's capacity to engage in his or her own health. This term, however, does not address an individual's external context, nor does it focus on behavior.³⁵ (*Please see *Appendix B* on pg. 19 for additional information on evidence-based tools related to engagement, activation, and shared-decision making.)

The Committee adapted a multidimensional framework for patient engagement, developed by Carman et al. (2013), that reflects the Oregon context. See Figure 1 on the following page. Activities along the continuum of engagement remain the same, but the levels of engagement were modified to reflect the specific actors in Oregon's health care environment: individuals and their families; health care teams, including providers, front-office staff, non-traditional health workers, etc.; the medical home; CCOs; community-based organizations; and finally, state governance and policy.

Figure 1: Multidimensional Framework for Individual and Family Engagement



Committee Process and Rationale

Recognizing the importance of OHP members' willingness and ability to engage in, participate, and manage their own health and health care, the Committee spent six months (January-June 2013) exploring a range of strategies to support this goal. The process comprised of an extensive review of research and hearing from a diverse range of stakeholders and national experts on approaches and experiences from both commercial and state Medicaid programs. (*Please see *Appendix A* on pg. 18 for a full list of invited experts that presented to the Committee.)

The Committee determined that strategies focused on cost-sharing or the use of financial incentives and disincentives could have negative or unintended effects for OHP members. Furthermore, there is limited evidence that supports the effectiveness of such approaches in Medicaid, which are restricted by federal law, and are summarized in the next section.

The proposed strategies, important to improving health outcomes among less advantaged Oregonians, are presented as a framework for enhancing policies and interventions aimed at supporting person- and family-engagement at all levels of Oregon's Health System Transformation.³⁶ The actions are designed, specifically, to address the diverse background and complex health care needs of current and future OHP members.

The committee's overall deliberation process and key steps are summarized as follows:

- Examined a broad range of strategies designed to encourage individuals to take ownership of their health and health care by promoting personal responsibility and quality- and cost-conscious decision-making.
- Recognized even nominal cost-sharing including premiums and co-pays can serve as a barrier to accessing necessary preventive and primary care services for low-income, vulnerable populations.
- Reviewed available research from state Medicaid incentive programs that use a variety of approaches, including financial and non-financial incentives, to promote healthy behavior and appropriate utilization of health care among their members.
- Concluded there is insufficient evidence on the efficacy and cost-effectiveness of incentive based approaches within state Medicaid programs.
- Focused on innovative approaches designed to improve individual engagement and accountability for one's own health, using person- and family-centered approaches to care and engagement.
- Adopted a set of strategies and actions to enhance alignment, coordination and create synergy among person- and family- centered care efforts already underway through Oregon's Health System Transformation.

Key Considerations: What's the Evidence?

The Committee gathered input from a diverse group of stakeholders and representatives from various agencies within the Oregon Health Authority that included Addictions and Mental Health Division, Division of Public Health, and the Office of Equity and Inclusion, local and national experts on patient engagement and activation, non-traditional and community-based health workers, providers, and officials with Florida's Medicaid Program. The committee was provided with peer-reviewed articles on national and state-level patient engagement activities, evidence-based strategies, and relevant literature highlighting available research. Information shared by the stakeholders as well as current research informed the set of strategies developed by the MAC for consideration by the Oregon Health Policy Board (OHPB).

Consumer-Directed Health Care and Cost-Sharing

The Committee began its work by examining strategies designed to encourage individuals to take ownership of their health and health care by promoting personal responsibility and quality- and cost-conscious decision-making. Starting with the commercial market, the Committee reviewed consumer-directed approaches that use mechanisms focused on benefit design and the use of financial levers to urge individuals to make more cost-sensitive decisions. A common form of this approach is a health savings account linked with a high deductible health plan. Proponents of this approach believe that a consumer in control of, and at greater risk for, his or her health care costs will be better engaged, and may make more appropriate health and health care utilization

decisions.³⁷ While such approaches originated in the commercial and Medicare market, state Medicaid programs have started to experiment with these approaches. [See next section for more information.]

Policy approaches reviewed by the Committee related to consumer-directed health care in the context of Medicaid programs include:³⁸

- Allocation of control over Medicaid funds to recipients – Medicaid recipients have greater exposure to the cost of their health care, which is believed to promote more cost-effective utilization decisions.
- Provision of financial and non-financial incentives for engaging individuals in healthy behaviors, chronic disease self-management programs, and cost-effective health care utilization.
- Requirements of beneficiaries to make financial contributions to care – require cost-sharing at nominal (\$3-5) or substantive levels.
- Removal of barriers to high value care – individuals receive more high value, appropriate health care.
- Provision of assistance with decision support – provide individuals in Medicaid support, information, education and advice, facilitating informed choices they make related to their health and health care and assisting them to implement healthy lifestyle choices.
- Offering incentives to individuals to use “Centers of Excellence” providers shown to provide quality care at reasonable cost.

Early in the Committee’s process, and informed by its previous work in developing the recommended Essential Health Benefit Benchmark Plan for Oregon’s Medicaid expansion population(s), the MAC understood that even nominal cost-sharing, including premiums and co-pays can serve as a barrier to accessing necessary preventive and primary care services for low-income, vulnerable populations. Furthermore, evidence indicates that nominal cost-sharing can lead to unintended consequences such as increased use of the emergency department after delaying care.^{39,40} Past experience in Oregon and in other states have demonstrated that implementing cost-sharing in Medicaid is complex and administratively burdensome, and costs can often outweigh anticipated state savings.⁴¹ Federal law also imposes strict cost-sharing limitations and benefit design requirements for all Medicaid populations. Thus, federal requirements currently restrict the use of certain consumer-directed health care approaches in Oregon’s current health care environment.⁴²

Medicaid Incentive Programs to Encourage Healthy Behavior

Subsequently, the Committee reviewed information from state Medicaid incentive programs that use a variety of approaches, including financial and non-financial incentives, to promote healthy behavior and appropriate utilization of health care among their members. Several state Medicaid programs are offering economic rewards (i.e. financial incentives) for healthy behavior based on the assumption that financial incentives will improve the health of individuals enrolled in Medicaid and help control health care costs. A key challenge is to incentivize individuals to modify unhealthy behaviors and maintain those modified behaviors over the long-term.

According to a 2011 report, commissioned by CMS, a panel of national experts recommended that states consider adopting a broad definition of “incentive” (p. 3). The notion of incentives in terms of person- and family-centered care should surpass providing financial incentives or money to Medicaid beneficiaries for certain health promotion behaviors.⁴³

According to the report, incentives can include but are not limited to:⁴⁴

- Waiving premiums, deductibles, coinsurance payments for participation in health improvement programs and activities or achieving certain positive health outcomes;
- Reimbursement for community-based programs designed to target behaviors of interest (e.g. paying for physical activity classes, completion of a certified smoking cessation program, or paying for Weight Watchers);
- Transportation to and from medical appointments; and
- Gasoline debit cards or phone cards.

The report also recommends that states consider a tiered incentive approach to participation in programs in an effort to sustain behavior changes over the long-term, especially in the areas of physical activity, nutrition, and smoking cessation. For example:

- Engaging in counseling aimed at teaching individuals how to quit smoking, attempts at behavior change (e.g., completing a smoking cessation program), actual behavior change (e.g., not smoking one week after completing the program), and finally achievement of health goals (e.g., remaining “quit” after 6 months).
- Rewarding appointments with providers to discuss health improvement goals, making attempts to improve behavior (e.g., becoming more physically active, eating a more nutritious diet), and finally attaining a behavior change goal (e.g., losing weight, lowering cholesterol levels).⁴⁵

When considering a broad definition of “incentive,” the report asserts a “penalty” or “stick” approach to incentives is counterproductive.⁴⁶ Based on review of available evidence, individuals, generally, respond better to a “rewards” program instead of a program perceived to be punitive in nature. Another policy issue is ensuring that any “incentive” program is responsive to the needs of a particular community including ensuring available resources and programs. The report concluded by raising the issue around individuals with co-morbidities who often have limited ability and resources to engage in health improvement programs outside the medical system.⁴⁷

The most frequently cited Medicaid incentive based programs are Florida’s Enhanced Benefits Reward\$ Program, Idaho’s Preventive Health Assistance program and West Virginia’s Mountain Health Choices Program. (*Please see *Appendix C* on pg. 21 for additional information on state Medicaid programs.)

Lessons learned by examining findings from these states indicate that program effectiveness would be improved by:

- Addressing lack of program awareness, perceived need for insurance, and misconceptions about program eligibility due to historic lack of eligibility for coverage, particularly among low-income adults, all served as barriers to enrollment.
- Educating Medicaid beneficiaries about new initiatives can be challenging due to the low literacy and health literacy levels of the population, and the difficulty of reaching them through traditional communication channels, such as phone, mail and email.^{48,49,50}
- Ensuring that the behaviors tracked are relevant. While it is easier to track wellness visits than lifestyle behavior changes, lifestyle behavior changes offer the greatest potential for Medicaid savings. States have yet to identify effective systems to track recipients' engagement in these behaviors and it is more administratively burdensome to do so.
- Addressing recipients' barriers to engaging in healthy behaviors by design programs to help beneficiaries overcome barriers, such as transportation or cost to participate in sports and exercise programs.

Current Experiments with Incentives for Medicaid Recipients

There is limited evidence to date on the impact and cost-effectiveness of such approaches within state Medicaid programs.⁵¹ This may change soon due to the Affordable Care Act's (ACA) section 4108 that provides an opportunity to test the effectiveness of incentives in engaging Medicaid enrollees in preventive health behavior and improving clinical outcomes. In September 2011, CMS awarded 10 states \$85 million over five years to design, implement, and evaluate Medicaid incentive programs. Key goals of the ACA's section 4108 include: increasing tobacco cessation, controlling or reducing weight, lowering cholesterol and blood pressure, and preventing the onset of diabetes or improving diabetes management. [*See *Appendix D* on pg. 25 for a complete list of the 10 grants including key characteristics.]

Based on a broad definition of "incentive" as described including provisions in the ACA designed to encourage behavior modification, states may also be interested in programs that aim to:

- Create healthier school environments, including increasing healthy food options, physical activity opportunities, promotion of health lifestyle, emotional wellness, prevention curricula, and activities to prevent chronic diseases;
- Create infrastructure to support active living and access to nutritious foods in a safe environment;
- Develop and promote programs to increase access to nutrition, physical activity and smoking cessation, enhance safety in a community;
- Assess and implement worksite wellness programs and incentives;
- Work to highlight health options at restaurants and other food venues;
- Address special population needs, including all age groups and individuals with disabilities, and individuals in urban and rural areas.

The federal opportunity highlights the importance of rigorous evaluation for each of the 2011 Medicaid incentive state programs. Early findings from these programs indicate that Medicaid incentive programs should be better designed so that enrollees can understand them and incentives are attractive enough to motivate participation. Ideally, each of the ten states will address central questions about the relationship between reward magnitude and effectiveness.⁵² Collectively, these efforts will help determine the degree to which incentive programs change health behavior, improve related health outcomes and are cost-effective within Medicaid programs. The Committee recommends tracking these efforts overtime to inform future work in Oregon that may consider the use incentives within OHP to improve health in a cost-effective manner.

Conclusion

Individuals who are more highly engaged and activated are less likely to have unmet medical needs; more likely to have regular check-ups, including screenings and immunizations; adhere to treatment and obtain regular chronic care; and, engage in health behaviors such as eating a healthy diet, regular exercise, and avoid adverse behaviors such as smoking and illegal drug use.^{53,54,55,56,57} This is particularly the case when services and supports are tailored to their individual needs, goals, preferences and circumstances.⁵⁸ The Committee believes that such innovative approaches, designed to improve individual engagement and accountability for one's own health in a person-and family-centered health system, will ultimately support the achievement of Oregon's three-part aim for all Oregonians.

Recommendations in Full

The recommended policy strategies seek to enhance alignment, coordination and create synergy among person- and family-centered efforts already underway through Oregon's Health System Transformation. The key is to effectively and equitably engage individuals and their families across all levels of the health system. Paramount to this is addressing the unique barriers and challenges experienced among OHP members. The continuum of person- and family-centered engagement in care is characterized across three levels: (1) direct patient care and partnership(s), (2) integration of patients' values in the design and governance of health care organizations, and (3) shared leadership and policy making that's responsive to patients' perspectives.⁵⁹

The MAC envisions a number of key actors that could help adopt and implement these strategies. Key partners include members of the OHP and their families and/or representatives; providers and practices, especially those in recognized, patient-centered primary care homes; the Patient-Centered Primary Care Institute (PCPCI); Coordinated Care Organizations (CCOs) and their community partners; the Oregon Health Authority and its Transformation Center, in addition partners such as Cover Oregon, health professional associations, and other stakeholders.

According to Carmen et al. (2013), it is difficult to "develop interventions at one level, such as direct care, when supports are needed at the levels of organization design and governance and of policy making to increase those interventions' effectiveness" (p. 227). The set of strategies and actions described below were developed based on available evidence and designed to target all three levels of the continuum. Ultimately, the strategies and actions recognize the new roles of health care professionals, policy makers, and individuals and families in working towards creating an accountable high-performance health system that *meaningfully* and *effectively* engages OHP members.

Strategy #1: OHP members provide information to providers and the OHA about how to effectively address barriers to individual and family engagement and improve the health system.

Rationale: To better understand how best to support individuals' efforts to participate in their health, there is a need to systematically and regularly collect information from OHP members on their level of engagement in their health and health care, their experience of care and satisfaction. This will identify specific opportunities, facilitators, and barriers for individuals to improve and maintain their health. The goal is to solicit information and understand members' barriers to accessing care, ability for self-management, and fostering shared responsibility for health.

- Action: Providers routinely and consistently engage OHP members and their families as key partners and participants in the health care process by providing timely, complete, unbiased and understandable information in accessible and

appropriate formats on health conditions and treatment options, taking into account cultural, linguistic, and age appropriate factors.

- Action: Practices recognize and utilize members' experiences through outreach efforts including surveys, focus and advisory groups, and social media to guide practice level improvement.
- Action: OHP members and families directly partner with care teams, non-traditional health care workers, and community-based organizations to access and engage in community-based self-management programs.
- Action: OHA coordinates and aligns use of patient satisfaction and experience of care surveys statewide to address such things as purchasing strategies to assist practices and CCOs, preferred survey types (e.g. Picker, Press Ganey; HCAHPS, CG, & PCMH), use of benchmarks, survey timelines and redundancies with administration, and public reporting of information.

Strategy #2: Ensure ongoing education and training on evidence-based best practices for person- and family-centered engagement in health and health care.

Rationale: To fully support OHP members and their families in their own health and health care, practices and health care professionals, including community-based organizations, require education and sustained training in this arena. Such efforts should focus on effective use of techniques and best practices that create opportunities for individuals to make informed decisions and support health improvement of OHP members in their communities across Oregon.

- Action: Practices and providers receive regular and ongoing education and training from technical experts such as the Patient-Centered Primary Care Institute (PCPCI) and other learning forums on approaches to support person- and family-centered care. Examples include use of the Patient Activation Measure (PAM), shared decision-making and the use of decision aids, how to address low literacy and health literacy skills, and support for community-based self-management and wellness programs.
- Action: CCOs receive ongoing training and technical assistance from the OHA Transformation Center on how to work with practices to implement use of patient level data to inform practice and system level improvements.

Strategy #3: Leverage resources that support evidence-based best practices for person- and family-centered engagement and activation in health and health care.

Rationale: The Committee concluded that several evidence-based tools that would be helpful to sustain practice-level engagement efforts might not be affordable, individually, particularly for resource-limited small or rural practices.

- Action: PCPCI develop and disseminate practice-level tools for providers to routinely ask members and their families about their values, needs, knowledge, preferences and circumstances in culturally and linguistically appropriate ways.

This will allow greater member feedback to be integrated into individually tailored and appropriate care plans.

- **Action:** OHA should work with CCOs and their delivery system partners to achieve economies of scale in order to make evidence-based tools more affordable and available to practices of all sizes throughout the state such as:
 - Patient Activation Measure (PAM)** or other evidence-based activation measurement tool(s), to assess the skills and readiness of the individuals for engagement. Results can be used to determine the appropriate levels of intervention and allocation of resources. For example, a patient with complex and chronic health needs and low activation level may need the most intense interventions and resources versus someone with low acuity and a high level of activation.
 - Shared Decision Making tools that are evidenced based, to engage individuals and their families about discrete health conditions and support medical decisions by providing information, helpful strategies, and other supports.
- **Action:** OHA works with community stakeholders to develop a sustainable system for evidence-based self-management program delivery and financing to ensure broader availability of community-based programs, such as Living Well with Chronic Conditions, across the state. The work should ensure linkages with PCPCHs and CCOs to the extent possible, working with the PCPCI and through the OHA Transformation Center to coordinate and align resources, provide targeted technical assistance and learning collaboratives.

Strategy #4: Create opportunities across all levels of the health system to support OHP members as integral partners in Oregon’s Health System Transformation.

Rationale: A comprehensive person- and family-centered transformed health system will need to encompass patients, families, their representatives, health professionals, and community partners working in active partnership at various levels across the system—direct care, organizational design and governance, and policy making—to improve members’ health and health care.

- **Action:** CCOs systematically and meaningfully engage representatives of diverse populations (including but not limited to cultural, language and age considerations) and community stakeholders to develop their community health assessments (CHAs) and community health improvement plans (CHIPs). For example, OHA should work closely with CCOs and their Community Advisory Councils to ensure the resources and support of person- and family-centered care strategies are available to foster the needs and primary goals of the members and community served by their CCO.
- **Action:** OHP members and their families serve as “equal and active partners” by fostering meaningfully and sustained participation in CCO advisory panels,

** The Patient Activation Measure® (PAM®) assessment gauges the knowledge, skills and confidence essential to managing one’s own health and health care.

provider/practice level advisory groups, and in local and state committees, councils, and boards, as OHP member advocates.

Strategy #5: Coordinate the adoption and spread of evidence-based best practices for person- and family-centered engagement in health and health care.

Rationale: Critical to this effort will be the promotion and alignment of multi-payer approaches to increase spread across provider practices and communities. OHA should work to ensure coordination and alignment of person- and family-centered models of care across the OHA, including CCOs, Public Employees' Benefit Board (PEBB), Oregon Educators Benefit Board (OEBB), the PCPCH Program, Cover Oregon and other payers. The goal is for OHA to leverage resources and activities statewide to disseminate best practices appropriate for OHP members and their families.

- Action: OHA should incentivize and disseminate the use of evidence-based best-practices for person- and family-care models of care that are sensitive to and account for the needs of diverse communities. This may be accomplished through the OHA Transformation Center coordinating with Innovator Agents, CCOs, regional learning collaboratives, and recognized PCPCHs to incentivize and disseminate the use of evidence-based best-practices for person- and family-centered models of care that are sensitive to and account for the needs of diverse communities.
- Action: OHA works with CCOs to increase the number of recognized PCPCH practices; modify existing PCPCH Standards to support robust person- and family-centered care and engagement models; and consider alternative payment methodologies to incentivize practices with resources to adopt and sustain patient engagement activities.

Appendices

Appendix A: List of Invited Presenters and Experts

Cara Biddlecom, MPH, Public Health Division, OHA

Bill Bouska, Innovator Agent, OHA Transformation Center

Bryant Campbell, PEBB Member

R. Paul Duncan, PhD, Florida Medicaid Reform Evaluation Team

Danna Drum, Public Health Division, OHA

L.J. Fagnan, MD, Executive Director, Oregon Rural Practice-Based Research Network (ORPRN)

Judith H. Hibbard, DrPH, Institute for Policy Research and Innovation, University of Oregon

Mary Minniti, CPHQ, Program and Resource Specialist, Institute for Patient- and Family-Centered Care

Michael Morris, MS, Administrator, Addictions and Mental Health Division, OHA

Kelly Volkman, RN, MPH, Health Navigation Program Manager, Benton County Health Services

Julie Wu, Office of Equity and Inclusion, OHA

Appendix B: Evidence Based Tools

Tool	Description
Patient Activation Measure	<p>The Patient Activation Measure (PAM) is a tool for measuring the level of an individual’s capacity to manage his or her own health and health care. PAM is assessed through a series of answers to questions that gauge a person’s self-concept as a manager of his or her health and health care. The measure is scored on a 0-100 scale, and people are categorized into four levels of activation, with level 1 the least activated and level 4 the most activated. The score incorporates responses to 13 statements about beliefs, confidence in managing health related tasks, and self-assessed knowledge. The measure has been proven to be reliable and valid across different languages, cultures, demographic groups, and health statuses.^f</p> <p><i>For more information on activation and PAM see:</i> http://www.insigniahealth.com/solutions/patient-activation-measure</p>
Shared Decision-Making	<p>Shared decision-making occurs when provider and individuals exchange important information: providers help individuals understand medical evidence about the decisions they are facing, and individuals help providers understand their needs, values, and preferences concerning these decisions.^{g,h} Then, ideally after allowing time for reflection, individuals and providers decide together on a care plan consistent with medical science and personalized to each individual’s needs, values, and preferences.ⁱ</p> <p><i>For more information on shared decision-making and decision aids see:</i> http://sdmtoolkit.org/</p>
Health Literacy	<p>Improving health outcomes relies on patients’ full engagement in prevention, decision-making, and self-management activities. Health literacy, or “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions”^j is essential to those actions. However, relatively few Americans are proficient in understanding and acting on available health information.^k Health literacy has also been described as “a shared function of social and individual factors such as education, culture, and language. Additionally, health care providers need to have strong communication and assessment skills, as do the media, the marketplace, and government agencies—to provide health information in a manner appropriate to the</p>

^f Hibbard, J. and Greene, J. What the Evidence Shows About Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs. *Health Affairs*, 32, No.2 (2013):207-214.

^g Fowler, F., Levin, C., and Sepucha, K. Informing And Involving Patients To Improve The Quality Of Medical Decisions. *Health Affairs*, Vol. 30, No. 4 (2011): 699–706.

^h Charles C., Gafni A., & Whelan T. Shared Decision-Making in The Medical Encounter: What Does It Mean? (Or It Takes At Least Two To Tango). *Soc Sci Med*, Vol. 44, No. 5 (1997):681–92.

ⁱ Friedberg, M., et al. A Demonstration of Shared Decision-Making In Primary Care Highlights Barriers To Adoption And Potential Remedies. *Health Affairs*, Vol. 32, No. 2 (2013): 268-275.

^j Ratzan, S. and Parker, R. Introduction. Selden, C., Zorn, M., Ratzan, S., Parker, R., Editors. In: National Libraries of Medicine Current Bibliographies in Medicine: Health Literacy. Vol. NLM No. CBM 2000-1. Bethesda, MD: National Institutes of Health, U.S. Department of Health and Human Services.

^k Kutner, M., Greenberg, E. Jin, Y., and Paulsen, C. The Health Literacy of America’s Adults: Results From The 2003 National Assessment Of Adult Literacy. Washington (DC): *National Center for Educational Statistics*; 2006 Sep.

Tool	Description
	<p>intended audience. The complexity of the health care system and the way patients experience it contribute to the difficulty of being health literate. Addressing health literacy is no less daunting than the task of addressing disparities.”^l</p> <p><i>For more information on health literacy see:</i> http://content.healthaffairs.org/content/32/2/357.abstract</p>
<p>Self-management</p>	<p>Self-management is a core requirement for person- and family-centered care. Individuals are empowered through education and information that help them to navigate the delivery system and seek appropriate and timely care.⁶⁰ The available evidence is relatively strong and suggests that expanding education and self-management support can be beneficial towards improving patient care outcomes and patient satisfaction at all levels of the delivery system.⁶¹ For example, self-management leads to improved health outcomes and reduced hospitalizations for patients with chronic disease; self-management also results in better adherence to medications and improved chronic disease control without incurring higher costs.^m</p> <p>The Oregon Health Authority and the Department of Human Services support several evidence-based self-management programs. The programs are also considered evidence-based by the US Centers for Disease Control and Prevention and/or the Administration on Aging. These programs provide individuals with the tools and connect them to resources to support self-and family-management or case management on a variety of issues such as nutrition, fitness, tobacco cessation, chronic health conditions, fall prevention, family violence, suicide prevention, and care transitions.</p> <p><i>For more information on community-based self-management programs see:</i> http://public.health.oregon.gov/PreventionWellness/SelfManagement/Pages/index.aspx</p>

^l IOM (Institute of Medicine). 2009. *Toward Health Equity and Patient-Centeredness: Integrating Health Literacy, Disparities Reduction, and Quality Improvement: Workshop Summary*. Washington, DC: The National Academies Press.

^m Epstein, M. A Review of Self-Management Interventions Targeting Academic Outcomes for Students with Emotional and Behavioral Disorders. *Journal of Behavioral Education*, Vol. 14, No. 3 (2005): 203-221.

Appendix C: Medicaid Programs Designed to Increase Individual Engagement and Personal Responsibility

Characteristics of Healthy Indiana Plan (HIP)	
Characteristics	Details
Authority	<ul style="list-style-type: none"> State legislation; CMS 1115 Medicaid Demonstration Waiver (2008-2012)
Start date	<ul style="list-style-type: none"> January 1, 2008
Financing	<ul style="list-style-type: none"> Increased cigarette tax As a Medicaid waiver, the program is eligible for federal matching funds but must be budget neutral to the federal government.
Eligibility and Enrollment	<ul style="list-style-type: none"> Adults 19-64 years of age. Parents and caretaker relatives between 22%-200% FPL. Adults without children up to and including 200% FPL. Individuals above 200% FPL who are uninsured for six-months and do not have access to ESI are allowed to purchase the plan at full cost.⁶²
Goals	Put program enrollees in greater control of and at greater risk for his or her health care costs to promote engagement and more appropriate health and health care utilization decisions.
Coverage	<ul style="list-style-type: none"> Coverage for <u>preventive services</u> up to \$500 a year at no cost to participants. A <u>high deductible health plan</u> that covered state-specified benefits up to \$300,000 per year or \$1 million of lifetime expenses, with no cost-sharing after the \$1,100 deductible was met.ⁿ A <u>POWER account</u> valued at \$1,100 to pay for the deductible, available in full to the member after his or her first contribution was made. A <u>POWER Account “Roll Over”</u> for HIP enrollees who met all of their preventive service requirements, the entire remaining balance of their POWER account rolled over to the following year, reducing the required contribution for that year. For enrollees who did not meet the preventive service requirements, only the individual’s portion, based on his or her percent contribution, rolled over.
Cost-sharing	<ul style="list-style-type: none"> <u>POWER Account Monthly Contributions</u> were made by enrollees on a sliding scale, from 2%-5% of income,^o and could be reduced by payments from an enrollee’s employer.^p The State and the federal government subsidized the remaining amount at the state’s regular match rate. <u>Co-pays</u> of \$3-\$25 were required for all nonemergent use of the emergency department.^q
Results	Results from the first three years of the demonstration show HIP had served a total of 77,466 members; 87% of those eligible made monthly contributions to their POWER Account; established enrollees were more likely to use preventive services, compared to new enrollees: 69% compared to 28%; 94% of members said they were satisfied with HIP and 99% indicated they would re-enroll.
Comments	In order to meet the Affordable Care Act’s Medicaid expansion requirements, HIP would have to add vision, dental and maternity benefits. The enhanced HIP would cost 44% more than traditional Medicaid, totaling \$1.85 billion for 336,500 HIP enrollees during the first full year of the expansion. It is undetermined whether CMS will approve HIP as the coverage vehicle for Indiana’s Medicaid expansion populations in 2014.

ⁿ HIP’s benefits differ from those offered through the Medicaid state plan as it does not provide coverage for maternity services, vision or dental services, and has annual and lifetime benefits.

^o HIP policy requires that individuals make their monthly contributions within 60 days or face expulsion from the program for 12 months.

^p While these employers did not offer health insurance to their employees their contributions supported “the program’s goals to provide affordable consumer directed coverage.” Employers are also allowed to contribute up to 50% of the required contribution.

^q The copayment for caretakers is \$3 to \$25, depending on income, and is \$25 for non-caretakers regardless of income.

Appendix C: Medicaid Programs Designed to Increase Individual Engagement and Personal Responsibility

Characteristics of Florida's Enhanced Benefits Reward\$ Program	
Characteristics	Details
Authority	Florida's Agency for Health Care Administration's (AHCA), the agency responsible for the administration of its Medicaid program received approval to implement a CMS 1115 Research and Demonstration Waiver in Oct. 2005; the Legislature approved implementation of the waiver in Dec. 2005.
Start date	Began pilot program in Broward and Duval counties in September 2006; and expanded to Baker, Clay, and Nassau counties in September 2007.
Financing	AHCA assesses 2% of the monthly risk-adjusted capitated rate paid to each health maintenance organizations (HMOs) participating in the demonstration.
Eligibility and Enrollment	Medicaid beneficiaries in five pilot counties; required groups include disabled beneficiaries receiving Supplemental Security Income (SSI), parents, and children; other beneficiaries could participate on a voluntary basis. All Medicaid beneficiaries were automatically enrolled in the program and sent information after they chose a health plan.
Goals	Providing incentives (credits) for people to engage in healthy behavior
Target behavior	Receiving routine checkups, immunizations, and cancer screening; attending health appointments; adhering to medication regimens; and participating in programs for tobacco cessation, weight loss, diabetes
Incentive magnitude	\$7.50–\$25 per payment, \$125 per year maximum
Incentive type	<ul style="list-style-type: none"> • Credits are earned for specific health care utilization and wellness and prevention visits outside of a clinical setting • Credits are used to purchase approved health-related products and supplies at a Medicaid participating pharmacy (using Medicaid gold card or Medicaid ID number and government issued photo ID) • Credits may be carried over but if the enrollee loses Medicaid eligibility for one year, all credits are forfeited
Results	Since implementation of the program in Sept. 2006 through June 30, 2012, a total of 499,209 recipients have earned \$53.8M in credits; just over half redeemed; majority of credits earned were for childhood preventive care (45%) or adult/child office visits (25%), with <1% earned for participating in weight loss or tobacco cessation programs; lack of participation in programs that decrease chronic disease. ^f
Comments	Compliance, participation, success poorly defined; majority of credits (81%) earned by keeping routine physician visits and/or immunizations; < 1% earned for participating in a disease management program; none were earned for participating in other types of health improvement activities; analysis of program noted that most behaviors would have taken place in the absence of the program; ^g credit redemption rate of 50% suggests that credit amounts were too small and not salient to beneficiaries, or that participants had insufficient knowledge of program; qualitative interviews with health plans participating in the EBR program indicated that the program emphasized passive, more routine behaviors, rather than active behaviors requiring lifestyle changes. ^h

^f Florida Medicaid Reform: Year 6 Annual Report (July 1, 2011 – June 30, 2012). 1115 Research and Demonstration Waiver. Florida Agency for Health Care Administration.

^g Medicaid Reform: Beneficiaries Earn Enhanced Benefits Credits But Spend Only a Small Proportion. OPPAGA. July 2008.

^h Duncan, P. Florida's Enhanced Benefits Reward\$ Program. Presentation to the Oregon Medicaid Advisory Committee. January 23, 2013.

Appendix C: Medicaid Programs Designed to Increase Individual Engagement and Personal Responsibility

Characteristics of Idaho's Preventive Health Assistance (PHA) Benefits Program ^{u,v}		
Details		
Characteristics	Behavioral PHA	Wellness PHA
Authority	Two State Plan Amendments; authority granted under the Deficit Reduction Act of 2005	Amendment to the state's Children's Health Insurance Program
Start date	January 2007	
Financing	Unpublished	Unpublished
Eligibility and Enrollment	<p>Adult Medicaid beneficiaries are sent a health questionnaire at the time of initial Medicaid eligibility determination and annually thereafter; each beneficiary may only participate in one program at a time and may participate in the:</p> <ul style="list-style-type: none"> • Tobacco cessation program if questionnaire indicates the individual or their child wants to quit using tobacco; or the • Weight management program if questionnaire indicates the individual or their child (> age 5) has a Body Mass Index in the obese or underweight range, and wants to improve their health through weight management. 	Children in families with income between 134-185% FPL, who are also required to pay monthly premiums
Goals	Promoting healthy behavior	Promoting child wellness with financial premium support for child's CHIP coverage.
Target behavior	Weight management and tobacco cessation	Staying up-to-date on well-child visits
Incentive magnitude	\$200 maximum in vouchers per beneficiary	10 points per month maximum (equivalent to \$10)
Incentive type	Vouchers for weight management programs or tobacco cessation products	Points exactly offset the \$10/mo. premium for children between 134-149% FPL, and offset two-thirds of the \$15/mo. premium for children between 150-185% FPL
Results	Only 1,422 of the approximately 185,000 beneficiaries participated after 2 years	Significant increase in proportion of CHIP children up-to-date on well-child visits, compared to control
Comments	Limited impact on tobacco cessation and weight management; no data on success.	Children requiring only one annual visit had largest increase in adherence

^uGreene J. Using consumer incentives to increase well-child visits among low-income children. *Med Care Res Rev*, Vol. 68 No. 5. (2011): 579–93.

^v Idaho Department of Health and Welfare. Facts, figures, trends, 2008–2009. Available from: <http://healthandwelfare.idaho.gov/AboutUs/FactsFiguresTrends/tabid/1127/Default.aspx>

Characteristics of West Virginia’s Mountain Health Choices Program ^w	
Characteristics	Details
Authority	State Plan Amendment under the Deficit Reduction Act of 2005
Start date	May 2006
Financing	Regular FMAP
Eligibility and Enrollment	<p>Certain eligibility groups were moved to “Secretary approved” coverage. The affected groups were:</p> <ul style="list-style-type: none"> • Infants with incomes below 150% FPL, • Children age one to six with incomes below 133% FPL, • Children age six to nineteen with incomes below 100% FPL, • Working parents with incomes below 37% FPL, and • Non-working parents with incomes below 19% FPL. <p>To qualify for the enhanced plan, individuals have to sign a member responsibility agreement and enter into a health improvement contract with their physician that includes a wellness plan.</p>
Goals	Providing incentives for people to take more responsibility for their health with a choice between an “enhanced” or “basic” plan. The objective is to steer participants into the lower cost basic plan unless they adhere to behavioral commitments to improve health.
Target behavior	Signing a member responsibility agreement and developing a wellness plan with physician to enroll in enhanced plan, which offers beneficiaries more extensive coverage than the basic plan; adhering to member agreement to maintain coverage under enhanced plan.
Incentive magnitude	Maintaining access to enhanced plan
Incentive type	More extensive coverage, including unlimited prescriptions, tobacco cessation services, diabetes and weight management programs.
Results	Only 10% of eligible adults enrolled in enhanced plan; enhanced plan members were more likely than others to have more doctor visits and take their medications, and to have physicians involved in decision to enroll.
Comments	Criteria for determining adherence and continued eligibility were ambiguous; low-literacy patients at risk of being assigned to basic plan by default.

^w West Virginia Department of Health and Human Resources. Mountain Health Choices. Available from: <http://www.dhhr.wv.gov/bms/mhc/Pages/default.aspx>.

Appendix D: ACA Medicaid Incentives CDC Grants for States

Affordable Care Act: Medicaid Incentives for Prevention of Chronic Diseases Grants (10 states received 5-year grants in 2011)^x

State	Goal	Incentive	Evaluation
California	Tobacco cessation and diabetes management	\$10–20 per activity	Two evaluations: RCT and cost-effectiveness
Connecticut	Tobacco cessation	\$5–15 per activity	Evaluation of the effect of the incentives on smoking cessation rates, receipt of evidence-based smoking cessation treatments, health care use, cost savings, incremental cost-effectiveness
Hawaii	Diabetes prevention, detection, and management	\$20–25 per activity	Pre- versus post-intervention comparison; analysis using non-Medicaid patients with diabetes as control group
Minnesota	Increased weight loss and diabetes prevention, improved cardiovascular health, reduced health care spending	\$10–50 per activity	Prospective group RCT; evaluation of effectiveness of group versus individual incentives; cost-effectiveness evaluation
Montana	Increased weight loss, reduced lipid and blood pressure levels, diabetes prevention	\$320 maximum per Beneficiary	Crossover design will enable evaluation of process and health outcome measures in relation to incentives
New Hampshire	Increased exercise; improved nutrition; modification of risk factors for cardiovascular disease	Unknown	Evaluation using an Equipoise stratified randomization design; cost effectiveness evaluation
New York	Tobacco cessation, hypertension control, diabetes prevention, diabetes self-management	\$250 maximum per beneficiary	Four separate RCTs; evaluation of effectiveness of process versus outcome incentives in each RCT to be conducted by the University of Pennsylvania
Nevada	Increased weight loss, lowered cholesterol and blood pressure, diabetes prevention and management	Unknown	RCT, evaluation of effectiveness to be conducted by the University of Nevada, Reno
Texas	Improved health self management among Medicaid patients with SSI or a mental health or substance abuse diagnosis	\$1,150 maximum (flexible spending account) per beneficiary	Longitudinal RCT; cost-effectiveness evaluation to be conducted by the University of Florida
Wisconsin	Tobacco cessation (with focus on pregnant women)	\$595 maximum for pregnant women, \$350 maximum for other beneficiaries	RCT

NOTES: Incentive values based on publicly reported information. RCT is randomized controlled trial. SSI is Supplemental Security Income.

^x CMS.gov. MIPCD: the states awarded [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services. Available from: <http://innovation.cms.gov/initiatives/MIPCD/MIPCD-The-States-Awarded.html>.

References

- ¹ Carman, K., et al. Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies. *Health Affairs*, Vol. 32, No.2 (2013): 223-231.
- ² Dixon, A., Greene, J., and Hibbard, J. Do Consumer-Directed Health Plans Drive Change In Enrollees' Health Care Behavior? *Health Affairs*, Vol. 27, No. 4 (2008):1120-1131.
- ³ Wright, B., Carlson, M., Smith, J., et al. Impact of Changes to Premiums, Cost-sharing, and Benefits on Adult Medicaid Beneficiaries: Results from an Ongoing Study of the Oregon Health Plan. *Commonwealth Fund*, (July 2005): 22 pages.
- ⁴ Fronstin, P., Sepulveda, M., and Roebuck, M. Consumer-directed Health Plans Reduce the Long-term Use of Outpatient Physician Visits and Prescription Drugs. *Health Affairs*, Vol. 32, No. 6 (2013): 1126-1134.
- ⁵ Bachrach, Deborah. Cost Sharing Requirements and Considerations for Oregon. Presentation to the Medicaid Advisory Committee. October 24, 2012.
- ⁶ Ibid.
- ⁷ Blumenthal, K., et al. Medicaid Incentive Programs to Encourage Health Behavior Show Mixed Results to Date and Should be Studied and Improved. *Health Affairs*, 32, No.3 (2013):497-507.
- ⁸ Hibbard, J. and Greene, J. What the Evidence Shows About Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs. *Health Affairs*, 32, No.2 (2013):207-214.
- ⁹ Carman, K., et al. (2013).
- ¹⁰ Hibbard, J., Mahoney, E., Stock, R., and Tusler, M. Do Increases in Patient Activation Result in Improved Self-Management Behaviors? *Health Services Research*, 42(4), (2007):1443-63.
- ¹¹ Mosen, D., Schmittiel, J., Hibbard, J., et al. Is Patient Activation Associated with Outcomes of Care for Adults with Chronic Conditions? *The Journal of Ambulatory Care Management*, 30(1), (2007):21-9.
- ¹² Gerber, L., Barron, Y., Mongoven, J., McDonald, M., et al: Activation Among Chronically Ill Older Adults with Complex Medical Needs: Challenges to Supporting Effective Self-management. *The Journal of Ambulatory Care Management*, 34(3), (2011): 292-303.
- ¹³ Epstein, R., Fiscella, K., Lesser, C., and Stange, K. Why The Nation Needs A Policy Push On Patient-Centered Health Care. *Health Affairs*, 29, No.8 (2010):1489–1495.
- ¹⁴ Carman, K., et al. (2013).
- ¹⁵ Adler, N. and Newman, K. Socioeconomic Disparities in Health: Pathways and Policies. *Health Affairs*, Vol. 21, No. 2. (March/April 2002): 60-76.
- ¹⁶ McGinnis, J., Williams-Russo, P. and Knickma, J. The Case for More Active Policy Attention to Health Promotion. *Health Affairs*, Vol. 21, No. 2. (March/April 2002):78-93.
- ¹⁷ Lee, P. and Paxman, D. Reinventing Public Health. *Annual Review of Public Health* 18 (1997): 1–35.
- ¹⁸ Mokdad, A., et al. Actual Causes of Death in the United States, 2000. *JAMA*, (2004 Mar 10);291(10):1238-45.
- ¹⁹ Mokdad, A., et al. (2004).
- ²⁰ Blumenthal, K., et al. (2013).

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- ²¹ Crossing The Quality Chasm: A New Health System For The 21st Century. Committee On Quality Of Health Care In America, *Institute of Medicine*. (2001): p.6.
- ²² Mende, S. and Roseman, D. The Aligning Forces for Quality Experience: Lessons on Getting Consumers Involved in Health Care Improvements. *Health Affairs*, Vol. 32 No.6 (2013): 1092-1100.
- ²³ Maree, G. C. Personal Responsibility in Medicaid: Challenges and Opportunities. Legislative Briefing. Topeka, Kansas. February 19, 2009. *Kansas Health Institute*.
- ²⁴ Ibid.
- ²⁵ Carman, K., et al. (2013).
- ²⁶ Minniti, Mary. Successful Examples of Patient Engagement Strategies. Institute of Patient-And Family-Centered Care. *Presentation to the Oregon Medicaid Advisory Committee*, February 27, 2013.
- ²⁷ Epstein, R. Why The Nation Needs A Policy Push On Patient-Centered Health Care. *Health Affairs*, Vol. 29, No. 8 (2010): 1489–1495.
- ²⁸ Epstein, R. et al. (2010).
- ²⁹ Beach, M., Saha, S., and Cooper, L. The Role And Relationship Of Cultural Competence And Patient-Centeredness In Health Care Quality. *The Commonwealth Fund*. October 2006.
- ³⁰ Carman, K., et al. (2013).
- ³¹ Ibid.
- ³² Ibid.
- ³³ Hibbard, J. and Greene, J. (2013).
- ³⁴ Hibbard, J. and Mahoney, E. Toward A Theory Of Patient And Consumer Activation. *Patient Education and Counseling*, Vol. 78, No. 3 (2010):377-81.
- ³⁵ Ibid.
- ³⁶ Carman, K., et al. (2013).
- ³⁷ Dixon, A., Greene, J., and Hibbard, J. Do Consumer-Directed Health Plans Drive Change In Enrollees' Health Care Behavior? *Health Affairs*, Vol. 27, No. 4 (2009): 1120-1131.
- ³⁸ Green, J. Issue Brief: State Approaches to Consumer Direction in Medicaid. *Center for Health Care Strategies, Inc.* July 2007.
- ³⁹ Wright, B., et al. (2005).
- ⁴⁰ Fronstin, P., et al. (2013).
- ⁴¹ Bachrach, Deborah. Cost Sharing Requirements and Considerations for Oregon. Presentation to the Medicaid Advisory Committee. October 24, 2012.
- ⁴² Ibid.
- ⁴³ Thomson Reuters. Guidance Document on Preparing a Solicitation for Section 4108 of the Patient Protection and Affordability Act: Incentives for Prevention of Chronic Diseases in Medicaid. February 2011, pg. 3. Available from: <http://innovation.cms.gov/Files/x/MIPCD-CME-Guidance.pdf>.
- ⁴⁴ Ibid. p. 3.
- ⁴⁵ Ibid. p .4.
- ⁴⁶ Ibid. p. 4.
- ⁴⁷ Ibid. p. 5.
- ⁴⁸ Office of Program Policy Analysis and Government Accountability. Medicaid Reform: Beneficiaries Earn Enhanced Benefit Credits But Spend Only a Small Proportion. Report No. 08-45. July 2008.

-
- ⁴⁹ Alker, J. and Hoadley, J. The Enhanced Benefits Rewards Program: Is it Changing the Way Medicaid Beneficiaries Approach their Health. Jessie Ball DuPont Fund. Briefing #6, July 2008.
- ⁵⁰ Barth, J. and Greene, J. Encouraging Healthy Behaviors in Medicaid: Early Lessons from Florida and Idaho. *Center for Health Care Strategies, Inc.*, July 2007.
- ⁵¹ Blumenthal, K., et al. (2013).
- ⁵² Ibid.
- ⁵³ Hibbard, J. and Greene, J. (2013).
- ⁵⁴ Carman, K., et al. (2013).
- ⁵⁵ Hibbard, J., Mahoney, E., Stock, R., & Tusler, M. (2007). Do Increases in Patient Activation Result in Improved Self-management behaviors? *Health Services Research*, Vol. 42, No. 4 (2007): 1443-63.
- ⁵⁶ Mosen, D., et al. (2007).
- ⁵⁷ Gerber, L., et al. (2011).
- ⁵⁸ Epstein, R., et al. (2010).
- ⁵⁹ Carman, K., et al. (2013).
- ⁶⁰ Epstein, M. A Review of Self-Management Interventions Targeting Academic Outcomes for Students with Emotional and Behavioral Disorders. *Journal of Behavioral Education*, Vol. 14, No. 3 (2005): 203-221.
- ⁶¹ Bodenheimer, T., Lorig, K., Holman, H., Grumbach, K. Patient Self-management of Chronic Disease in Primary Care. *JAMA*. 2002;288 (19):2469-2475.
- ⁶² Healthy Indiana Plan 1115 Waiver Extension App. Indiana Family and Social Services Administration. Submitted 12/28/2011.

REVIEW OF LITERATURE: PATIENT ENGAGEMENT – THE ROLE THAT DISINCENTIVES & INCENTIVES PLAY

SEPTEMBER 2013

PRESENTED TO: Task Force on Individual Responsibility &
Health Engagement (HB2859)

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Review of Literature: Patient Engagement – The Role That Disincentives & Incentives Play

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Review of Literature: Patient Engagement – The Role That Disincentives & Incentives Play

PURPOSE & SCOPE OF WORK

The purpose of this endeavor is to introduce options or mechanisms for patient engagement to the Task Force on Individual Responsibility and Health Engagement with the objective of assisting them in recommending the best strategies to incorporate for Oregon Health Plan members. After a brief overview of the health behavior change science that relates to patient engagement, a review of literature is provided on the role that incentives, disincentives and other evidence-based interventions play, including advantages and efficacy, disadvantages and selected references. This review is not intended to be an exhaustive review of the literature in its entirety nor is it intended to serve as a definitive guide on which options to use.

METHODOLOGY

Research sources included comprehensive searches in Medline, Google Scholar, RAND and Cochrane databases. In addition, the author has access to NIH and CHCS research findings as Primary/Co-Investigator in several research studies. In considering the evidence, more weight was given to comprehensive review articles and well-performed meta-analyses. Research findings from large well-controlled clinical trials are frequently highlighted and, occasionally, innovative or unique research findings/cases from smaller, less well-controlled studies are mentioned. In addition, research studies that targeted Medicaid populations were also given priority. Lastly, in considering lifestyle changes, there is a special focus on presenting smoking cessation efforts that have used engagement strategies, as this is a significant issue for the Medicaid population in Oregon.

GLOSSARY OF TERMS

The following terms are key to understanding and applying the concepts covered in this review:

1. **Complex behavior change:** A behavior that requires sustained change; usually a lifestyle change or treatment adherence¹
2. **Contingent:** Having a cause-and-effect (causal) relationship with the occurrence of something else; conditional; provisional²
3. **Cost-sharing:** Any contribution consumers make towards the cost of their healthcare as defined in their health insurance policy³
4. **Cultural competence:** The acceptance of the value of other perspectives and beliefs, along with the need to accommodate the patient by offering alternative options or modifying procedures⁴

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5. **Disincentive:** Mechanisms such as fees, policies, procedures, rules or taxes that intentionally or unintentionally, directly or indirectly, discourage or prevent desirable or undesirable actions, behavior or decisions²
6. **Health Literacy:** The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions⁴
7. **Incentive:** Inducement or supplemental reward that serves as a motivational device for a desired action or behavior²
8. **Noncontingent:** Not attached with any conditions; not provisional upon anything²
9. **Patient Activation:** The knowledge, skills, beliefs and behaviors that a patient needs to become a successful manager of his or her health and health care⁵
10. **Personal Agency:** The understanding of oneself as an agent who is capable of having an influence over one's own motives, behavior, and possibilities⁴
11. **Self-efficacy:** An individual's confidence in managing his/her health or changing a health habit⁴
12. **Simple behavior change:** A behavior that can be accomplished directly; usually in a single visit or session¹

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INTRODUCTION

Although there are few more timely topics in health care today, patient engagement has not been well-defined or measured and involves numerous patient behaviors, depending on the stakeholder's interest. For the limited scope of this paper, per the framework suggested by Gruman et al.¹, patient engagement can be divided into two distinct sets of behaviors: (1) actively managing or navigating the health care system; and (2) actively managing one's own health. However, Carmen et al.⁶ make a compelling case that we need to expand our scope to include both patient and family engagement in a multidimensional framework that occurs across the health care system, from the direct care setting to incorporating patient engagement into organizational design, governance and policy making. Moreover, the consideration and implementation of effective patient engagement strategies must be considered within the context of organizational and community milieu that consistently supports a person-centered approach.

BACKGROUND ON HEALTH BEHAVIOR CHANGE THEORY

Although there is little definitive literature that directly relates to patient engagement, there are theories and models in health behavior science that can be applied to health care settings and practice. There are basic and common traits in human nature such as the quest for autonomy and self-determination, the valuing of physical and emotional well-being, the ambivalence about change, the tendency to push back against forces that are perceived as controlling or demanding, and the motivation to take a difficult path only if the benefits are perceived as worth it⁴. Then there are variables that can be barriers to behavior change, such as mental illness, readiness to change, patient activation, self-efficacy, learned helplessness, and personal agency – all which are influenced by socioeconomic and education levels, as well as cultural, gender and age factors⁴. There are also barriers imposed by practitioners to patient activation that include lack of cultural competency, failure to accommodate low health literacy, failure to assess/adjust for the patient's readiness to change or activation level, use of an authoritarian approach and the absence of incorporation of best practices in patient engagement and health behavior change⁷.

Layer the multiple risk factors and chronic conditions that many patients face on top of the complexity of motivation and self-regulation, and it's no wonder that health care providers are challenged to influence treatment adherence and preventive practices. In recent years, more attention has been placed on the role

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that incentives, disincentives and cost-sharing can play in engaging patients and inducing more individual responsibility for self-management and personal health⁸.

OVERVIEW OF RESEARCH ON PATIENT ENGAGEMENT

There is literature in the health psychology and behavior change science realms that can be applied to the health care setting, as well as current findings about patient engagement issues in the health management literature. This section provides a brief overview of some of the most relevant data, along with ramifications for health care interventions to address patient engagement.

1. **Patient with low activation generally do not engage easily.** Patient activation is defined as knowledge, skills, beliefs and behaviors that a patient needs to become a successful manager of his or her health and health care⁵. Typical stressors of a low SES population, along with mental illness and addictions, act as barriers to activation⁵. When a patient is not empowered to take charge of his/her health, has low self-confidence about his/her ability to manage chronic conditions, and/or has low health literacy, it is not surprising that engagement levels are correlated with patient activation level⁹.
2. **Activation is developmental.** Judy Hibbard has identified four clear levels of patient activation, along with characteristics of each⁵. Like self-esteem, patient activation is influenced in part by experiences, example, educational level, economic means and the environment; likewise, the level also tends to be consistent over multiple activities or conditions and can develop over time.
3. **Patient activation can be addressed and improved with the proper intervention.** In a quasi-experimental design¹⁰ over an eight-month period, employees with chronic conditions at a large medical university were enrolled into a health management program and received two to three health coaching sessions, based on an evidence-based approach. As compared to a similar control group, the treatment group had statistically significant improvement in patient activation levels, among other psychosocial outcomes, along with clinical outcomes.
4. **There are important similarities and differences between individuals who typically enroll in health management programs and those that do not.** In a follow-up evaluation study to a large clinical trial¹¹, the similarities and differences between full-, partial- and non-adopters were teased out via focus groups, interviews and surveys. Similarities between non-adopters and the adopters included: they were just as concerned about their health; the benefits of good health were more important to them than incentives; they wanted program variety, convenience and options for types of programming formats (online, health

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coach, social group, class, etc.). Differences were that full adopters had a much deeper understanding of their motivations for engagement in health management programs as compared to non-adopters; non-adopters expressed more perceived barriers to engagement; non-adopters needed more persistent (but not pushy) invitations to join health management programs; and opt-out provisions were more important to non-adopters than adopters.

5. **Engagement rates improve when practitioners use a patient-centered approach.** A recent correlation study showed a positive correlation between enrollment rates of nearly 5000 members of a commercial health plan and evidence-based health coaching skills of 52 nurses in a disease management program¹².
6. **Practitioners can inadvertently evoke resistance during patient interactions and decrease engagement.** Most individuals who are not following their treatment plan or making health lifestyle choices are ambivalent – they know what they “should” be doing, but it’s challenging to make these lifestyle changes. A practitioner’s interactions with the patient about these issues can evoke counter-change talk or discord from the patient if a directive, authoritative or confrontational approach is used, if the practitioner gently scolds, if s/he does not validate challenges/barriers, or if s/he repeats instructions the patient already knows¹³. As individuals defend their point of view, this perceived resistance to the behavior (which is actually an interpersonal tension that resulted from the practitioner’s behaviors) leads to an increase in the confrontational behaviors of the practitioner⁷. This discord or interpersonal tension is actually a predictor of poor clinical outcome; the more discord during the session, the less likely the patient is to make the behavior change or engage in the practitioner’s point of view⁷. Therefore, the least desirable situation in health care if we want to engage the patient is for the practitioner to argue for the change while the member argues against it. Yet, this type of interaction is a highly common one when patients are struggling to follow their treatment plan⁴.

We can apply these insights directly to health care settings by training practitioners in an evidence-based health coaching approach and encouraging them to address important constructs such as patient activation, self-efficacy and personal agency. In addition, organizations may need to implement a workplace initiative to identify job aids, patient materials, policies and procedures that work against patient engagement and implement those that support it instead.

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THE ROLE OF DISINCENTIVES AND INCENTIVES IN PATIENT ENGAGEMENT

Disincentives

Disincentives are mechanisms such as fees, policies, procedures, rules or taxes that intentionally or unintentionally, directly or indirectly, discourage or prevent desirable or undesirable actions, behavior or decisions². Currently, cost-sharing is the most prominent form of disincentive being considered in the health care setting¹⁴. Cost-sharing practices for Medicaid include: deductibles, copayments, coinsurance, premiums or enrollment fees.

On one hand, individuals can be significantly influenced in their health behaviors by policy changes that are widely marketed and/or if penalties are perceived as likely and unpleasant¹⁵. Examples include smoking cessation rules in workplaces and public arenas, drinking and driving laws, the seat belt law, and the motorcycle helmet law. There are numerous examples of successful compliance in employer-sponsored wellness programs to participant in health risk assessments and health screenings when additional health insurance premiums are required for non-participants¹⁶. In addition, a review of past cost-sharing practices clearly demonstrates that they significantly decrease utilization of health services and result in decreased health care spending^{17,18,19}, although there has been mixed results in the Medicaid population regarding emergency room and hospital utilization¹⁴. There doesn't appear to a negative effect on quality of care for individuals who are relatively healthy and have economic means – at least in the short-term follow-up studies^{14,20,21}. Participants in cost-sharing plans have self-reported that they worry less about their health, have fewer restricted-activity days and generally are satisfied with care²⁰.

However, on the other side, the research is clear that premiums and enrollment fees act as barriers to obtaining and maintaining coverage for low-income groups^{14,20,22,23}. Penalty fees also cause resentment on the part of participants and can damage relationships between payers and patients^{22,24}. Penalty fees are also not effective for risky, entrenched behaviors or for changing complex behaviors on a long-term basis, such as weight loss^{25,26}. A controlling, authoritarian approach also diminishes intrinsic motivation and is negatively correlated with behavior change^{27,28}. In fact, even positive feedback given in what is perceived as a controlling manner, negatively affects intrinsic motivation²⁷.

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The benefits that have been seen in the literature for cost-sharing measures appear to be limited to those who are healthy and have means^{14,21,23}. Seemingly, many patients cannot distinguish the differences between low and high value and necessary and unnecessary services; in some studies, using cost-sharing to reduce spending in low value areas has caused a rebound effect of patients substituting high cost services or going without needed care^{14,29,30}. Since the spending cuts under cost-sharing practices were consistently across the board, regardless of the high or low value of the service, the result was decreased quality of care for the sickest and poorest, as well as a decrease in preventive services and medication compliance^{14,21,23}. Beneficiaries forgo preventive care and medications under these practices^{21,31}, even when preventive services are fully covered, leading to higher incidents of serious medical conditions requiring more expensive care. In a review of CHHPs (Consumer Directed Health Plans), for every \$10 increase in copay for statin medications, there was a five-point drop in medication compliance for those under Medicaid coverage²¹. There are concerns that changes in cost-sharing and premiums can result in increased demand and additional pressure on safety-net providers, as noted by a 20% increase in ER visits by the uninsured in Oregon after cost-sharing measures were enacted. This rebound effect would likely result in lower reimbursement rates for providers, contributing to the reluctance of providers to add individuals with Medicaid coverage to their practices¹⁴.

In theory, using cost-sharing principles more deliberately could intentionally reduce health care spending in high cost, low value treatments/services^{20,21,23}; however, even proponents of cost-sharing measures urge policymakers to consider unintended consequences²⁰.

Incentives

Incentives are an inducement or supplemental reward that serves as a motivational device for a desired action or behavior². There are many different types of incentives including cash, gifts, lotteries, vouchers and point systems.

There is strong evidence that attractive and immediate financial incentives can increase initial participation in health management and community programs, such as health risk assessments, health screenings, health competitions and lifestyle management programs^{16,32}. Economic incentives also appear to be effective for encouraging individuals to complete simple preventive care tasks (e.g. vaccinations, screenings) and for distinct, well-defined behavioral goals (at least short-term), with strong evidence for populations with low

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socioeconomic status^{16,19,33}. Although understudied, the use of financial incentives to encourage medication adherence has some support in the literature, including those individuals with mental illness or addictions³⁴.

In a pooled, systematic review, researchers report that smokers are more than twice as likely to quit if they have full coverage for quit interventions versus having partial coverage³². In a review of six controlled clinical trials, researchers found systematic use of financial incentives had promise as an efficacious intervention for promoting smoking cessation among economically disadvantaged pregnant women (improving birth outcomes), as well as among recently postpartum women³⁵. There is more evidence about the effectiveness of incentives in smoking cessation for short-term versus long-term outcomes, although in one smoking cessation clinical trial, with a significant amount of incentives (\$750), the treatment group demonstrated long-term outcomes months after the incentives ceased²⁹.

There is insufficient evidence to suggest that economic incentives or competitions, by themselves, are enough to sustain the long-term complex behavior changes required for health promotion, such as exercising, losing weight and medication adherence, as the effect of the incentives diminishes as the reward disappears^{16,18,19,33}. In a large clinical trial for weight loss³⁶, there was no correlation between weight loss and external incentives; rather greater weight losses were consistently associated with increases in autonomous (intrinsic) motivation instead. The research is mixed for smoking, with incentives mostly failing to elicit long-term change, and the most studied populations for long-term changes in smoking cessation are high SES, white and employed populations³⁷. Although “social privilege” models exist in educational and correctional settings, as well as in the airline industry, there is a dearth of research about the application of this strategy in the health care setting.

Perhaps the most concerning findings for incentives lies in the research that has examined the effect that incentives have on intrinsic motivation. A large meta-analysis²⁷, followed later by well-controlled study³⁸ applying the same variables to the health care realm, demonstrated strong evidence that expected tangible rewards significantly decreased intrinsic motivation, particularly for task-contingent tangible rewards. In other words, in certain conditions, incentives could very well undermine individuals’ taking responsibility for motivating or regulating themselves^{27,38}. This effect runs directly oppositional to the goal of activating or empowering individuals with chronic conditions. And even unexpected and task-noncontingent rewards have a neutral effect on intrinsic motivation, compared with positive feedback (given in an informational versus a

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controlling manner), which enhances intrinsic motivation²⁷.

Although more research is needed to identify the mechanics of how incentives work and the size needed to induce different behaviors; in general: (1) the amount of the cash incentive is positively correlated to the response rate^{16,19}; (2) coupons are preferred to gifts, lotteries, or points^{16,19}; and (3) unexpected (random) and task-noncontingent rewards do not seem to worsen intrinsic motivation as task contingent-based incentives do²⁷.

Combination

While it seems intuitive to use various options that complement each other, unfortunately, the literature is sparse in this area. There are some positive findings in the workplace – when incentives and competitions are coupled with client education, smoking cessation groups and telephone cessation support, there is significant increase in number of workers who quit using tobacco¹⁸. Additionally, incentives, disincentives and interventions have also been successfully used in various combinations in employer-sponsored wellness programs to increase participation and lower health risks¹⁶. However, in another clinical trial for smoking cessation³⁹, feedback for intrinsic motivation significantly outperformed both the group receiving external motivation (incentives) and the group receiving both external and internal reinforcement, leaving a question mark as to the value of adding the incentives to the intervention. All in all, there is inadequate well-controlled research regarding a combination of incentives, disincentives and interventions to make a definitive statement about the efficacy and cost-effectiveness of this option, especially within a Medicaid population.

THE USE OF OTHER EVIDENCE-BASED APPROACHES TO ENGAGE THE PATIENT

Although the main scope of this project is directed towards a review of using of disincentives and incentives with a Medicaid population to increase patient engagement, it would be untoward not to include a mention of other evidence-based strategies to engage patients. One such evidence-based communication approach originated in the addictions and counseling field and does not rely on either incentives or disincentives to engage individuals. Motivational Interviewing is a “...collaborative, goal-oriented style of communication with particular attention to the language of change”²⁸. Although there are limited well-controlled studies with a Medicaid population, there are over 200 clinical trials that demonstrate efficacy of the MI approach with topics common to a Medicaid population, such as addiction, mental illness and multiple chronic conditions⁴⁰.

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In a recent systematic review and meta-analysis of MI in medical care settings, researchers found that MI produced a statistically significant and positive impact on a range of outcome measures, including dental caries, death rate, cholesterol level, blood pressure, HIV viral load, obesity, physical strength, quality of life, amount of alcohol consumed, dangerous drinking, smoking abstinence, marijuana use, self-monitoring, sedentary behavior, patient confidence, intention to change, and engagement in treatment⁴¹. Other variables which support this approach as a viable option for engaging Medicaid patients are: (1) it tends to be most helpful for less ready, unmotivated, less activated individuals; (2) it is a standardized approach that can be taught and measured by validated assessment tools; and (3) it is a single framework with which to address shared decision-making, self-efficacy, personal agency and patient activation^{28,42}. The downside of this approach rests in the complexity of the skill-set – it takes a concerted effort to train health care providers to a proficiency level linked with outcomes and an organizational change initiative is generally needed in addition to ongoing staff training²⁸.

While MI is the most studied and standardized approach for patient engagement, there is a growing body of evidence that addresses the importance of constructs such as patient activation, shared decision-making and health literacy^{4,5,9}. Health coaching approaches have been developed for each of these areas, although none has been fully developed to the point where there is a validated instrument to measure fidelity to a certain set of criteria. However, as mentioned above, there is evidence that, with additional training, health care workers can use the MI approach to address these important variables and clinics may identify them as targeted behaviors in their health coaching interventions^{10,43}.

Another important area of consideration in addressing strategies to engage patients is the value of marshaling community support and resources. Oregon has made a concerted effort to build a health workforce (formerly called non-traditional health workers) that is comprised of community health workers, peer wellness specialist, patient health navigators, and doulas. The literature is clear about the success that these community resources play in engaging individuals, especially those underserved individuals who have not had a positive experience in previous health care experiences or who may not trust those in authority⁴⁴.

For a summary table of this review of patient engagement strategies see Appendix A.

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CONCLUSION

As more definitive research emerges on the value and efficacy of using various strategies to engage patients, it is clear that stakeholders must take into account the complexity of human nature and behavior change. It may be helpful to study what other states have incorporated to date to engage their Medicaid population. A recent review by Blumenthal et al.⁸ of Medicaid incentive programs, whose objective was to encourage healthy behaviors, reflected mixed results to date. For an overview of this review see Appendix B.

In conclusion, this task demands that we think creatively and continue to pilot programs that test reasonable theories, so that we can develop new models of best practice for the health care system of the future.

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REFERENCES

- ¹ Gruman J, Rovner MH, French ME et al. From patient education to patient engagement: Implications for the field of patient education. *Pat Ed Couns*. 2010;78:350–356.
- ² Business Dictionary. Accessed September 17, 2013. Available at: www.businessdictionary.com.
- ³ Agency for Healthcare Research and Quality. Cost-sharing. Accessed September 17, 2013. Available at: www.ahrq.org.
- ⁴ Butterworth SW, Andersen B. Module 4: Health Coaching. In Chronic Care Professional (CCP) Health Coaching Certification Manual, 5th Edition. (2013) Saint Petersburg: HealthSciences Institute.
- ⁵ Greene J, Hibbard JH. Why does patient activation matter? An examination of the relationships between patient activation and health-related outcomes. *J Gen Intern Med*. 2012;27(5):520-526.
- ⁶ Carman K, Dardess P, Maurer SS, et al. Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies.
- ⁷ Miller WR, Rollnick S. *Motivational Interviewing: Helping People Change*. Third Edition. 2012. New York: Guilford Press.
- ⁸ Blumenthal KJ, Saulsgiver KA, Norton L, Troxel AB, et al. Medicaid Incentive Programs to Encourage Healthy Behavior Show Mixed Results to Date and Should Be Studied and Improved. *Health Aff*. 2013;32(3):497-507.
- ⁹ Butterworth, SW. Application of MI in Low Socioeconomic Group Setting: Overcoming Language, Cultural & Disability Challenges. Symposium participant at World Congress of Behavioral and Cognitive Therapies, Barcelona, Spain. (July 2007)
- ¹⁰ Linden A, **Butterworth** SW, Prochaska JO. (2010). Motivational interviewing-based health coaching as a chronic care intervention. *Journal of Evaluation in Clinical Practice*, 16, 166-174.
- ¹¹ Butterworth SW, Prochaska JO, Burden V, Redding C. Evaluation of Project META (Motivating Employees Towards Action). Research Presentation to 2010 Art & Science of Health Promotion Conference, Hilton Head, SC (March 2010)
- ¹² Butterworth SW, Smithline N. Breakthrough Results in Engagement: Bridging Science and Practice. HealthSciences Institute Learning Collaborative (September 2012).
- ¹³ Moyers TB, Martin T, Christopher PJ, Houck JM, Tonigan JS, Amrhein, P.C. Client Language as a Mediator of Motivational Interviewing Efficacy: Where is the Evidence? *Alcoholism: Clinical & Experimental Research*. 2007;31(3): 40-47.

Review of Literature: Patient Engagement – The Role That Disincentives & Incentives Play

- ¹⁴ Premiums and Cost-Sharing in Medicaid: A Review of Research Findings. Kaiser Commission on Medicaid and the Uninsured, February 2013. Accessed September 9, 2013. Available at: <http://www.kff.org/medicaid/8417.cfm>
- ¹⁵ Sallis JF, Owen N, Fisher EB. Ecological Models of Health Behavior. Chapter in Glanz K, Rimer BK, Viswanath (ed). *Health Behavior and Health Education: Theory, Research and Practice*. 4th Edition. 2008. San Francisco: Jossey-Bass.
- ¹⁶ Mattke S, Lui H, Caloyeras JP, Huang CY, et al. Workplace Wellness Programs Study: Final Report. A RAND Health Research Report. Sponsored by U.S. Department of Labor and U.S. Department of Health and Human Services. 2013. Accessed September 3, 2013. Available at: <http://www.dol.gov/ebsa/pdf/workplacewellnessstudyfinal.pdf>.
- ¹⁷ Halpin HA, McMenemy SB, Rideout J, Boyce-Smith G. The Costs and Effectiveness of Different Benefit Designs for Treating Tobacco Dependence: Results from a Randomized Trial. *Inquiry*. 2006;43:54-64.
- ¹⁸ Leeks KD, Hopkins DP, Soler RE, Aten A, Chattopadhyay SK. Worksite-based incentives and competitions to reduce tobacco use. A systematic review. *Am J Prev Med*. 2010;38(2 Suppl):S263-74.
- ¹⁹ Kane RL, Johnson PE, Town RJ, Butler M. A Structured Review of the Effect of Economic Incentives on Consumers' Preventive Behavior. *Am J Prev Med* 2004;27(4):327-252.
- ²⁰ The Health Insurance Experiment: A Classic RAND Study Speaks to the current Health Care Reform Debate. The RAND Corporation. 2006. Accessed September 3, 2013. Available at: http://www.rand.org/pubs/research_briefs/RB9174/index1.html.
- ²¹ Lowsky D, Chari R, Hussey PS, Mulcahy et al. Flattening the Trajectory of Health Care Spending: Engage and Empower Consumers. The RAND Corporation. 2012. Accessed September 3, 2013. Available at: http://www.rand.org/content/dam/rand/pubs/research_briefs/2012/RAND_RB9690z3.pdf.
- ²² Schmidt H, Voigt K, Wikler D. Carrots, Sticks, and Health Care Reform – Problems with Wellness Incentives. *NEJM*. 2010;362:e3.
- ²³ Rezayatmand R, Pavlova M, Groot W. The impact of out-of-pocket payments on prevention and health-related lifestyle: a systematic literature review. *Eur J Pub Health*. 2013;23(1):74-79.
- ²⁴ Thomson Reuters (Healthcare) Inc. Guidance Document on Preparing a Solicitation for Section 4108 of the Patient Protection and Affordability Act: Incentives for Prevention of Chronic Diseases in Medicaid: Final

Review of Literature: Patient Engagement – The Role That Disincentives & Incentives Play

Report. February, 2011. Accessed September 3, 2013. Available at:

<http://innovation.cms.gov/Files/x/MIPCD-CME-Guidance.pdf>.

- ²⁵ John LK, Loewenstein G, Troxel AB, Norton L, Fassbender JE, Vopp KG. Financial Incentives for Extended Weight Loss: A Randomized, Clinical Trial. *J Gen Int Med*. 2011;26(6):621-626.
- ²⁶ Jeffery RW, Bjornson-Benson WM, Kurth CL, Johnson SL. Effectiveness of monetary contracts with two repayment schedules of weight reduction in men and women from self-referred and population samples. *Behav Ther*. 1984;15:273-279.
- ²⁷ Deci EL, Ryan RM, Koestner R. A meta-analytic review of experiments examining the effects of extrinsic rewards on intrinsic motivation. *Psychol Bull*. 1999;125(6):627-668.
- ²⁸ Miller WR, Rose GS. Toward a Theory of Motivational Interviewing. *Am Psychol*. 2009;64(6):527-537.
- ²⁹ Volpp KG, Loewenstein G, Asch DA. Choosing Wisely: Low-Value Services, Utilization, and Patient Cost Sharing. *JAMA*. 2012(308(16)):1635-1336.
- ³⁰ Loewenstein G, Volpp KG, Asch DA. Incentives in Health: Different Prescriptions for Physicians and Patients. *JAMA*. 2012;307(13):1375-1376.
- ³¹ Wood vs Betlach. The United States District Court for the District of Arizona, February, 2013. Accessed September 1, 2013. Available at: <http://hr.cch.com/hld/WoodvBetlach.pdf>.
- ³² Cahill K, Perera R. Competitions and incentives for smoking cessation. [Review] *The Cochrane Library*. 2011;6:1-53.
- ³³ Lynagh MC, Sanson-Fisher RW, Bonevski B. What's Good for the Goose is Good for the Gander. Guiding Principles for the use of Financial Incentives in Health Behaviour Change. [Review] *Int J Behav Med*. 2013;20(1):114-20.
- ³⁴ DeFulio A, Silverman K. The use of incentives to reinforce medication adherence. [Review] *Prev Med*. 2012;55(1):S8-S94.
- ³⁵ Higgins ST, Washio Y, Heil SH, Solomon LJ, Gaalema DE, Higgins TM, Bernstein IM. Financial incentives for smoking cessation among pregnant and newly postpartum women. [Review] *Prev Med*. 2012;55(Suppl):S33-S40.
- ³⁶ Crane MM, Tate DF, Finkelstein EA, Linnan LA. Motivation for Participating in a Weight Loss Program and Financial Incentives: An Analysis from a Randomized Trial. *J Obesity*. 2012; Article ID 290589, 9 pages.

Review of Literature: Patient Engagement – The Role That Disincentives & Incentives Play

- ³⁷ Troxel AB, Volpp KG. Effectiveness of Financial Incentives for Longer-Term Smoking Cessation: Evidence of Absence or Absence of Evidence. [Review] *AJHP*. 2012;26(4):204-207.
- ³⁸ Moller AC, McFadden HG, Hedeker D, Spring B. Financial Motivation Undermines Maintenance in an Intensive Diet and Activity Intervention. *J Obesity*. 2012; Article ID 740519, 8 pages.
- ³⁹ Curry SJ, Wagner EH, Grothaus LC. Evaluation of intrinsic and extrinsic motivation interventions with a self-help smoking cessation program. *J Consult Clin Psychol*. 1991;59(2):319-324.
- ⁴⁰ Mid-Atlantic ATTC. Motivational Interviewing: Bibliography. Accessed September 3, 2013. Available at: http://www.motivationalinterview.org/quick_links/bibliography.html.
- ⁴¹ Lundahl B, Moleni T, Burke BL, Butters R, Tollesfson D. Motivational interviewing in medical care settings: A systematic review and meta-analysis of randomized controlled trials. *Pat Ed Counseling*. 2013; In press. Accessed September 3, 2013. Available at: <http://www.sciencedirect.com/science/article/pii/S0738399113002887>.
- ⁴² Butterworth S, Linden A, McClay W. Health Coaching as an Intervention in Health Management Programs. *Dis Man Health Outc*. 2007;15(5):299-307.
- ⁴³ Butterworth, SW. Patient Activation and Motivational Interviewing. Motivational Interviewing Network of Trainers (MINT) Annual International Forum, San Diego, US (October, 2010).
- ⁴⁴ Rosenthal EL, Brownstein JN, Rush CH, Hirsch GR, et al. Community Health Workers: Part of the Solution. *Health Aff*. 2010;7:1338-1342.

APPENDIX A: SUMMARY TABLE FOR RESEARCH REVIEW OF PATIENT ENGAGEMENT STRATEGIES

OPTION	ADVANTAGES & EFFICACY	DISADVANTAGES	SELECTED REFERENCES
<p>Disincentives</p> <ul style="list-style-type: none"> – Policy – Penalty fees – Cost-sharing <ul style="list-style-type: none"> ▲ Deductibles ▲ Copayments ▲ Coinsurance ▲ Premiums ▲ Enrollment fees – Demanding/controlling approach 	<ul style="list-style-type: none"> • Individuals can be significantly influenced in their health behavior by policy changes that are widely marketed and/or affect them adversely; smoking cessation, drinking and driving, wearing seat belts³⁴ • Successful compliance in employer-sponsored wellness programs to participate in health risk assessments and health screenings^{13,23} • Cost-sharing significantly decreases utilization of health services and results in decreased health care spending, with mixed results regarding ER visits and hospitalization^{3,25,26,27} • Cost-sharing does not seem to have effect on quality in care short-term on majority of patients^{3,25,26} • Participants in cost-sharing plans have self-reported that they worry less about their health, have fewer restricted-activity days and generally are satisfied with care²⁵ • In theory, using cost-sharing principles more deliberately could intentionally reduce health care spending in high cost, low value treatments/services^{14,25,27} 	<ul style="list-style-type: none"> • Penalty fees cause resentment on part of participants and can damage relationship between payer and patient^{17,19} • Premiums and enrollment fees act as barriers to obtaining and maintaining coverage for low-income groups^{3,17,25,27} • Cost-sharing results in equal cuts for both highly effective and less effective services, including emergent and non-emergent ER visits^{3,25,26} • Decreased quality of care for sickest and poorest; decrease in preventive services occur even when fully covered^{3,25,26} • Beneficiaries forgo preventive care and medications leading to higher incidences of serious medical conditions requiring more expensive care^{2,26} • Penalty fees not effective for risky, entrenched behaviors or for changing complex behaviors on long-term basis; especially those that are challenging or entrenched, such as weight loss^{1,7} • In a review of CHHPs (Consumer Directed Health Plans), every \$10 increase in copay for statin medications equaled 5-point drop in medication compliance for Medicaid population²⁶ • State savings from cost-sharing and premiums may accrue due to declines in coverage and utilization more so than from increases in revenues³ • Changes in cost-sharing and premiums can result in increased demand and additional pressure on safety-net providers, as noted by 20% increase in ER visits by uninsured in Oregon; can result in lower reimbursement rates³ • [Many] patients cannot distinguish between low/high value and necessary/unnecessary services; in some studies, using cost-sharing to reduce spending in low value areas has caused a rebound effect of patients substituting high cost services or going without needed care^{3,14,15} • A controlling, authoritarian approach diminishes intrinsic motivation and is negatively correlated with behavior change^{11,16} 	<p>¹John et al., 2011 ²Wood vs. Betlach, 2013 ³Kaiser Commission, 2013 ⁷Jeffery et al., 1984 ¹¹Deci et al., 1999 ¹³Madison et al., 2013 ¹⁴Volpp et al., 2012 ¹⁵Loewenstein et al., 2012 ¹⁶Miller & Rose, 2009 ¹⁷Schmidt et al., 2010 ¹⁹Thomson Reuters, 2011 ²³Mattke et al., 2013 ²⁵RAND HIE, 2006 ²⁶Lowsky et al., 2012 ²⁷Rezayatmand et al., 2013 ³⁵Sallis et al., 2008</p>

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OPTION	ADVANTAGES & EFFICACY	DISADVANTAGES	SELECTED REFERENCES
<p>Incentives</p> <ul style="list-style-type: none"> – Waiver of fees – Reimbursement of fees – Gifts – Gift cards – Cash payments – Vouchers – Lotteries – Point system – Special privilege 	<ul style="list-style-type: none"> • In pooled, systematic review, researchers report that smokers more than twice as likely to quit if full coverage versus partial coverage²⁹ • In seminal smoking cessation clinical trial with \$750 in incentives, treatment group demonstrated long-term outcomes, months after incentives had ended¹⁸ • In review of six controlled trials, researchers found systematic use of financial incentives has promise as efficacious intervention for promoting smoking cessation among economically disadvantaged pregnant and recently postpartum women and improving birth outcomes²² • In large review to determine whether competitions and incentives lead to higher longer-term quit rates, some evidence found that recruitment rates can be improved by rewarding participation, which may result in higher absolute numbers of individuals who quit²⁹ • Economic incentives appear to be effective for simple preventive care (e.g. vaccinations, screenings) and short-term for distinct well-defined behavioral goals, with strong evidence for vulnerable low SES populations^{6,9,24} • Incentives increase participation in employer- and community-sponsored health risk assessments, health screenings, health competitions and other health management programs^{13,23} • Although more research is needed to identify mechanics of how incentives work and size needed for different behaviors, in general: (1) amount of cash incentive correlated with response rate to incentive; and (2) coupons are preferred to gifts, lotteries, or points^{6,24} • Unexpected and task-noncontingent rewards do not worsen intrinsic motivation as other incentives do¹¹ • Although understudied, incentive-based medication adherence interventions are promising, even among individuals with mental illness or addiction²⁰ 	<ul style="list-style-type: none"> • Insufficient evidence to suggest economic incentives by themselves are enough to sustain the long-term lifestyle changes required for health promotion, such as quitting smoking, exercising, and losing weight^{5,6,9,24} • In seminal smoking cessation clinical trial with \$750 in incentives, the cost-benefit ratio is questionable; 30% drop-out rate from treatment group and only 9% abstinence rates after 6 months (compared with 4% information-only control group)¹⁸ • In recent rigorous review of smoking cessation and incentive research in workplace, authors concluded that studies to date simply have been inadequately powered to address the question of whether incentives increase long-term smoking cessation rates; most studied populations for incentives and smoking cessation are high SES, white, employed²¹ • In large review to determine whether competitions and incentives lead to higher long-term quit rates, it was concluded that they did not (with exception of one study)²⁹ • In large clinical trial for weight loss, no correlation with external incentive; rather greater weight losses consistently associated with increases in autonomous (intrinsic) motivation¹⁰ • A large meta-analysis, followed later by well-controlled study applying same variables to health care realm, demonstrated strong evidence that expected tangible rewards significantly decreased intrinsic motivation, particularly for task-contingent tangible rewards; i.e., reward contingencies undermine people's taking responsibility for motivating or regulating themselves^{11,12} • Although promising results applying incentives for medication adherence, little research to support outcomes that last beyond incentive period²⁰ • Positive feedback (given in informational vs. controlling manner) enhances intrinsic motivation; unexpected and task-noncontingent rewards do not¹¹ • Although 'special privilege' models exist in school and prison systems, as well as in airline industry, there is dearth of research about application in health care setting 	<p>²⁷Kaper et al., 2005</p> <p>⁵Leeks et al., 2010</p> <p>⁶Kane et al., 2004</p> <p>⁹Lynagh, 2013</p> <p>¹⁰Crane et al., 2011</p> <p>¹¹Deci et al., 1999</p> <p>¹²Moller et al., 2012</p> <p>¹³Madison et al., 2013</p> <p>¹⁸Volpp et al., 2009</p> <p>²⁰DeFulio & Silverman, 2012</p> <p>²¹Troxel & Volpp, 2012</p> <p>²²Higgins et al., 2012</p> <p>²⁴Mattke et al., 2013</p> <p>²³Blumenthal et al., 2013</p> <p>²⁹Cahill & Perera 2010</p>

APPENDIX A: SUMMARY TABLE FOR RESEARCH REVIEW OF PATIENT ENGAGEMENT STRATEGIES

OPTION	ADVANTAGES & EFFICACY	DISADVANTAGES	SELECTED REFERENCES
<p>Motivational Interviewing</p> <ul style="list-style-type: none"> – A collaborative, goal-oriented style of communication with particular attention to the language of change³² 	<ul style="list-style-type: none"> • >200 clinical trials demonstrate efficacy of MI approach; include topics common to Medicaid population such as addiction, mental illness and multiple chronic conditions³⁴ • In recent systematic review and meta-analysis of MI in medical care settings, researchers found that MI produced a statistically significant and positive impact on range of outcome measures: dental caries, death rate, cholesterol level, blood pressure, HIV viral load, obesity, physical strength, quality of life, amount of alcohol consumed, dangerous drinking, smoking abstinence, marijuana use, self-monitoring, sedentary behavior, patient confidence, intention to change, and engagement in treatment³¹ • Most helpful for less ready, unmotivated, less activated individuals^{16,32} • Standardized approach that can be taught and measured by validated assessment tools^{20,32} • Single framework to address shared decision-making, self-efficacy, personal agency and patient activation^{32,33} 	<ul style="list-style-type: none"> • Limited well-controlled studies with Medicaid population where MI proficiency was evaluated/assured • Complex skill-set and concerted effort needed to train health care providers to proficiency level linked with outcomes^{16,32} • Organizational change initiative generally needed in addition to ongoing staff training³² 	<p>¹⁶Miller & Rose, 2009 ³⁰Butterworth et al., 2007 ³¹Lundahl et al., 2013 ³²Miller & Rollnick, 2012 ³³Linden, Butterworth & Prochaska, 2010 ³⁴Mid-Atlantic ATTC, 2012</p>
<p>Combination</p> <ul style="list-style-type: none"> – Incentives – Disincentives – Interventions 	<ul style="list-style-type: none"> • When coverage of drugs is conditional on participation in health coaching, Medicaid population did not decrease use of drug benefit as compared with control group⁴ • When incentives and competitions are coupled with client education, smoking cessation groups and telephone cessation support, there is significant increase in number of workers who quit using tobacco⁵ • Incentives, disincentives and interventions have been successfully used in various combinations in employer-sponsored wellness programs to increase participation and lower health risks²³ 	<ul style="list-style-type: none"> • In clinical trial for smoking cessation, feedback for intrinsic motivation significantly outperformed group receiving external motivation (incentives) and group receiving both external and internal reinforcement⁸ • Inadequate well-controlled research with combination of incentives, disincentives and interventions to make definitive statement about efficacy and cost-effectiveness, especially with Medicaid population 	<p>⁴Halpin et al., 2006 ⁵Leeks et al., 2010 ⁸Curry et al., 1991 ²³Mattke et al., 2013</p>

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References:

- ¹John LK, Loewenstein G, Troxel AB, Norton L, Fassbender JE, Vopp KG. Financial Incentives for Extended Weight Loss: A Randomized, Clinical Trial. *J Gen Int Med*. 2011;26(6):621-626.
- ²Wood vs Betlach. The United States District Court for the District of Arizona, February, 2013. Accessed 9/01/13. Available at: <http://hr.cch.com/hld/WoodvBetlach.pdf>.
- ³Premiums and Cost-Sharing in Medicaid: A Review of Research Findings. Kaiser Commission on Medicaid and the Uninsured, February 2013. Accessed 9/01/13. Available at: <http://www.kff.org/medicaid/8417.cfm>.
- ⁴Halpin HA, McMenamin SB, Rideout J, Boyce-Smith G. The Costs and Effectiveness of Different Benefit Designs for Treating Tobacco Dependence: Results from a Randomized Trial. *Inquiry*. 2006;43:54-64.
- ⁵Leeks KD, Hopkins DP, Soler RE, Aten A, Chattopadhyay SK. Worksite-based incentives and competitions to reduce tobacco use. A systematic review. *Am J Prev Med*. 2010;38(2 Suppl):S263-74.
- ⁶Kane RL, Johnson PE, Town RJ, Butler M. A Structured Review of the Effect of Economic Incentives on Consumers' Preventive Behavior. *Am J Prev Med* 2004;27(4):327-252.
- ⁷Jeffery RW, Bjornson-Benson WM, Kurth CL, Johnson SL. Effectiveness of monetary contracts with two repayment schedules of weight reduction in men and women from self-referred and population samples. *Behav Ther*. 1984;15:273-279.
- ⁸Curry SJ, Wagner EH, Grothaus LC. Evaluation of intrinsic and extrinsic motivation interventions with a self-help smoking cessation program. *J Consult Clin Psychol*. 1991;59(2):319-324.
- ⁹Lynagh MC, Sanson-Fisher RW, Bonevski B. What's Good for the Goose is Good for the Gander. Guiding Principles for the use of Financial Incentives in Health Behaviour Change. [Review] *Int J Behav Med*. 2013;20(1):114-20.
- ¹⁰Crane MM, Tate DF, Finkelstein EA, Linnan LA. Motivation for Participating in a Weight Loss Program and Financial Incentives: An Analysis from a Randomized Trial. *J Obesity*. 2012; Article ID 290589, 9 pages.
- ¹¹Deci EL, Ryan RM, Koestner R. A meta-analytic review of experiments examining the effects of extrinsic rewards on intrinsic motivation. *Psychol Bull*. 1999;125(6):627-668.
- ¹²Moller AC, McFadden HG, Hedeker D, Spring B. Financial Motivation Undermines Maintenance in an Intensive Diet and Activity Intervention. *J Obesity*. 2012; Article ID 740519, 8 pages.
- ¹³Madison K, Schmidt H, Volpp KG. Smoking, Obesity, Health Insurance, and Health Incentives in the Affordable Care Act. *JAMA*. 2013;310(2):143-144.
- ¹⁴Volpp KG, Loewenstein G, Asch DA. Choosing Wisely: Low-Value Services, Utilization, and Patient Cost Sharing. *JAMA*. 2012(308(16):1635-1336.
- ¹⁵Loewenstein G, Volpp KG, Asch DA. Incentives in Health: Different Prescriptions for Physicians and Patients. *JAMA*. 2012;307(13):1375-1376.
- ¹⁶Miller WR, Rose GS. Toward a Theory of Motivational Interviewing. *Am Psychol*. 2009;64(6):527-537.
- ¹⁷Schmidt H, Voigt K, Wikler D. Carrots, Sticks, and Health Care Reform – Problems with Wellness Incentives. *NEJM*. 2010;362:e3.
- ¹⁸Volpp KG, Troxel AB, Pauly MV, et al. A Randomized, Controlled Trial of Financial Incentives for Smoking Cessation. *N Eng J Med*. 2009;360:699-709.

APPENDIX A: SUMMARY TABLE FOR RESEARCH REVIEW OF PATIENT ENGAGEMENT STRATEGIES

- ¹⁹Thomson Reuters (Healthcare) Inc. Guidance Document on Preparing a Solicitation for Section 4108 of the Patient Protection and Affordability Act: Incentives for Prevention of Chronic Diseases in Medicaid: Final Report. February, 2011. Accessed September 3, 2013. Available at: <http://innovation.cms.gov/Files/x/MIPCD-CME-Guidance.pdf>.
- ²⁰DeFulio A, Silverman K. The use of incentives to reinforce medication adherence. [Review] *Prev Med*. 2012;55(1):S8-S94.
- ²¹Troxel AB, Volpp KG. Effectiveness of Financial Incentives for Longer-Term Smoking Cessation: Evidence of Absence or Absence of Evidence. [Review] *AJHP*. 2012;26(4):204-207.
- ²²Higgins ST, Washio Y, Heil SH, Solomon LJ, Gaalema DE, Higgins TM, Bernstein IM. Financial incentives for smoking cessation among pregnant and newly postpartum women. [Review] *Prev Med*. 2012;55(Suppl):S33-S40.
- ²³Mattke S, Lui H, Caloyeras JP, Huang CY, et al. Workplace Wellness Programs Study: Final Report. A RAND Health Research Report. Sponsored by U.S. Department of Labor and U.S. Department of Health and Human Services. 2013. Accessed September 3, 2013. Available at: <http://www.dol.gov/ebsa/pdf/workplacewellnessstudyfinal.pdf>.
- ²⁴Blumenthal KJ, Saulsgiver KA, Norton L, Troxel AB, et al. Medicaid Incentive Programs to Encourage Healthy Behavior Show Mixed Results to Date and Should Be Studied and Improved. *Health Aff*. 2013;32(3):497-507.
- ²⁵The Health Insurance Experiment: A Classic RAND Study Speaks to the current Health Care Reform Debate. The RAND Corporation. 2006. Accessed September 3, 2013. Available at: http://www.rand.org/pubs/research_briefs/RB9174/index1.html.
- ²⁶Lowsky D, Chari R, Hussey PS, Mulcahy et al. Flattening the Trajectory of Health Care Spending: Engage and Empower Consumers. The RAND Corporation. 2012. Accessed September 3, 2013. Available at: http://www.rand.org/content/dam/rand/pubs/research_briefs/2012/RAND_RB9690z3.pdf.
- ²⁷Rezayatmand R, Pavlova M, Groot W. The impact of out-of-pocket payments on prevention and health-related lifestyle: a systematic literature review. *Eur J Pub Health*. 2013;23(1):74-79
- ²⁸Kaper J, Wagena EJ, Severens JL, Van Schayck CP. Healthcare financing systems for increasing the use of tobacco dependence treatment. [Review] The Cochrane Library. 2005;1:1-39.
- ²⁹Cahill K, Perera R. Competitions and incentives for smoking cessation. [Review] The Cochrane Library. 2011;6:1-53.
- ³⁰Butterworth S, Linden A, McClay W. Health Coaching as an Intervention in Health Management Programs. *Dis Man Health Outc*. 2007;15(5):299-307.
- ³¹Lundahl B, Moleni T, Burke BL, Butters R, Tolleson D. Motivational interviewing in medical care settings: A systematic review and meta-analysis of randomized controlled trials. *Pat Ed Counseling*. 2013; In press. Accessed September 3, 2013. Available at: <http://www.sciencedirect.com/science/article/pii/S0738399113002887>.
- ³²Miller WR, Rollnick S. *Motivational Interviewing: Helping People Change*. Third Edition. 2012. New York: Guilford Press.
- ³³Linden A, Butterworth SW, Prochaska JO. Motivational Interviewing-Based Health Coaching as a Chronic Care Intervention. *J Eval Clin Prac*. 2010;16:166–174.

APPENDIX A: SUMMARY TABLE FOR RESEARCH REVIEW OF PATIENT ENGAGEMENT STRATEGIES

³⁴ Mid-Atlantic ATTC. Motivational Interviewing: Bibliography. Accessed September 3, 2013. Available at: http://www.motivationalinterview.org/quick_links/bibliography.html.

³⁵ Sallis JF, Owen N, Fisher EB. Ecological Models of Health Behavior. Chapter in Glanz K, Rimer BK, Viswanath (ed). *Health Behavior and Health Education: Theory, Research and Practice*. 4th Edition. 2008. San Francisco: Jossey-Bass.

APPENDIX B: MEDICAID PILOT PROGRAMS OF INCENTIVES FOR PREVENTION OF CHRONIC DISEASES, 2011^{23*}

STATE	GOAL	INCENTIVE	RESEARCH SUPPORT	OUTCOMES
California	Tobacco cessation and diabetes management	\$10-20 per activity	Low	NA
Connecticut	Tobacco cessation	\$5-15 per activity	Low	NA
Florida	Routine checkups, Immunizations, cancer screening, Clinic attendance, medication adherence, tobacco cessation, weight loss, diabetes management	\$7.50 - \$25; \$125/year maximum	High (simple) Low (complex)	Only half of credits redeemed (200,000); majority for childhood preventive care (43%) or adult/child office visits (28%); <1% earned for weight loss or tobacco cessation; lack of participation in programs that decrease chronic disease
Hawaii	Diabetes prevention, detection and management	\$20 - \$25 per activity	Low	NA
Idaho	I. Weight management and tobacco cessation II. Well-child visits	I. \$200 maximum in vouchers II. 10 points (\$10)/ month	I. Low II. Medium	I. <1% participation; no data on success II. Significant increase in well-child visits as compared to control group
Minnesota	Weight loss, diabetes prevention, improved CV health, reduced health care spending	\$10 - 50 per activity	Low	NA
Montana	Weight loss, reduction in lipids and blood pressure, diabetes prevention	\$320 maximum	Low for long term	NA
New Hampshire	Increased exercise, improved nutrition, reduced CV risk factors	Unknown	??	NA
New York	Tobacco cessation, hypertension control, diabetes prevention and self-management	\$250 maximum	Low	NA
Nevada	Weight loss, lowered cholesterol and blood pressure, diabetes prevention and management	Unknown	??	NA
Texas	Improved health self-management among patients with SSI or mental health or substance abuse diagnosis	\$1150 maximum (FSA)	Medium	NA
West Virginia	Sign a contract and develop wellness plan; adhere to agreement to maintain coverage	Maintain access to enhanced plan	Low	Only 10% of eligible adults enrolled in enhanced plan; enhanced plan members more likely to have more doctor visits and to have physicians involved in decision to enroll
Wisconsin	Tobacco cessation with focus on pregnant women	I. \$595 maximum/ pregnant women; II. \$350 maximum/other	I. High for short-term II. Low for long-term	NA

*Table adapted from Blumenthal et al., 2013

Appendix 8

Health Information Technology Task Force Recommendations



**Oregon's Business Plan Framework for Health Information
Technology and Health Information Exchange (2014-2017)**
Health Information Technology Task Force Recommendations

Oregon Health Authority

May 30, 2014

Oregon
Health
Authority

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Fighting more than cancer, a patient's voice for health information technology

When Regina Holliday learned her husband, Fred, had stage 4 kidney cancer, she had questions - and desperately needed answers. What happens next? Has it spread? What tests does he need?



Regina Holliday, patient rights advocate

Without access to his health record, Regina and Fred found themselves battling more than cancer. He became a number within a bureaucracy where his treatments were often late or overlooked.

Electronic health records and the secure exchange of information between doctors and patients are among the strategies in Oregon's drive for better health, better care and lower costs. With health information technology efforts widely adopted, patients and practitioners could securely manage care together, scheduling appointments, filling prescriptions and coordinating all aspects of treatment.

Health records inaccessible

Fred spent 26 days hospitalized without access to his own health record. When Regina asked the hospital for a copy of his health record, she was told it would take 21 days and would cost hundreds of dollars.

After transferring to a different hospital for a second opinion, the Hollidays received an out-of-date and incomplete health record. The new staff spent six hours trying to stitch together an accurate record over the phone and by fax.

Through the duration of Fred's care, he visited two emergency rooms, received treatment at five facilities and needed emergency transportation 46 times. Not one practitioner or health care facility shared Fred's health record or disclosed his treatments, recent tests, medications or blood transfusions, creating an administrative nightmare for a family in crisis.

Tragedy inspires action

Sadly, Fred died in 2009, just months after his diagnosis. Regina has since become a national voice advocating for better communication between patients and doctors — as well as between practitioners — through the switch to paperless health records and electronic information exchange. *Regina Holliday has [created a series of painted murals](#) depicting the need for clarity and transparency in medical records.*

"In the end, we are all patients," Regina said. "We all want access to quality health care and timely answers to our questions. Having access to our own electronic records, and allowing doctors to securely share records electronically, we can achieve better care and better health."

Executive Summary and Roadmap

Oregon is on an extraordinary path to transform the delivery of health care to improve health outcomes, quality of care, and reduce costs. This “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 and outcomes, quality of care, and new modes of sharing care information amongst all members of care teams.

In 2012, the Oregon Health Authority (OHA) focused first on its Medicaid population, implementing the coordinated care model through new Coordinated Care Organizations (CCOs). These regional care networks bring all types of health care providers (physical health, behavioral health and dental) together to deliver coordinated care, while being held accountable for outcomes. CCOs now operate in every county in Oregon, and cover more than 90 percent of Oregonians on Medicaid. Moving forward, Oregon is working to accelerate and spread the coordinated care model beyond the Medicaid population to public employees, Medicare, and private payers.

Health information technology (HIT) refers to a wide range of products and services—including software, hardware and infrastructure—designed to collect, store and exchange patient data to support patient-centered care.

Health information exchange (HIE) is the electronic movement of health information among organizations following national standards. HIE facilitates sharing of health information across technological and organizational boundaries to enable better care.

Because HIT/HIE services are necessary to support health system transformation, OHA has worked closely with a wide range of stakeholders to identify HIT/HIE needs, and specifically identify how the State, and statewide services could address some of those needs. In fall of 2013, OHA convened an HIT Task Force to synthesize stakeholder input and develop this HIT/HIE 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 HIT/HIE efforts ensure that the care Oregonians receive is optimized by HIT. “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/family centric care.

In an HIT-optimized health care system:

- Providers have access to meaningful, timely, relevant and actionable patient information to coordinate and deliver “whole person” care.
- Systems (health systems, CCOs, health plans) effectively and efficiently collect and use aggregated clinical data for quality improvement, population management and incentivizing health and prevention. In turn, policymakers use aggregated data and metrics to provide transparency into the health and quality of care in the state, and to inform policy development.
- Individuals and their families access their clinical information and use it as a tool to improve their health and engage with their providers.

In order to achieve the goals outlined above, the State will need to fill several roles (see the diagram on the following page):

The State will coordinate and support community and organizational HIT/HIE efforts.

- Recognizing that HIT/HIE efforts must be in place locally to achieve a vision of HIT-optimized health care, the State can support, facilitate, inform, convene and offer guidance to providers, communities and organizations engaged in HIT/HIE.

The State will align requirements and establish standards for participation in statewide HIT/HIE services.

- To ensure that health information can be seamlessly shared, aggregated, and used, the State is in a unique position to establish standards and align requirements around interoperability and privacy and security, relying on already established national standards where they exist.

The State will provide a set of HIT/HIE technology and services.

- New and existing state-level services connect and support community and organizational HIT/HIE efforts where they exist, fill gaps where these efforts do not exist, and ensure all providers on a care team have a means to participate in basic sharing of information needed to coordinate care.

Technology: The State’s overall technology approach to statewide HIT/HIE coverage relies on five elements, largely dependent on local investments made by providers, hospitals, health systems, plans, CCOs and communities in electronic health records (EHRs) and other technology, and supported by statewide services:

1. Community/organizational HIEs and health systems provide HIT services and HIE coverage to some providers. Providers and hospitals adopt and use EHRs and HIT/HIE services in meaningful ways to coordinate care and treat patients.
2. Statewide Direct secure messaging provides a foundation for sharing information across organizations and differing technologies, particularly as EHRs upgrade to meet new federal certification and “Meaningful Use” requirements that include Direct secure messaging capabilities.
3. Oregon’s current state HIE, CareAccord®, provides basic HIE services, including Direct secure messaging, with a focus on providers without access to community and organizational HIEs and health systems’ HIT services.
4. New statewide HIT/HIE services (“enabling infrastructure”) tie together local efforts and fill gaps, enabling exchange and HIT functions (such as identifying providers or locating patient records) across community and organizational HIEs, health systems and providers.
5. State aggregation of core clinical metrics data supports Medicaid purposes. These data are used to improve care and reduce costs.

At the December 2013 CCO Summit, several CCO executives reflected on the impact of an “HIT-optimized” health care system in Oregon

“We have one provider who is both a physical and behavioral health provider, who never ‘til now was able to get data from both sides of her practice into one tool for a patient.”

- Janet Meyer, Health Share of Oregon

“Investing in Jefferson HIE is important. The number one frustration of our case managers is the wasted duplication of services and tests.”

- Bill Guest, Cascade Health Alliance

“Having an integrated shared care plan will transform care coordination.”

- Terry Coplin, Trillium Community Health Plan

“We are moving toward using technology as a foundation to make decisions about care.”

- Phil Greenhill, Western Oregon Advanced Health

STATE SUPPORT OF COMMUNITY & ORGANIZATIONAL HIT/HIE EFFORTS

COMMUNITY & ORGANIZATIONAL HIT/HIE EFFORTS:

Community HIEs

- Jefferson HIE
- Central Oregon HIE
- Gorge Health Connect
- Bay Area Community Informatics Agency

Organizational HIT/HIE efforts of

- CCOs
- Health Systems
- Health Plans
- Providers
- Hospitals
- Hosted EHRs
- Data Aggregators & Intermediaries

SUPPORT

The State will support community & organizational efforts by:

- Promoting EHR adoption & Meaningful Use
- Leveraging national standards & federal EHR incentives
- Promoting statewide Direct secure messaging
- Providing guidance, information & technical assistance
- Assessing changing environments and convening stakeholders

STANDARDIZE & ALIGN

The State will work with stakeholders to:

- Adopt standards for safety, privacy, security & interoperability
- Establish a Compatibility Program for statewide enabling infrastructure
 - Align metrics & reporting

PROVIDE

The State will provide:

- Statewide enabling infrastructure
- CareAccord to ensure access to HIT/HIE
- Clinical metrics data for Medicaid

Governance, Operations, and Policy: Establishing the right governance, operations and policy roles is needed to ensure that statewide HIT/HIE efforts support HIT-optimized health care. The State will continue its current efforts to provide oversight, transparency, policy and guidance, and accountability for statewide HIT/HIE services. Over time, the operation of statewide services will transfer from OHA and its contractors to an external organization. This “HIT designated entity” would be responsible for managing contractors, implementing new services and operating existing statewide services.

The State will also develop policies and standards encompassed in a compatibility program for users of statewide HIT/HIE services. This program will lay out minimum standards that health care entities would need to meet to participate in statewide HIT/HIE services; standards would focus on interoperability and privacy and security, leveraging national standards where they exist, and anticipating new standards as they evolve.

Financing: Ongoing funding for statewide HIT/HIE services is critical to ensure sustainability. Initial funding for Oregon’s statewide HIT/HIE services has come from federal grants, and Oregon will seek additional implementation funding from the Centers for Medicare & Medicaid Services (CMS) to support Medicaid-related costs. While federal grant funding can play a large role in implementing new services, the State’s goal is to bring on board private partners who see value and invest in private use of these services to create long-term financial sustainability for essential HIT/HIE services.

Roadmap to Statewide HIT/HIE: Oregon’s HIT/HIE services are being developed in phases:

- The first phase of development (2010-2013) saw the advent of a statewide strategic plan and the launch of CareAccord®, Oregon’s state HIE.
- The next phase is upon us (2014-2015): OHA is currently working with CCOs and stakeholders to develop and implement statewide HIT/HIE priority elements that are necessary to support health system transformation.
- This Business Plan Framework envisions a following phase (2016 and beyond) that expands statewide services and anticipates new public/private partnership structures to implement and operate statewide HIT/HIE efforts.

See the Roadmap chart on the following page for an outline of these phases.

The broad interest and agreement from stakeholders in OHA’s work provides an excellent foundation for the work ahead. This Business Plan Framework outlines that work, establishes principles, describes challenges, and sets a path forward for developing the right state-level services and technology to support HIT-optimized health care.

Oregon's HIT/HIE Roadmap to Support Health System Transformation

2010-2013
Phase 1

2014-2015
Phase 1.5

2016 Forward
Phase 2.0

Governance, Operations and Policy

Oregon Health Authority (OHA) with HIT Oversight Council (HITOC) and HIT Task Force

- Strategic planning, oversight, transparency, policy, accountability

OHA

- Implementation, operations

OHA with HITOC

- Strategic planning, transparency, policy
- Steering Committee/CCO TAG**
- Phase 1.5 oversight, accountability
- Planning for HIT Designated Entity
- Develop compatibility program

OHA

- Implementation, operations

OHA with HITOC and Steering Committee

- Strategic planning, oversight, transparency, policy, accountability
- Compatibility program

HIT Designated Entity

- Implementation, operations

Technology and Services

CareAccord

- CareAccord Direct secure messaging (launched May 2012)
- Trust/interstate efforts (National Association for Trusted Exchange, Direct Trust)

CareAccord

- Direct secure messaging; access to enabling infrastructure. Trust/interstate efforts.

Enabling infrastructure

- Provider directory/information services
- Patient/provider attribution
- Statewide hospital notifications

Services for Medicaid

- Clinical Quality Metrics Registry
- Technical assistance to eligible providers

CareAccord

- Direct secure messaging; access to enabling infrastructure. Trust/interstate efforts.

Enabling infrastructure and Medicaid services

- Enhanced statewide enabling services and record location
- Supporting query and data analytics

Finance

Office of the National Coordinator for HIT (ONC)

- ONC Cooperative Agreement (2010 – February 2014)

CMS/State Match/Investors

- Planning broad-based financing model
- CMS funding for Medicaid share for implementation
- Seeking non-Medicaid investors
- State/CMS contribute ongoing funding for services that support state Medicaid operations

Public/private partnership

- Broad-based financing model provides financial stability
- State/CMS contribute ongoing funding for services that support state Medicaid operations

I. Objective, Methodology, and Scope

Objective: Support health system transformation with the right level of HIT/HIE in Oregon

In 2011, the Oregon legislature passed landmark legislation to transform the way services are delivered through the Oregon Health Plan (Medicaid) to achieve the triple aim of better health, better care and lower costs. In 2012, the Oregon Health Authority (OHA) implemented Coordinated Care Organizations (CCOs). These regional care networks bring all types of health care providers (physical health, behavioral health and dental) together to deliver coordinated services, with an emphasis on health and prevention. Required by contract to achieve certain health system transformation goals, 16 CCOs are now serving more than 90% of Oregon’s Medicaid population. With time, Oregon plans to spread the coordinated care model beyond Medicaid populations, to public employees, Medicare, and private plans.

With the advent of CCOs, OHA recognized the necessity of re-assessing Health Information Technology (HIT) and Health Information Exchange (HIE) needs across the state. Successful implementation of the CCO model relies on certain HIT/HIE services that allow accessible and secure sharing of patient information.¹

Because HIT/HIE services are necessary to support health system transformation and ensure the triple aim of better health, better care and lower costs, OHA worked closely with stakeholders to identify needs and priorities, culminating in an HIT Task Force to establish this State HIT/HIE Business Plan Framework. The chapters reflect key recommendations that will inform Oregon’s long-term HIT/HIE landscape:

- Chapter II: Vision, Goals, Principles, and Challenges
- Chapter III: Role of the State and Statewide Efforts Recommendations
- Chapter IV: Technology Recommendations
- Chapter V: Governance, Policy, and Operations Recommendations
- Chapter VI: Financing Recommendations

Methodology and Scope

HITOC: In 2009, Oregon’s Health Information Technology Oversight Council (HITOC) was legislatively created to provide oversight of HIT development in the state. The council engaged in an intensive strategic planning effort, involving more than 100 Oregonians who volunteered to be on HITOC and its eight workgroups, subcommittees, and ad hoc groups, to develop Oregon’s Strategic and Operational Plans for HIE in 2010. The council members anticipated a changing EHR and HIT environment, and endorsed a “monitor and adapt” approach that envisioned revisiting the strategic plans over time. HITOC’s work was a strong foundation for discussions with new stakeholders as OHA assessed Oregon’s new HIT/HIE environment in 2013.

¹ See Appendix B for further background.

Listening sessions: During the spring of 2013, OHA conducted interviews with CCOs, health plans, State leadership and representatives of statewide and regional healthcare groups.² The goal of these interviews was to assess existing HIT/HIE services and determine which services were necessary to support health system transformation.

The listening sessions helped identify:

- The scope of community and organizational HIT/HIE efforts, including gaps for providers in Oregon
- HIT/HIE elements necessary to support health system transformation
- Input on which of these critical HIT/HIE elements should be offered statewide, and how any statewide services should be governed and financed
- Input on the right role for the State, including policy, standards and guidance

HIT Task Force: Oregon Health Authority analyzed the information obtained from the listening sessions and determined that further stakeholder feedback was necessary to develop the Business Plan Framework. In the fall of 2013, OHA convened the Health Information Technology Task Force (Task Force). Comprised of a wide group of Oregon's HIT/HIE stakeholders, the 19-member Task Force met in five public meetings and a series of smaller workgroups between September and November 2013.

Listening sessions found consistent messages that HIT/HIE are needed to support:

- Care coordination across all members of a care team, and
- Data aggregation and analytics incorporating clinical data.

Listening sessions also uncovered variations:

- Varying levels of technical capacity across Oregon's health care communities, and
- Differing opinions on the best role of the State and statewide services.

During these meetings, OHA staff presented the Task Force with proposed recommendations informed by HITOC's prior work and the listening session results. The Task Force deliberated on issues of the State's role in HIT/HIE services, technology, governance and finance and provided the final input for this report.

Scope of this document: As noted through this document, statewide HIT/HIE infrastructure is expected to be developed in phases. Current efforts (Phase 1) include CareAccord® Direct secure messaging web-portal based services. For 2013-2015, OHA has secured State funding to leverage federal grants. These funds are being used to develop six elements (Phase 1.5) described in the Chapter IV Technology Recommendations. The HIT Task Force reviewed the Phase 1.5 elements and validated the overall approach to statewide HIT/HIE efforts that would rely on Phase 1.5 elements. They then considered the additional efforts needed to meet the goals and solve the problems identified for Oregon, with particular focus on 2016 and beyond (Phase 2.0). This document describes the complete picture of statewide Oregon's statewide HIT/HIE development for 2014-2017.

² See Appendix A for a complete list of organizations and outcomes from the listening sessions.

Primer on Health Information Exchange and Federal Role in Facilitating HIT/HIE

Health Information Exchange (HIE) allows providers, patients, and other participants to appropriately access and securely share a patient's health information electronically. Efficient HIE relies on interoperability and standards across technologies. Once standardized, the information shared can integrate into the recipients' Electronic Health Records (EHRs), further enhancing the usability of patient data and improving patient care.

There are currently three key forms of HIE:

- [Directed exchange](#) allows providers to easily and securely send patient information—such as laboratory orders and results, patient referrals, or discharge summaries—directly to other health care professionals. This information is sent over the Internet in an encrypted, secure, and reliable way among health care professionals who trust each other. Directed exchange is commonly compared to sending a secured email.
- [Query-based Exchange](#) allows providers to find and/or request information on a patient from other providers. It is often used for unplanned care.
- [Consumer-mediated exchange](#) provides patients with access to their health information, allowing them to manage their health care online in a similar fashion to how they might manage their finances through online banking. When in control of their own health information, patients can actively participate in their care coordination.

Storing Patient Data: HIE architecture determines where patient data is stored and how it is accessed by HIE participants.

- The centralized model has a clinical data repository that is maintained by the HIE. Users access and update the system directly. Hospitals and larger health systems may use this model to ensure interoperability and ease of access.
- In the federated model, patient data remains in the individual EHRs or clinical data repositories of health systems, hospitals or providers. The HIE provides the connectivity, interoperability and record location services necessary to exchange data, but is not responsible for data storage.
- A hybrid model incorporates a centralized data repository for some information, while providing connection to federated EHRs or clinical data repositories for other patient information.

See Chapter IV. Technology for more information on the technology model proposed in for Oregon, as well as further information on CareAccord®, Oregon's state HIE.

Federal role in facilitating HIE: HITECH Act of 2009

The 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act seeks to improve American health care delivery and patient care through an unprecedented investment in HIT. The Act funds a complementary set of programs such as:

- Incentives to eligible Medicaid and Medicare providers for adopting and meaningfully using certified EHRs. ***See EHR Incentives/Meaningful Use Primer on page 16.***
- State HIE Cooperative Agreements to fund state HIE efforts, administered by the Office of the National Coordinator for HIT (ONC). These funds ended in early 2014.
- Technical assistance for providers through funding of Regional Extension Centers
- Workforce training, including curriculum development

See Appendix B for further background on some of the HITECH-funded programs in Oregon

II. Vision, Goals, Principles, Challenges

Vision and Goals

The HIT Task Force helped OHA establish a vision for Oregon of a transformed health system where HIT/HIE efforts ensure that the care Oregonians receive is optimized by HIT. “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/family centric care.

In an “HIT-optimized” health care system:

- Providers have access to meaningful, timely, relevant and actionable patient information to coordinate and deliver “whole person” care.
- Systems (health systems, CCOs, health plans) effectively and efficiently collect and use aggregated clinical data for quality improvement, population management and incentivizing health and prevention. In turn, policymakers use aggregated data and metrics to provide transparency into the health and quality of care in the state, and to inform policy development.
- Individuals and their families access their clinical information and use it as a tool to improve their health and engage with their providers.

ONC Vision for HIE

“All patients, their families, and providers should expect consistent and timely access to standardized health information that can be securely shared between primary care providers, specialists, hospitals, behavioral health, Long Term Post-Acute Care, home and community-based services, other support and enabling services providers, care and case managers and coordinators, and other authorized individuals and institutions.”

[Strategy and Principles to Accelerate HIE, Office of the National Coordinator for HIT \(ONC\), Aug. 2013](#)

The State will pursue the above goals to ensure that HIT supports the triple aim of better health outcomes, better quality of care and lower costs.

Principles for Statewide HIT/HIE Efforts

The HIT Task Force established principles for moving forward with statewide HIT/HIE efforts.

Leverage existing resources and national standards, while anticipating changes:

- Consider investments and resources already in place.
- Leverage Meaningful Use and national standards; anticipate standards as they evolve.
- Monitor and adapt to changing federal, state and local environments.

Demonstrate incremental progress, cultivate support and establish credibility:

- Advance through relentless incrementalism: define a manageable scope, deliver, and then expand.
- Communicate frequently with measureable progress. Demonstrate optimal value for patients and providers toward the triple aim of better health, better care and lower costs.
- Provide public transparency into development and operations of statewide resources.
- Be a good steward of limited public resources.
- Establish long-term financial, leadership, and political sustainability. These are interdependent.

- Seek broad stakeholder involvement and support. Statewide resources cannot be developed alone.

Create services with value:

- Maximize benefits to Oregonians while considering costs. Do not disenfranchise (“do no harm”), and be inclusive of providers that face barriers to participation.
- Support provider participation in HIT-optimized health care; meet providers where they are. Recognize the challenges especially for smaller, independent providers and providers who are not eligible for federally-funded EHR incentives.
- Prioritize efforts to achieve a common good and that local entities could not do on their own.
- Cultivate and communicate about value at the individual, provider, system and state levels. Champions and personal stories can be very effective.
- Support new models of “HIT-optimized” health care that result in better quality, whole person care and improved health outcomes and lower costs for all.

Protect the health information of Oregonians:

- Ensure information sharing is private and secure and complies with HIPAA and other protections.

HIPAA Privacy Rule

The HIPAA Privacy Rule protects personal health information while still allowing the flow of health information for treatment, payment, or operations. Providers and other entities that access health information can only share information as outlined in the rule, or with the written permission of the person.

Challenges

The Task Force identified a number of important factors for consideration when proceeding with HIT/HIE efforts:

Providers face very real technology burdens, which may impede new HIT/HIE efforts: Practices face many large HIT changes in the near term, including ICD-10³, EHR upgrades required in 2014 for all providers seeking EHR incentive payments, and practice changes for providers seeking to meet Meaningful Use Stage 2 requirements. Multiple metrics and reporting requirements demanded by different payers and programs also create a significant administrative burden for many providers. Adding new HIT/HIE expectations on providers is likely to be very challenging in this environment. Providers want to see value and benefits from their considerable investments in EHRs and HIT/HIE, and many are frustrated that their EHRs do not give them back useful information at a patient panel level.

HIT/HIE efforts must be inclusive: Behavioral health, dental and long term care must be included in HIT/HIE efforts to achieve health care transformation, but most of these providers lack the economic incentives available to eligible providers in the Medicare and Medicaid EHR Incentive Programs.

³ The 10th revision of the International Statistical Classification of Disease and Related Health Problems (ICD), a medical classification list by the World Health Organization. ICD codes are used worldwide for morbidity and mortality statistics, reimbursement systems, and automated decision support in health care. Congress recently delayed the deadline for ICD-10 adoption by at least one year, so requirements for all HIPAA-covered entities (e.g., health care providers) to adopt ICD-10 will take effect no earlier than October 2015.

Providers must adopt and use EHRs and HIT/HIE services to see the benefits: Providers will need support and technical assistance to integrate information technology into their workflow.

Providers face challenges navigating the EHR vendor arena: Small providers are constrained by the “out-of-the-box” capabilities provided in their EHRs, and have limited financial ability to customize their EHRs to produce metrics and reporting. Their ability to meet changing demands is limited.

Incentives are misaligned: New payment models which incentivize health and prevention are evolving, but providers are still largely paid on a fee for service basis. Without new payment models in place, providers may not see the value of HIT/HIE investments. For example, better sharing of health information can prevent hospital admissions and duplicative laboratory tests. For hospitals and laboratories paid by the admission or test, better sharing of health information can reduce revenue until new payment models are in place.

Sustainability is challenging: Although the benefits of HIT/HIE infrastructure are of interest to many stakeholders, many are reluctant to invest without clear demonstration of value and return on investment. At the same time, for many services, participation by a critical mass of providers is needed to realize the return on investment.

Beware unintended consequences: The addition of new HIT/HIE services, however well-intentioned, could inadvertently contribute to information overload. For example, alerts designed to call attention to important information about a patient are useful only if the provider can act on the information. “Alert fatigue” can occur when a provider is overwhelmed by the volume of messages and begins to ignore them.

Workforce training is needed: Health system transformation not only increases demand for primary care providers but also increases demand for knowledgeable staff who can adapt to new technology and implement new workflows which maximize the benefits of HIT/HIE services. Training and retention of staff is an additional cost and concern for providers.

Primer on EHR Incentives and Meaningful Use

The Medicaid and Medicare EHR Incentive Programs provide incentive payments to eligible professionals and hospitals as they implement and demonstrate that they meet “Meaningful Use” requirements for using certified EHR technology. Eligible professionals can receive up to \$44,000 through the Medicare EHR Incentive Program over 5 years or up to \$63,750 through the Medicaid EHR Incentive Program over 6 years. Eligible hospitals may be eligible for significant incentives from both programs. To receive incentive payments, eligible professionals and hospitals must meet several criteria, including:

- Meet eligibility requirements related to provider type (MDs, NPs, DOs, and others) and either Medicaid patient volume or Medicare Part B claims.
- Use certified EHR technology that meets requirements established by the Office of the National Coordinator for Health Information Technology (ONC) as secure and interoperable.
- Meet Meaningful Use requirements for actual use of the EHR (see below). For Medicaid EHR incentives, providers can receive their first year’s payment by adopting, implementing or upgrading (AIU) to certified EHR technology.

Meaningful Use: To receive an incentive payment, both eligible professionals and hospitals have to show that they are “meaningfully using” their EHRs by meeting thresholds for a number of objectives established by CMS. The incentive programs are staged in three steps with increasing requirements for participation.

- **Stage 1** sets the baseline for electronic data capture and information sharing. All providers begin participating by meeting the Stage 1 requirements for a 90-day period in their first year of Meaningful Use and a full year in their second year of Meaningful Use.
- **Stage 2** focuses on data exchange. After meeting the Stage 1 requirements, providers will then have to meet Stage 2 requirements for two full years.
- **Stage 3** (expected to be implemented in 2017 through future rule making) will focus on advanced clinical process and improved outcomes.

NEW for 2014: All providers seeking incentives must use EHRs that meet new certification standards that apply in 2014.

- 2014 standards include capabilities for Direct secure messaging and automated quality reporting capabilities of clinical quality metrics, among other things.
- For 2014 only, all providers, regardless of their stage of Meaningful Use, are required to demonstrate Meaningful Use for only a 90-day reporting period.

Resources:

- EHR incentives for Oregon providers: <http://www.medicadehrincentives.oregon.gov/>.
- A complete up-to-date list of certified EHR systems: [ONC Certified HIT Product List \(CHPL\)](#).
- [Click here](#) to view Stage 1 objectives and measures from the CMS website. Click [here](#) for a Stage 2 Guide for Eligible Professionals published by CMS.

III. The Role of the State in Achieving HIT-Optimized Health Care

To determine the State's role, the Task Force started by discussing the critical HIT/HIE elements needed to support health system transformation. Then within those needs, the Task Force identified which elements should be uniquely provided at the State level and which could be provided locally, considering the variability of expertise, technology and knowledge of communities, health plans, CCOs, health systems and providers.

The Task Force focused on three goals which lead to an HIT-optimized health care system:

- Providers have access to meaningful, timely, relevant and actionable patient information to coordinate and deliver “whole person” care.
- Systems (health systems, CCOs, health plans) effectively and efficiently collect and use aggregated clinical data for quality improvement, population management and incentivizing health and prevention. In turn, policymakers use aggregated data and metrics to provide transparency into the health and quality of care in the state, and to inform policy development.
- Individuals and their families access their clinical information and use it as a tool to improve their health and engage with their providers.

To identify the right role for State efforts, the Task Force approached each goal from three potential categories of State involvement:

The State will coordinate and support community and organizational HIT/HIE efforts.

- Recognizing that HIT/HIE efforts must be in place locally to achieve a vision of HIT-optimized health care, the State can support, facilitate, inform, convene and offer guidance to providers, communities and organizations engaged in HIT/HIE.

The State will align requirements and establish standards for participation in statewide HIT/HIE services.

- To ensure that health information can be seamlessly shared, aggregated, and used, the State is in a unique position to establish standards and align requirements around interoperability and privacy and security, relying on already established national standards where they exist. These standards can ensure that local and statewide policies and operations result in the needed and anticipated statewide infrastructure to support health system transformation.

The State will provide a set of HIT/HIE technology and services.

- As described more fully in Chapter IV: Technology Recommendations, new and existing state-level services connect and support community and organizational HIT/HIE efforts where they exist, fill gaps where do these efforts do not exist, and ensure all providers on a care team have a means to participate in basic sharing of information needed to coordinate care.

STATE SUPPORT OF COMMUNITY & ORGANIZATIONAL HIT/HIE EFFORTS

COMMUNITY & ORGANIZATIONAL HIT/HIE EFFORTS:

Community HIEs

- Jefferson HIE
- Central Oregon HIE
- Gorge Health Connect
- Bay Area Community Informatics Agency

Organizational HIT/HIE efforts of

- CCOs
- Health Systems
- Health Plans
- Providers
- Hospitals
- Hosted EHRs
- Data Aggregators & Intermediaries

SUPPORT

The State will support community & organizational efforts by:

- Promoting EHR adoption & Meaningful Use
- Leveraging national standards & federal EHR incentives
- Promoting statewide Direct secure messaging
- Providing guidance, information & technical assistance
- Assessing changing environments and convening stakeholders

STANDARDIZE & ALIGN

The State will work with stakeholders to:

- Adopt standards for safety, privacy, security & interoperability
- Establish a Compatibility Program for statewide enabling infrastructure
 - Align metrics & reporting

PROVIDE

The State will provide:

- Statewide enabling infrastructure
- CareAccord to ensure access to HIT/HIE
- Clinical metrics data for Medicaid

GOAL 1: Providers have access to meaningful, timely, relevant and actionable patient information to coordinate and deliver “whole person” care.

Many patients receive care from multiple providers. Currently, when a patient’s providers are not all within the same health system or network, the providers may have difficulty accessing each other’s information about the patient. This problem is even greater for providers not eligible for Medicaid and Medicare EHR incentive payments, such as most behavioral health and long-term care providers. Without EHRs or other technology systems incorporating HIT standards, these providers are less likely to exchange information electronically.

As a result, not all providers caring for a patient have access to needed information at the point of care. The current state of health information exchange creates several issues:

- Fragmented, uncoordinated care undermines the quality of care and patient outcomes. High-cost and high-risk populations lack “whole person” coordinated care that includes sharing information across physical, behavioral, dental and other care settings. Critical pieces of the care management puzzle, including information from long term care, social services, education, and other sectors, are not currently connected.
- Poor communication across transitions of care leads to wasteful spending and poor patient experiences and outcomes.
- Providers often rely on a patient’s memory to inform their care.
- Inefficiencies and redundancies result from the gaps in information in the current system.

Challenges for behavioral health patients and providers

- Providers often rely on the patient to inform them about current medications. If this information is inaccurate or incomplete, providers can prescribe drugs that will result in medication reactions or complications.
- Behavioral health care providers are often not notified when their patients are admitted to the hospital or booked into a jail facility. This creates a delay in treatment, and can exacerbate the behavior that led to the hospitalization or arrest.

To address the problems outlined above, sharing patient information is critical:

Access to the right patient information at the point of care, including relevant information from across the care spectrum. This requires the sharing of information between unaffiliated providers across organizational and technological boundaries. This also requires the ability to produce and ingest information in formats that are structured to be integrated and automated within EHRs and workflows.

Provider capacity, interest and demand to use the information requires providers having the right technology (EHRs or other standards-based technology), as well as providers valuing and expecting electronic access to shared information.

Better information means better, more affordable care

Giving providers access to meaningful, timely, relevant and actionable information allows providers to provide the most informed care and can: reduce costly redundancy, ensure accuracy, and increase the likelihood of better outcomes. This means more efficient and effective care, better workflows and better outcomes, all of which can reduce costs.

Care team process and workflow to use the information and organize around “whole person” care. This could include practice changes to participate in “virtual care teams” around complex patients, and it may be facilitated by technology tools such as virtual care team tools and shared care plans.

Goal 1: Recommendations

The State will support community and organizational efforts by:

Promoting EHR adoption and Meaningful Use: The State will ensure providers can access EHR incentive payments, including providing technical assistance to Medicaid providers. Strategies to promote and facilitate full use of certified EHR technology include aligning State requirements with EHR Incentive Program requirements to further incent Meaningful Use (e.g., leverage clinical quality measures that are built into certified EHRs); leveraging automated capabilities within EHRs, such as new automated (CCDA/QRDA) formats for clinical metric reporting; and monitoring and assessing rates of certified EHR adoption, Meaningful Use, and use of other technology.

In addition, the State will support participation in information sharing and meaningful care coordination by behavioral health, dental and long-term care providers, by examining barriers to participating in care teams, highlighting promising approaches, and using State Medicaid levers where applicable.

Leveraging national standards and federal EHR incentives: The State will promote and leverage the use of national HIT/HIE standards (including EHR certification and Meaningful Use standards) which enable interoperability, privacy and security, and efficiencies, as well as promote and leverage provider participation in the EHR incentive programs, which require the use of EHRs that meet these standards. Levers such as State contracts with providers, CCOs and health plans and State standards for Patient-Centered Primary Care Home (PCPCH) can also reinforce the use of national HIT/HIE standards, EHR adoption and Meaningful Use.

Promoting statewide Direct secure messaging: By supporting local efforts and connectivity between local HIEs and CareAccord®, the State will enable providers to share health information in a HIPAA-compliant manner within Oregon, as well as across organizational and state boundaries.

Providing guidance, information and technical assistance: The State will seek opportunities to provide clarity where possible on HIPAA and other legal restrictions on information sharing, particularly around behavioral health.

Assessing changing environments and convening stakeholders: The State will convene stakeholders to share best practices and discuss the impact of federal and statewide initiatives and implications for community and organizational HIEs.

The State will work with stakeholders to:

Adopt standards for safety, privacy, security and interoperability: To protect the security and privacy of shared patient information, the State will promote policies and practices to protect patient health information and ensure any statewide services or processes follow HIPAA and other federal and State requirements. Where possible,

the State will assist community HIE efforts with standard consent processes or guidelines.

Establish a compatibility program for statewide enabling infrastructure: The State will develop policies to support interoperability, including establishing a State compatibility program that includes national standards and sets baseline expectations for community, organizational and statewide HIT/HIE efforts to ensure interoperability, privacy and security and to facilitate the sharing of information. Where relevant to Oregon’s interests, the State will advocate nationally for standards and policy. See Chapter V. Governance for more discussion of the compatibility program.

The State will provide:

Statewide enabling infrastructure: The enabling infrastructure services will connect community and organizational HIEs where they exist, and provide core baseline services to ensure all providers can share information (see Chapter IV. Technology Recommendations for more details). The State will provide enabling infrastructure services that can facilitate both “push” and “query” capabilities to facilitate the exchange of health information.

CareAccord® to ensure access to HIT/HIE: CareAccord® is available throughout Oregon, including in areas where no community HIEs exist. By offering that service, the State provides an option for any provider, with or without an EHR, to access electronic health information through Direct secure messaging.

GOAL 2: Systems (health systems, CCOs, health plans) effectively and efficiently collect and use aggregated clinical data for quality improvement, population management and incentivizing health and prevention. In turn, policymakers use aggregated data and metrics to provide transparency into the health and quality of care in the state, and to inform policy development.

Currently, technology disparities affect the access that providers, health systems, health plans and CCOs have to clinical information beyond individual patient records – amassed for their population of patients or members. Historically, access to clinical data for quality improvement and oversight has been expensive and burdensome to collect (e.g., through manual chart audits). As electronic access to information becomes more available, medical chart audit reviews for accreditation and regulatory requirements will no longer be needed. Time gaps between collection, review and the ability to act will decrease, making the information more valuable to providers, health systems, CCOs, health plans and the State.

The use of Clinical Quality Measures (CQMs) facilitates the aggregation of clinical information. CQMs are process and outcomes measures used to measure the current quality of patient care and identify opportunities for improvement. Health plans, CCOs, health systems and providers all need CQMs to achieve the triple aim of better health, better care and lower costs. Unfortunately, not all of these groups have the ability to effectively and efficiently collect and use aggregated CQMs and other clinical data.

A new standard for CQM reporting

Clinical Quality Measures are utilized for quality program reporting, including reporting required for Meaningful Use under the EHR Incentive Program. Starting in 2014, EHRs certified for Meaningful Use must be able to generate CQM data in a standardized format, called Quality Reporting Data Architecture (QRDA). This format facilitates electronic reporting, without placing an extra burden on providers, and is valuable functionality provided by 2014 certified EHRs.

Aggregated clinical data have several different uses:

Provider-level uses: Actionable CQMs, alerts and other patient-level information are needed by point-of-care providers and the care team to look across their patient panels and identify care needs. These tools allow providers to identify patients who have gaps in care (e.g., missing recommended screenings), are at risk for poor outcomes (e.g., missing follow-up visits after hospitalization or being outliers within their chronic care cohorts) or have other signs of needing additional, proactive care. Clinical quality measures can provide insight into areas of success and areas for improvement. To be most useful for providers, these data and metrics should include the ability to “drill-down” to the patient level, so patient follow-up and practice changes can occur.

Management-level uses: Health plans, CCOs, health systems and providers need CQMs and data to:

- Ensure quality: Identify, monitor and improve quality of care.
- Manage populations: Identify and manage their patients/populations effectively.
- Pay differently: Transform care delivery via new payment models that are based on paying for value and health outcomes rather than visits.

To be most useful for management-level users, these data and metrics should be collected frequently enough to demonstrate the impact of new delivery care models and help identify where resources and course corrections could yield better outcomes.

Policy-level uses: The State monitors population health, and seeks to ensure value in the health care delivery system. Data that is particularly relevant at the policy level may include provider or management-level metrics, but may also include less frequently collected indicators, such as patient satisfaction surveys.

The HIT Task Force described several challenges to ensuring that aggregated clinical data and metrics are available to support the above uses:

Myriad unaligned metrics and reporting requirements create difficulties: Providers and health systems face a daunting number of reporting requirements across health plans, Medicare, Medicaid and pay-for-performance programs. Reporting metrics and other data often requires reporting many similar, but not identical, pieces of information. This lack of alignment increases administrative burdens and reduces comparability of data.

Collecting and reporting metrics and other clinical data can be burdensome for providers: This challenge is particularly great given major HIT changes hitting providers in 2014 and 2015 (including ICD-10, requirements for Meaningful Use Stage 2, and 2014 EHR upgrades needed to be eligible for EHR incentives).

Certified EHRs vary in terms of ability to generate and report CQMs: For example, although ONC has established 64 electronic CQMs, EHR certification standards require only nine CQMs to be pre-programmed into the EHR for automated reporting capabilities. While EHR vendors may “switch on”

additional metrics for a cost, this is a financial burden that smaller providers may not be able to absorb.

The credibility of metrics depends on provider workflow: Even for the Meaningful Use CQMs that are pre-programmed into EHRs, the ability to produce high-quality, accurate data for each metric relies on the workflow and processes that ensure providers are entering appropriate data into the relevant fields of their EHR.

Aggregating and analyzing clinical data can be challenging for some CCOs, health plans and health systems: Aggregating clinical data across different EHRs is a specialized technical skill set. While some CCOs, health plans and health systems have the capabilities or obtain them through community HIEs and other “data intermediaries,” access to these services is not statewide. Access to these capabilities is limited, especially for smaller providers.

Individual-level data may be necessary to drive positive change: While some health plans and CCOs may be able to access provider- or clinic-level metrics, it may still be challenging to access individual-level clinical data. Individual-level clinical data allows the greatest flexibility in analytics, including the ability to drill down to identify patients in greatest need of follow-up. One HIT Task Force member noted that showing providers their performance results can elicit reactions of denial, unless the providers can see the specific list of patients where they are not meeting the performance target.

Translating data into action: Providers are ready for information that allows them to better understand and manage their patient panels. However, the ability to translate metrics into practice improvements and/or to target patients needing care varies among providers and can depend on the utility of the reported data. Having excellent analysis of performance data, trends and benchmarking are of little use if providers are not able to take action or change practices to realize improvements. Health systems, CCOs and health plans also vary in their ability to work with practices and target their resources.

Governance and ownership of data: Much of the patient data used for quality improvement, population management and incentives for health and prevention is covered under HIPAA provisions for health plan or provider treatment, payment, or operations purposes. The intersection of HIPAA with other privacy protections, such as 42 CFR Part 2, can create uncertainty about what information can be shared and how. Questions may arise regarding who owns the data and who can access the data. Protecting patient privacy and assuring security are paramount when working with patient information.

Goal 2: Recommendations

The State will support community and organizational efforts by:

Promoting EHR adoption and Meaningful Use: To help communities realize the benefits of EHRs, the State can support providers’ efforts to adopt certified EHRs and meet Meaningful Use requirements, including raising awareness of new formats and functionality included in EHRs for electronic reporting of clinical quality measures.

Leveraging national standards and federal EHR incentives: The State will use available levers to promote participation in the EHR

incentive programs and certified EHR adoption, as Meaningful Use Stage 2 requirements provide better access to automated clinical quality measures, leveraging the new automated formats available in 2014-certified EHRs. Where relevant to Oregon's interests, the State will advocate nationally for standards and policy that further the ability of providers to seamlessly report clinical quality metrics from their EHRs.

Assessing changing environments and convening stakeholders: The State will monitor and report on how EHR vendors adapt to new 2014 certification standards and how new EHRs meet clinical quality metrics/reporting needs.

The State will work with stakeholders to:

Adopt standards for safety, privacy, security and interoperability:

Where possible, State standards will be aligned to national standards, such as HIPAA privacy provisions. See Chapter V. Governance for more discussion of standards and the compatibility program.

Align metrics and reporting: The State will use available levers to align metrics and reporting requirements across Oregon. In particular, the State will seek opportunities to align all clinical metric specifications and reporting requirements with those already required for national programs and standards, such as Meaningful Use and National Committee for Quality Assurance (NCQA) standards. In addition, the State will facilitate a "report once" model, where providers can report to one source and have the data count for multiple pay for performance programs. The State will advocate for all pay for performance programs to be aligned around a common set of metrics.

The State will provide:

Statewide enabling infrastructure: The enabling infrastructure services will provide core baseline services such as a provider directory and patient/provider attribution service to support analytics and use of aggregated clinical data (see Chapter IV. Technology Recommendations for more details).

Clinical metrics data for Medicaid: The State will develop a clinical quality metrics registry with the ability to aggregate key clinical quality data for the Medicaid program, develop benchmarks and other quality improvement reporting and calculate clinical quality metrics for paying quality incentives to CCOs and Medicaid EHR incentives to providers.

To provide transparency into statewide, regional and local performance, the State will use the registry data and other state data sources to produce information on utilization, cost, and performance on clinical quality metrics. Development of the clinical quality metrics registry will start small and is expected to expand beyond the three initial quality measures and potentially beyond Medicaid.

As the State-level clinical quality metrics registry evolves, it will likely have value for non-Medicaid pay-for-performance programs and the potential for reducing burden on providers by collecting Meaningful Use clinical quality measures for multiple programs. Leveraging data that is already being collected individually will provide economies of scale, reduce reporting burdens and, as more

populations and providers contribute data, increase the value of benchmarking and comparative data produced from the registry.

Technical Assistance to Medicaid providers: The State will contract for technical assistance to Medicaid providers to support EHR adoption and Meaningful Use. Technical assistance can improve credibility of EHR data underlying clinical quality measures, bolstering provider confidence in metrics.

GOAL 3: Individuals and their families access their clinical information and use it as a tool to improve their health and engage with their providers.

Individuals and their families or caregivers can partner with their providers when they are educated and engaged. Unfortunately, many individuals do not have access to and ownership of their complete health records, including treatments and goals. Further, individuals often have concerns about the privacy and security of their personal health information.

Individuals can also be empowered to provide some of their own clinical data using remote monitoring devices and new applications that allow them to engage with their health care teams remotely. For example, new chronic pain management applications for smart phones or tablets have patients estimate their pain levels on a regular basis, sending the patient-entered information to the care team for monitoring and immediate intervention when needed.

To reduce gaps in patient access to their health information:

- Individuals should have access to their complete health record, including treatments and goals in order to improve their understanding and engagement in their health care and outcomes.
- Individuals should have ways to provide important information into their health records, including clinical data and their preferences related to their care, such as end of life care and POLST forms.
- Individuals should have the capacity to facilitate care management by sharing data with their providers.
- Sufficient safeguards should be in place and be clearly communicated to patients so individuals have confidence in the privacy and security of their electronic health information.

Personal Health Records improve patient engagement

Individuals with access to their personal health information are more empowered to engage in their care and well-being. This can mean better outcomes and lower costs.

Goal 3: Recommendations

The State will support community and organizational efforts by:

Promoting EHR adoption and Meaningful Use: The State will use levers, such as promoting the EHR Incentive Program, to encourage providers to make protected health information available to patients. Meaningful Use Stage 2 requires eligible providers to give patients secure, electronic access to their health information.

Leveraging national standards and federal EHR incentives: To inform and support stakeholders, the State will monitor national efforts and standards, the evolving personal health record market and direct-to-consumer health care.

Promoting statewide direct secure messaging: The State will engage in national discussions around extending Direct secure messaging to patients.

Providing guidance, information and technical assistance: The State will support efforts to make patient information available electronically by informing stakeholders, supporting initiatives, and seeking to advance Meaningful Use requirements for making information available to patients.

Assessing changing environments and convening stakeholders: The State will identify and disseminate best practices, and seek opportunities to explore promising approaches. As part of that effort, the State will engage individuals to identify opportunities, preferences and barriers around engaging in their health care via electronic interaction with their health information.

Creating Oregon's HIT-Optimized Health Care System

All Oregonians have a stake in achieving HIT-optimized health care, and making the vision a reality will require participation, investment and support from all of Oregon's health care partners. The Task Force made recommendations for what health plans, CCOs, community and organizational HIEs, health systems, providers and individuals can do to ensure that all health care delivered in Oregon is optimized by HIT.

To ensure providers have access to meaningful, timely, relevant and actionable patient information to coordinate and deliver "whole person" care:

- Health plans and CCOs support and encourage Meaningful Use of certified EHRs and participation in HIE. Health plans and CCOs align reporting requirements with Meaningful Use clinical quality measures and State efforts and further incentivize Meaningful Use.
- Providers and health systems have the technology capabilities and workflows to participate in care coordination, including:
 - Pursuing Meaningful Use of EHR technology (particularly for providers eligible for EHR incentive payments), and incorporating the use of technology into workflows.
 - Participating in HIE across organizational and technological boundaries via Direct secure messaging and community, organizational, and statewide HIE efforts.
 - Sharing information and engaging in care coordination efforts.
 - Including all members of the care team in coordination and sharing information, including physical, behavioral health, dental, long-term care and social services partners.
- Individuals and their families or caregivers expect that providers have electronic access to their patient information, inform their providers on where patient-generated information can be accessed (such as a personal health record), and seek to engage in their care and outcomes.

To ensure systems and policy makers use aggregated clinical data and metrics for quality improvement, population management and incentivizing health and prevention; to inform policy development and to provide transparency into the health and quality of care in the state:

- Health plans and CCOs align quality reporting requirements with a core common set of clinical quality metrics relying on the EHR Incentive Program Meaningful Use metrics and specifications. They also invest in technology and processes to use aggregated clinical metrics data for effective population management, performance monitoring and creation of new payment models to reward outcomes rather than old models of paying for visits.
- Health plans, CCOs, health systems and providers work together to ensure the credibility and quality of clinical data generated from EHRs.
- Providers and health systems upgrade to meet 2014 EHR certification requirements that enable EHRs to produce clinical quality metrics, generate and report on clinical metrics data, implement workflow changes that may be needed to ensure quality of data, and make practice changes and target patients for interventions based on metrics and analysis of practice performance.

To ensure individuals and their families access their clinical information and use it as a tool to improve their health and engage with their providers:

- Health plans, CCOs, and community HIEs encourage and empower patient/provider relationships via electronic interaction with health information.
- Providers and health systems educate, engage and empower individuals through access to their health information as the providers have the primary relationship with individuals (and often their families).

IV. Technology and Services Recommendations

Overall Approach to Statewide Coverage

The Task Force considered several options for the State's overall approach to delivering statewide HIT/HIE coverage. These options are best viewed across a spectrum, with an entirely private model with no statewide support representing one extreme, and an entirely public model where the State provides all HIT/HIE services as the other. In light of past recommendations, current developments and Oregon's HIT/HIE environment, the Task Force decided to continue with an approach originally championed by HITOC in 2011.

This approach strikes a balance between the two extremes, and relies on the following six key elements: 1) community and organizational HIT/HIE efforts, 2) statewide Direct secure messaging, 3) CareAccord®, 4) new statewide enabling infrastructure services, 5) State aggregation of core clinical metrics data for Medicaid purposes and 6) technical assistance to providers to support EHR adoption and Meaningful Use.

1. Community and organizational HIE efforts

Various local efforts have emerged to offer HIE solutions. See Appendix B for more background on Oregon's HIT/HIE environment. Oregon has four community health information exchange organizations (HIEs) and many larger health systems have commercial HIE capabilities. These community HIEs and organizational HIEs may use various standards to connect their members internally, ranging from

industry standards (such as Integrating the Healthcare Enterprise (IHE) standards) to proprietary vendor solutions.

In 2014, providers seeking EHR incentive payments will need to upgrade to EHRs certified to 2014 standards, including the capacity to electronically transmit information using Direct secure messaging. Direct secure messaging vendors (Health Information Service Providers (HISPs)) can offer numerous ways for their members to interact with their services, including web portals and integration into their members' EHRs.

2. Statewide Direct Secure Messaging

Many Oregon providers will soon have the ability to share key health information electronically across organizational and technological boundaries, with the increased use of Direct secure messaging. As Oregon providers increasingly work together to coordinate care for Oregonians, there is an increased need to simply send the right patient information to the right place in time to make a difference in care.

Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories and more sophisticated attachments such as x-rays and echocardiograms. As electronic health records (EHRs) evolve in 2014 to meet EHR incentive program requirements, Direct secure messaging will be a core service within each certified EHR and national standards will support interoperability between Direct secure messaging providers (Health Information Service Providers, or HISPs).

Other important elements of Direct secure messaging include:

- **Provider directories:** Direct secure messaging assumes that the person sending a message has the Direct address of the person they are sending to. In many cases, that is not the case. To facilitate Direct secure messaging, providers may need to look up or query to find the Direct addresses of the entities and providers they wish to send information to. Some EHRs and HISPs are adding interoperable, standards-based internal provider listings that greatly facilitate this provider look up capability.
- **HISPs and trust communities:** Although each EHR may have Direct secure messaging available in 2014, it will be critical for health systems, hospitals and providers to ensure that their HISPs meet national standards and are interoperable with other HISPs. Selecting a HISP that is a member in applicable trust communities (the two leading, national trust communities are the National Association for Trusted Exchange (NATE) and DirectTrust) will enable parties to more easily exchange with their partners and broader nationwide networks without having to negotiate distinct relationships.

3. CareAccord®: Core baseline services

The vision for the CareAccord® Program, which includes Direct secure messaging, is to provide access to statewide HIE. Providers participating in community or organizational HIEs and providers who have Direct secure messaging (HISP) services integrated within their 2014 certified EHRs can engage in statewide HIE through accessing enabling infrastructure services that connects their local HIE or HISP to others in the state.

For other providers--such as providers in regions with no community HIE, those who have not upgraded to 2014 certified EHR technology, and others who are unlikely to use 2014-certified EHRs, such as long

term care, behavioral health and social service providers and care coordinators--the CareAccord® Program offers Direct secure messaging. In addition, the CareAccord® Program will provide other core baseline services statewide. This ensures no member of a care team is disenfranchised and unable to participate in electronic care coordination and exchange.

CareAccord® core baseline services include:

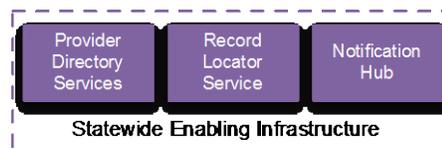
- Currently CareAccord® provides Direct secure messaging (HISP) via a web portal. Additional services for CareAccord® subscribers without EHRs or other technology will include:
 - Fillable forms or data entry templates to support common use cases (e.g., transition of care records from long term care facilities). These templates or forms can facilitate the ability of providers receiving the information to ingest the data into the patient record in the provider's EHR.
 - Translation for computer-generated attachments to make them human-readable.
- For Phase 1.5, the Task Force recommended that integration of Direct secure messaging into EHRs and provider workflows would be essential to achieving the value of sharing health information. The Task Force also recommended consideration for integration of Direct secure messaging into other systems in use by providers (such as social services case management systems).
- Access to CareAccord® statewide enabling infrastructure services to facilitate exchange within and outside of CareAccord®.
- Potential query capabilities in Phase 2.0, depending on the EHR incentive program Meaningful Use Stage 3 requirements and evolving national standards.

In terms of trust communities, CareAccord® is the first state health information exchange in the nation to receive Direct Trusted Agent Accreditation. The Direct Trusted Agent Accreditation Program measures privacy, security, confidentiality and best practices with Direct protocol, and enables CareAccord® subscribers to securely send Direct secure messages to any subscriber in the DirectTrust trust community. CareAccord® is also a member of NATE (National Association of Trusted Exchange), which currently enables exchange between CareAccord® subscribers and providers in California and Alaska.

4. Statewide enabling infrastructure services

Statewide enabling infrastructure services provide core services that facilitate efficient use of HIT and information exchange across organizational boundaries. Ensuring appropriate funding, governance and participation in the statewide enabling infrastructure services will be critical for the success of these efforts.

Practices, providers, hospitals, health systems, health plans, and others may directly participate in the State HIE without going through community or organizational HIEs or HISPs if they have the right technology. Following are the HIT Task Force recommended enabling infrastructure services.



Provider directory services: Provider directory services are critical for several uses: health information exchange, analytics, State program operations, health plan and health system operations, statewide common credentialing efforts underway at OHA, public health program operations, and others. Oregon's provider directory will be developed in phases, starting with key use cases (health information exchange, common credentialing, etc.) and expanding over time to serve other use cases. The provider

directory will include all types of providers and organizations that participate in these use cases, not just physical health providers and hospitals.

The provider directory services, which will be introduced in Phase 1.5 and enhanced in Phase 2.0 as needed to support emerging query standards and the evolution of provider directory standards, will:

- Enable lookup of parties (e.g., organizations and individuals) and their associated information (e.g., name, postal address, phone number, electronic service address for HIE purposes) using identifying characteristics. The provider directory would identify key affiliations, such as individual provider affiliation to their practices, health systems, health plans, etc.
- Act as a “router,” and a single lookup point, distributing lookup requests to provider directories at community and organizational HIEs and health systems and returning aggregated responses.
- May include core provider data in a central database (e.g., static data such as name, demographics, etc.).

Common credentialing: OHA is mandated to establish a common credentialing database and program by January 2016, which will provide credentialing organizations (hospitals, health systems, health plans, etc.) access to commonly held information necessary to credential all health care practitioners in the state. Common credentialing and provider directory efforts have many opportunities for synergies, and staff are working to ensure the two efforts align where possible. For example, common credentialing may leverage some of the statewide provider directory’s technology infrastructure, and common credentialing efforts can provide an excellent data source for the provider directory.

Additional considerations from the HIT Task Force: Provider directory services are integral to many functions beyond HIE. Keeping the provider information up to date is both important and challenging. Strategies that align providers’ self-interest to keep the information updated would be ideal, such as leveraging common credentialing processes.

Patient attribution, record locator service and query: Like provider directory services, a patient attribution service that includes provider affiliation services is critical for several uses: health information exchange, analytics, State program operations, health plan and health system operations, and others. Oregon’s patient/provider attribution services would be developed in phases, starting with key use cases (e.g., hospital notifications) and expanding over time to serve other use cases.

Patient/provider attribution provides base level data that can be used for record location when matching patient records from different data sources. Record location services would not include the development of a universal patient identifier, but rely on the state-of-the-art matching algorithms to match patient records from different data sources based on key demographic information.

Patient/provider attribution, record locator and query enabling services, which will be offered in Phase 1.5 and expanded in Phase 2.0, will offer the following:

- When given demographics and information related to a patient, potential sources of information for that patient, along with each source’s relationship to that patient (if known), are returned.
- Phase 1.5’s notification hub will have the (internal) ability to attribute patients to providers via information supplied by notification subscribers. This source data provides an incrementally developed patient/provider attribution service, which can be leveraged for health information exchange and analytics purposes.

- For Phase 2.0, facilitating statewide query capabilities will be important. Before investing in more robust statewide infrastructure, it will be critical to account for evolving national standards around query, including requirements for the Meaningful Use Stage 3.
- Contingent upon the evolving federal standards, Oregon’s enabling infrastructure services may include a record locator service in Phase 2.0. This service would build on and decouple the patient/provider attribution function from the notification hub while also providing data location capabilities to facilitate push and query-based exchange.

Additional considerations from the HIT Task Force: Although patient matching algorithms have come a long way, often a human decision is needed to make a sufficient match. This work can be complex and will likely evolve over time. OHA should explore leveraging other potential sources of patient/provider affiliation data.

Notification hub: The notification hub, which will be initially developed in Phase 1.5 and incrementally enhanced in Phase 2.0 as needed to support emerging notification standards and statewide alerting needs, will include the following:

- The hub will accept notifications and alerts and relay them to applicable parties statewide. For example, the hub receives daily information feeds from a hospital and sends notifications to the clinic or health plan affiliated with each individual seen in the hospital.
- Beyond those related to hospital admission/discharge, potential notifications and alerts to be considered for Phase 2.0 include:
 - Notifications to care teams when individuals transition into/between long term care settings. Nursing facilities could notify hospital discharge staff when beds become available, and hospital discharge staff could notify nursing facilities when a bed is needed.
 - Alerts to pediatricians and/or early education services providers when developmental screenings have occurred.
 - Notifications to health plans, CCOs, or care teams when individuals are released from jail.

Emergency Department Information Exchange (EDIE): OHA is participating in a public/private collaboration to bring the Emergency Department Information Exchange (EDIE) technology to all hospitals in Oregon in 2014. All 59 hospitals in Oregon have agreed to implement EDIE by November 1, 2014. The EDIE project will provide emergency departments with key care summaries for patients who have high utilization of emergency department services, with the goal of reducing unnecessary hospital services and improving outcomes. Statewide hospital notifications augment the work under EDIE, by notifying providers, health plans, and care coordinators when their members or patients are seen in any hospital in the State.

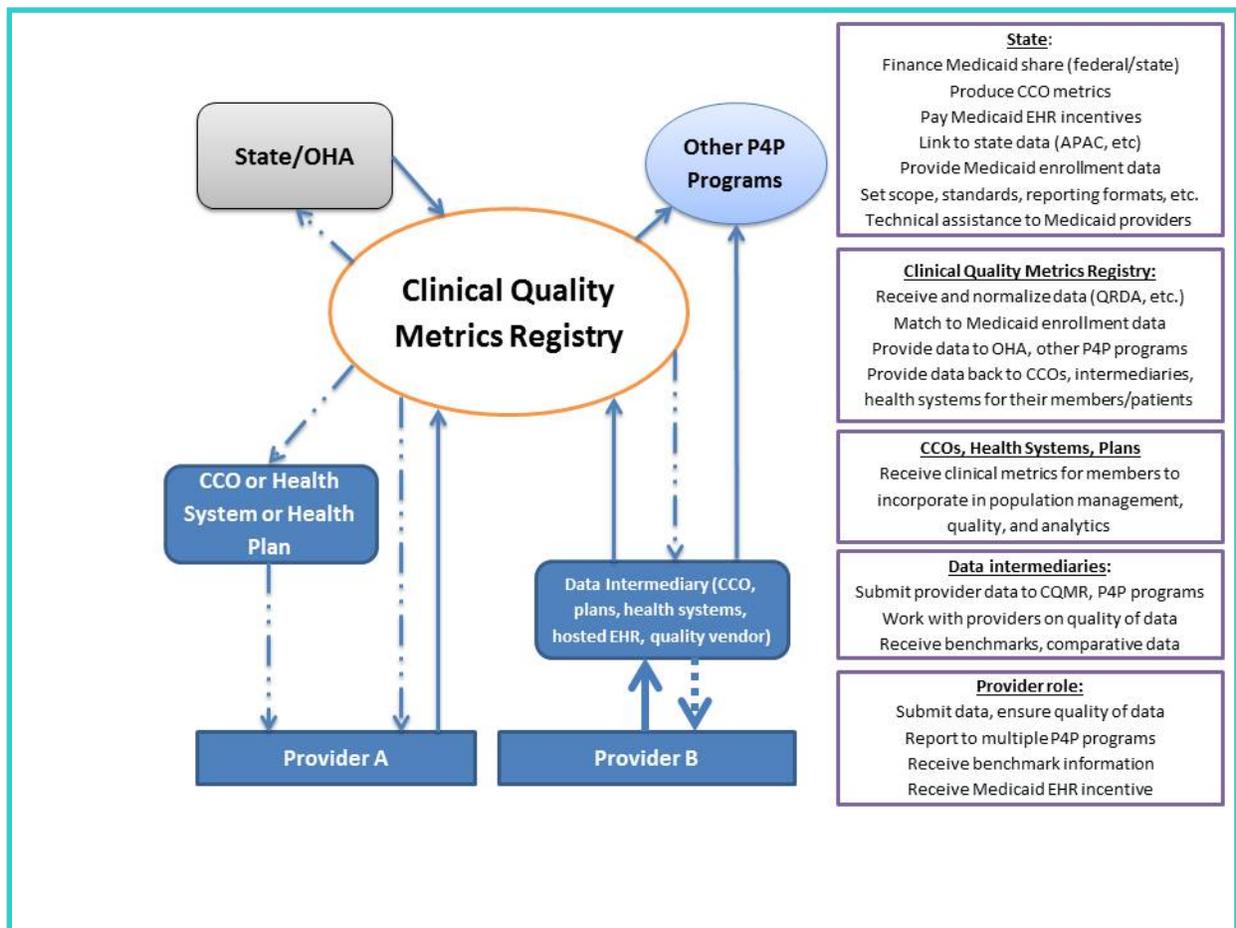
Additional considerations from HIT Task Force:

- Careful planning is needed around how statewide notifications services would interact with community or organizational notification efforts currently underway, with a focus on supporting those notifications by adding new data sources (e.g., hospital notifications from other regions).
- Close attention must also be paid to the provider/user’s experience and to avoiding “alert fatigue” and redundant alerts.
- Consideration must be given to how best to leverage the work underway with the EDIE project, as EDIE will be implemented in nearly all hospitals in the state. For example, EDIE may be

extensible to link to or provide further notifications services, which could minimize burden on hospitals in reworking interfaces for inpatient notifications. Also, it will be important to ensure that EDIE interfaces with CareAccord® and the statewide enabling infrastructure services.

5. State aggregation of clinical quality metrics for Medicaid purposes

OHA is planning to develop the ability to aggregate key clinical quality data for the Medicaid program, develop benchmarks and other quality improvement reporting, and calculate clinical quality metrics for paying quality incentives to CCOs and Medicaid EHR incentive payments to providers. Particular focus is on the three clinical CCO incentive metrics that are also EHR incentive program metrics: diabetes poor A1c control, hypertension, and depression screening. CCOs can leverage State infrastructure to meet reporting requirements to OHA and receive collected clinical data for their members for analytics/quality improvement. The registry could receive data either directly from providers (see Provider A example below) or from a data intermediary such as a CCO, health plan, system, quality vendor, or the like (see Provider B example below). Once developed for Medicaid, the registry could be expanded to other uses, as described on pages 24 of this document, under “Clinical metrics data for Medicaid”.



6. Technical assistance to Medicaid providers

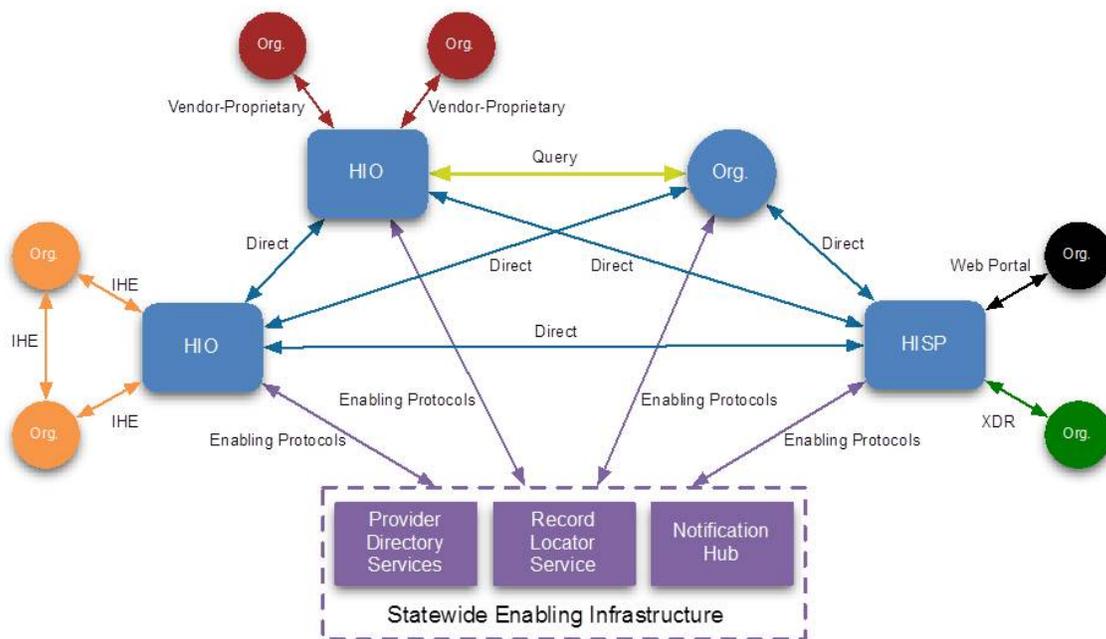
OHA has obtained Medicaid funding to provide technical assistance to Medicaid providers to support them in the Meaningful Use of their EHRs. Technical assistance will help providers to effectively use their EHR technology and realize the benefits of their investments in EHRs. By helping providers use workflows that support accurate entry of information into their EHRs, technical assistance increases the reliability of clinical data extracted from EHRs. Improving the credibility of EHR data, in turn, bolsters provider confidence in clinical quality metrics. Technical assistance also supports the aim of promoting EHR adoption and Meaningful Use, and will help Medicaid providers meet requirements to qualify for EHR incentive payments. In particular, this assistance can help further goals of achieving statewide Direct secure messaging by assisting providers seeking to meet Meaningful Use Stage 2 requirements related to using Direct secure messaging. Technical assistance contracts are anticipated to be in place in 2014, contingent upon CMS approval.

Oregon's Long-Term HIT/HIE Landscape: Putting the elements together

The diagram below attempts to illustrate the conceptual HIT/HIE landscape, incorporating four of the elements described above:

- Community and organizational HIEs and health systems provide HIT and HIE services to some providers.
- Statewide Direct secure messaging provides a foundation for sharing information across organizations and differing technologies. This is accomplished by a combination of efforts by providers, community and organizational HIEs, and State-level efforts. HISP participation in common trust communities is key to this interoperability, and is not reflected in the diagram below.
- State-sponsored CareAccord® provides common services as baseline HIE capabilities to those without access to community or organizational HIEs (in the diagram below, CareAccord® is represented as a HISP). Subscribers receive Direct secure messaging and access to statewide enabling infrastructure services through CareAccord®.
- Statewide enabling infrastructure ties together local efforts where they exist and provides enabling HIE and HIT functions (such as identifying providers or locating patient records) across community and organizational HIEs, health systems, providers and other entities. Enabling infrastructure also includes statewide notifications of hospital events. (Note: "Enabling Protocols" is a convenient way to refer to the set of mechanisms supported by each piece of enabling infrastructure services for interactions.)

Oregon's Long-Term HIT/HIE Landscape



Technology implementation considerations and principles:

The Task Force offered several principles to guide the State as it continues to implement HIT/HIE technology and services:

- HIT/HIE infrastructure and services must be interoperable. Interoperability will be reached through leveraging national standards and initiatives, including anticipating where national standards are evolving to be prepared for the future.
- Don't let "perfect" be the enemy of "good."
- Behavioral health, dental, long-term care and social services professionals must be included in the HIT/HIE environment.
- State communication and outreach must help providers understand the vision of HIT-optimized health care and participate in HIT/HIE services in meaningful ways.
- State-level services must have sufficient technical support to effectively implement and support delivery of services.
- The integration of the HIT/HIE enabling infrastructure services into existing technology and workflows directly correlates to the use and value of those services, and can greatly impact the business case for funding these services.

Phasing: Near-Term Development (Phase 1.5) and Longer Term (Phase 2.0)

As noted in the sections above, statewide HIT/HIE infrastructure is expected to be developed in phases. Current efforts (Phase 1) include CareAccord® Direct secure messaging web-portal based services. For 2014-2015, Oregon has State funding in place to leverage federal funding and develop six elements (“Phase 1.5”) described below. In 2015 and beyond, Oregon will seek additional funding for expansion of Phase 1.5 elements and potential addition of a record locator service (“Phase 2.0”).

In collaboration with and support of all 16 CCOS, OHA is accelerating development of core baseline services and enabling infrastructure services in 2014-2015 (“Phase 1.5”). The near-term statewide HIT/HIE priority elements were identified through the stakeholder process, including the listening sessions, conversations with the HITOC, and discussions with CCOs, health plans, providers and interested parties. The HIT Task Force incorporated Phase 1.5 efforts into its technology recommendations.

Oregon’s HIT/HIE Roadmap to Support Health System Transformation



V. Governance, Policy and Operations Recommendations

Background: HIT/HIE Governance

In approaching the issue of governance for statewide HIT/HIE services, the Task Force considered the common models of HIT/HIE governance, HITOC's 2010 governance recommendations, Oregon's current HIT/HIE environment, and themes from other state HIT/HIE governance models.

HIT/HIE Governance Models

There are three primary models for the governance of statewide HIT/HIE services:⁴

- Government-led: The government is directly responsible for the provision of HIT/HIE infrastructure as well as overseeing its use.
- Public Utility with Government Oversight: The private sector provides HIT/HIE infrastructure while the government provides regulatory oversight.
- Private Sector-led with Government Participation: The government collaborates and advises as a stakeholder in the private-sector provision of HIT/HIE infrastructure.

2010 HITOC Governance Recommendations

In 2010, a strategy work group convened by HITOC determined that Oregon's governance model should take a phased approach to developing a public utility with government oversight. In the first phase, the State would support existing community and organizational HIT/HIE efforts by providing HIE policies, requirements, standards and agreements. The work group anticipated that a financial sustainability plan and necessary legislation would allow for a second phase in which a state-designated entity would be created. The designated entity could serve as the central contracting point for community and organizational HIT/HIE efforts and act as the accrediting body by implementing the policies developed in the first phase.

Oregon's Current HIT/HIE Environment

Since 2010, Oregon's HIT/HIE environment has changed. Some local HIT/HIE efforts have come and gone, and the State has begun to provide HIT/HIE services to support health care transformation. Currently the State is responsible to:

- Provide public accountability and transparency into State efforts, including the CareAccord® program and the Medicaid EHR Incentive Program.
- Operate the CareAccord® program working with a contracted vendor. OHA chose this approach to fully utilize Oregon's federal HIE funding (from the American Recovery and Reinvestment Act (ARRA), Health Information Technology for Economic and Clinical Health (HITECH) Act State HIE Cooperative Agreement) through the Office of the National Coordinator for HIT (ONC). This approach also maximized the potential of Medicaid funding because the State retained

⁴ National Governors Association Center for Best Practices, "Health Information Technology (HIT) Governance & Coordination." <http://www.nga.org/cms/home/nga-center-for-best-practices/center-divisions/center-issues/page-health-issues/col2-content/main-content-list/health-information-technology-hi.html>.

operational authority and enhanced coordination between the HIE efforts and the Medicaid EHR incentive program.

- Convene the CCO HIT Advisory Group (HITAG) to guide the use of State funds in the implementation of Phase 1.5 services (started in October 2013).
- Establish, document and operationalize State policies related to HIT/HIE within legal parameters, including HIPAA and other federal regulatory requirements, such as 42 CFR Part 2.
- Manage the relationship with federal partners, including ONC for the ONC State HIE Cooperative Agreement and CMS for Medicaid HITECH Act funding and programs including the Medicaid EHR incentive program. The State also is responsible to ensure compliance with federal program requirements.

Other HIT/HIE Governance Considerations

In deliberating about Oregon’s HIT/HIE governance model, the Task Force considered common themes across governance models from other states and the 2010 HITOC recommendations. These themes informed the Task Force’s recommendations.

- In any governance model selected, the State will have some role in the oversight structure. At a minimum, the State will have an ongoing role in:
 - HIT/HIE strategy development
 - Contract/fiduciary oversight
 - Board/advisory council membership – in some states, government participation is in an ex-officio capacity
- The selection of a governance model affects the options for financing. To achieve stability, most governance models enable access to several sources of funding:
 - Initial funding via ONC State HIE Cooperative Agreement
 - Moving to subscription/membership fees,
 - Leveraging state allocations, and/or federal Medicaid funding paired with private funding.

Recommendations for Governance of HIT/HIE services

Principles and Characteristics

The HIT Task Force considered the following common principles and characteristics that HIT/HIE governance structures should incorporate regardless of organizational structure. These principles are described by the Markle Foundation as part of the “Markle Connecting for Health Common Framework for Private and Secure Health Information Exchange.”⁵

- **“Participation:** Regular and intentional public outreach and deliberations are an important aspect of legitimate decision-making and governance processes. Policies and procedures developed through a collaborative process that seeks early input, promotes broad participation, and provides public comment periods have a greater likelihood of being understood and supported by those they are designed to serve.”
- **“Transparency and Openness:** It is also important to provide clear explanations for the rationale behind final policies and decisions. This includes documenting the processes and decisions of any workgroups or subgroups and addressing comments received by the public. Transparency

⁵ <http://www.markle.org/health/markle-common-framework/connecting-professionals/hie-governance>

should be a goal in other administrative respects, including how operations are financially supported and sustained.”

- **“Representation:** Meaningful engagement and balanced representation of a wide variety of participants, including patients and consumers, is critical to the success of health information sharing efforts. Because the goal of safe, secure and appropriate health information sharing depends on the buy-in and participation of a wide variety of health care system participants, that same range of engagement and input is required for governance to succeed.”
- **“Effectiveness:** A successful governance model will create the structure and processes needed to support effective and efficient decision-making. To operate effectively, governance efforts need adequate resources and staff who are knowledgeable, dedicated and able to execute the policies and procedures. No single governance model works for all information sharing efforts, but rather an array of tools and processes that can be used by different entities and/or participants.”
- **“Flexibility:** Policies and procedures need to be flexible. Governance models should keep members informed and enable them to react quickly to a changing environment. ... Governance models should also accommodate constant and rapid innovations in technology. Flexibility will allow an entity to incorporate and maximize use of these technological innovations, and thus governance policies should remain technology-neutral.”
- **“Well-defined and bounded mission:** A plainly articulated vision that clearly sets forth the value case for information sharing, as well as a well-defined scope of authority, will help ensure that the governance processes are timely, relevant and appropriate. The scope should be limited to the necessary policies and procedures that must be commonly defined and agreed upon to achieve these two high-level objectives. Clearly articulating a high level mission is critical for prioritizing strategic objectives and addressing the issues appropriately as they emerge over time.”
- **“Accountability:** Accountability is a vital element of any governance process and should include procedures for the submission and handling of complaints related to policy violations. In addition, a clear and public dispute resolution process should be developed. ... Health information sharing efforts have a range of accountability and enforcement mechanisms to choose from to best fit their particular objectives and circumstances, but the existence of each should be shared publicly.”

State and Stakeholder Roles in Governance, Policy and Operations

After careful consideration, the Task Force proposed a governance model similar to the one conceived in HITOC’s 2010 recommendations. In this proposed governance structure, the State retains the following roles:

- Statewide direction and oversight
- Accountability and transparency
- Statewide standards and policies
- Policy implementation, including compliance with federal requirements (Medicaid, HIPAA, etc.)
- Meaningful ongoing engagement with stakeholders, including convening, policy and legal guidance and technical assistance.

While the State would retain those roles, an HIT designated entity (see “HIT Designated Entity Role” below) would transition into the operations role. To ensure that the State could step in if needed, some HIT Task Force members recommended fail-safe measures, such as provisions to allow the State to reset

the board of directors and/or to allow the State to exercise a direct relationship with the HIE vendors involved in the infrastructure and support, if the HIT Designated Entity does not fulfill its role.

Stakeholders would continue to provide input and feedback on statewide direction, standards and policies, and the direction and effectiveness of HIT/HIE programs and enabling infrastructure services. The HIT designated entity would be accountable to the State to meet its contracted and designated obligations, as well as accountable to its oversight board or steering committee.

HIT Designated Entity Role

In Phase 2.0, OHA intends to create a new entity or contract with an existing entity. The HIT designated entity would be responsible to implement policies and requirements developed by the State. The entity would:

- Become the central contracting point for data use and business associate agreements with community and organizational HIEs and data providers.
- Contract with technology vendors to implement and operate statewide HIT/HIE enabling infrastructure services.
- Coordinate with and support local efforts via HIE programs.

The Task Force considered the following options for the type of HIT designated entity, but did not recommend a specific type:

- Contracted non-profit entity, under the governance of a steering committee or board of directors
- Public corporation, established in legislation, with a board of directors
- Semi-independent entity (Oregon Patient Safety Commission is an example of this kind of entity)
- Special purpose non-profit (e.g., SAIF).

Regardless of the form it takes, the Task Force determined that the HIT designated entity should be:

- Mission focused on statewide HIT/HIE objectives, without conflicting business objectives
- Trusted and objective
- Responsive, with stable leadership and financing
- Transparent and accountable to State oversight
- Experienced

State HIT/HIE Compatibility Program

Under this proposed model, the Task Force determined that the ultimate responsibility for accountability for statewide HIT/HIE resides with the State. To ensure interoperability and the security of information exchanged through statewide services and to protect privacy, the Task Force recommended that the State should establish a new HIT/HIE compatibility program. Any entities seeking to participate in State enabling infrastructure services would need to meet compatibility program expectations. Community and organizational HIE efforts that meet the criteria will have increased credibility in their communities and may be able to attract providers and health system participants.

The purpose of an HIT/HIE compatibility program is to build public trust, accountability and transparency in statewide services, by:

- Ensuring interoperability to improve the use and value of information exchanged, while enabling seamless use of State services that rely on data and technology residing in multiple organizations.
- Ensuring privacy and security practices are in place.
- Providing quality assurance and recourse.

Key features of a State HIT/HIE compatibility program include:

- Core criteria and standards must be met as a condition of participation in statewide services. Entities could operate HIE services in Oregon without meeting the criteria, but would not be able to participate in statewide services. Thus, the criteria are not a mandate across the state, but a condition of voluntary participation. These criteria may be required through participation agreements, although the State may choose to use other more formal mechanisms to specify criteria (law, regulation).
- Any entity that participates directly in statewide services would need to meet compatibility criteria. Entities could include community HIEs, organizational HIEs, hosted EHRs, CCOs, health plans, HISPs, CareAccord®, etc. Entities that participate in statewide services indirectly would need to meet the participation criteria of the community or organizational HIE, but not necessarily the State-level criteria.
- The compatibility program could be carried out in a number of different ways. For example, the program could require documentation and site visits to “accredit” entities, or entities could attest to meeting standards and the State could reserve the right to validate the accuracy of the information attested. Also, the State could delegate the program to an external neutral entity or could retain the program in-house.
- In addition, the State may use other accountability levers to drive toward compliance. For example, using State contracts with providers, CCOs or health plans, the State may encourage or require participation in statewide services.
- The compatibility criteria and program will be developed during Phase 1.5 so they are in place when initial enabling infrastructure services are implemented.
- The compatibility program would reflect federal standards for interoperability, privacy and security of personal health information.

Phasing of Governance/Operations/Policy



VI. Finance Recommendations

Background: Current Financing for State HIT/HIE Services and Federal Funding for Medicaid Services

Statewide HIT/HIE infrastructure is essential for supporting health care transformation efforts, and requires significant financial investment and ongoing financial sustainability. Knowing this, the Task Force reviewed the State's current financing model and available federal funding for Medicaid services when considering the appropriate future financing model for statewide HIT/HIE services.

Federal Funding for Medicaid Services

One potential funding source for Phase 1.5 and 2.0 proposed HIT/HIE infrastructure relates to the Medicaid program. For HIT/HIE infrastructure that serves Medicaid purposes, the State can request 90% federal Medicaid funds to match 10% State funds to cover the "Medicaid share" of implementation costs. (The 90% federal funds combined with 10% State funds often are referred to as "90-10" funds.) For example, the clinical quality metrics registry is needed to collect electronic clinical quality measures for the Medicaid EHR Incentive Program and thus eligible for Medicaid funding. If, over time, the registry is used for purposes beyond Medicaid, private dollars would need to be used to cover costs attributable to private use.

The source for the 10% State matching funds must also meet specified federal Medicaid requirements. In addition, implementation efforts must comply with federal Medicaid procurement requirements and the Centers for Medicare and Medicaid Services (CMS) "Seven Conditions and Standards" for Medicaid funding.⁶ In formulating funding requests, OHA works closely with CMS to ensure compliance with all applicable requirements.

There are two potentially applicable funding streams through Medicaid. Each provides different opportunities and limitations for federal match funding.

- Medicaid Management Information System (MMIS) Funding: Most often thought about in terms of the funding for the State's Medicaid claims processing system, MMIS funds can also provide 90-10 funds for the initial build of IT infrastructure necessary for the administration of the Medicaid program and 75-25 funds for ongoing operations. MMIS-funded projects must be built for State Medicaid purposes, meaning the services will be used for the ongoing operations of Oregon's Medicaid program and be under the control of the State. When the project provides structural support for other State programs and private entities beyond Medicaid, then costs must be allocated between Medicaid and non-Medicaid users.
- Medicaid HIT/HIE (ARRA-HITECH) Funding: Enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009, the Health Information Technology for Economic and Clinical Health (HITECH) Act provides Medicaid 90-10 funds for technology, people and processes for the initial build of certain Medicaid HIT/HIE projects not eligible for MMIS funding. There is no Medicaid HIT/HIE federal funding for ongoing operations. Funding for design, development and

⁶ More information on the Seven Conditions and Standards is available from CMS <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/EFR-Seven-Conditions-and-Standards.pdf>

implementation funding ends in 2021. These HIT/HIE services are focused on the EHR/HIE promotion initiatives, including technology, people and processes that are necessary to encourage the adoption and Meaningful Use of certified EHR technology. CMS will not contribute Medicaid HIT/HIE funding for projects that could be funded by MMIS funds instead, and non-Medicaid users must pay their “fair share” for use of the services. Medicaid HIT/HIE funding is potentially available for statewide HIT/HIE services.

Financing for Phase 1.5 Development and EDIE Implementation

Financing for State HIE ongoing operations of CareAccord® and near-term development of Phase 1.5 services comes primarily from federal Medicaid matching dollars and State general fund investment. The State has had initial success collaborating with private investors to implement EDIE. Moving forward, continuing to identify the value for private investors and further developing these kinds of partnerships will be essential to create a consistent, long-term financing model.

- **CareAccord® statewide Direct secure messaging:** CareAccord® services were financed through February 2014 using federal funding from the Office of the National Coordinator for HIT (ONC) through Oregon’s State HIE Cooperative Agreement. A combination of federal Medicaid and State general funding has been secured for ongoing operations. At present, no private funds are used or fees charged for CareAccord®; the State would need legislative authority to set and collect fees.
- **Phase 1.5 core baselines and enabling infrastructure services:** Initial investment will come from federal Medicaid MMIS or Medicaid HIT/HIE funds (90-10 funding), with the State match coming from a \$3 million State general fund allocation. The State is currently seeking other partners to participate in fair share financing to extend services beyond Medicaid.
- **Emergency Department Information Exchange (EDIE):** The State partnered with the Oregon Health Leadership Council (OHLC), the Oregon Association of Hospitals and Health Systems (OAHHS), the Oregon Chapter of the American College of Emergency Room Physicians and others to implement the privately-led EDIE initiative. The State contributed a one-time, non-Medicaid investment (using Centers for Medicaid & Medicaid Innovation, State Innovation Model grant funds) to subsidize about half of the first year’s costs for implementing EDIE with the condition that the vast majority of hospitals participate. Ultimately, all of Oregon’s 59 hospitals agreed to implement EDIE by November 2014, and will receive the first year of the subscription service subsidized by OHA, OHLC and OHLC’s member plans. As of April 2014, the EDIE governing body and OHLC is considering a shared “utility” model to continue funding for the second and ongoing years of this service. This shared funding model would share costs between health plans, CCOs, and hospitals based on an entity’s relative size, such as membership share or revenue.

Challenges

The Task Force identified challenges the State faces in creating sustainable financing for statewide HIT/HIE services:

- The value of HIT/HIE services does not always accrue immediately. To gather investors, HIT/HIE services must either deliver value to stakeholders directly or there must be a promise of value later.
- HIE efforts in other states have failed due to unsustainable financing, especially when federal funding ended. In some cases, private financing partners, such as health plans, have not seen

much return on their investments in statewide HIT/HIE solutions. Financial commitments and support are paramount for the success of statewide HIT/HIE efforts, as well as leadership and political sustainability.

- Recurring income sources must be sufficient to sustain ongoing operations, which require revenue projections to align closely with demand and sufficient users to generate adequate operating income.
- Community HIEs face long-term financial uncertainty. Potential customers for community HIEs may be reluctant to invest for the reasons stated above. As statewide HIT/HIE services are implemented, consideration should be given to the impacts on sustainability for community HIEs.

Recommendations for Financing of Statewide HIT/HIE Services

Principles

The Task Force reviewed financing models from several states and past HITOC work, and compiled the following principles to inform Oregon's financing model for Phase 2.0 and forward.

- Ongoing sustainable financing for statewide services is dependent on broad-based support.
- Those who benefit from the statewide services should participate in funding.
- Services that support interoperability and provide key infrastructure should receive priority.
- Fee models should encourage use and maximize user value.
- Avoid complexity and unnecessary costs. Costs for HIT/HIE services are overhead to providing direct care to patients.
- Medicaid funding should be appropriately utilized (e.g., considering HITECH Act funds available for planning and implementation costs but cannot cover ongoing operations).
- Build small initially and demonstrate results to build support for financial partnerships. Keep technology scope small and incremental, focusing on high-value, foundational elements. Developing financing partners will be easier when costs are low and value is high. The ultimate financing model may depend largely on the size of the costs (i.e., partners may be willing to risk investment when costs are low).

Approach: Public/Private Partnership

The Task Force recommended that the most likely path to a sustainable financing model is a public/private partnership. The Task Force recommended the following approach to funding:

- Public/private financing models should evolve as stakeholders are engaged and see value. Oregon should remain open to potential financing partnerships and strategies. Financing models where those who benefit participate financially should be considered, such as:
 - A proportional funding model where some or all of the costs are split between stakeholders, including health plans, CCOs, community and organizational HIEs, health systems and the State, and where individual providers have minimal or no costs.
 - A subscription-based financing model where entities who participate in statewide services pay a subscription fee. Based on the statewide enabling infrastructure services technology model (see the Technology chapter), the entities participating directly in statewide services are community and organizational HIEs, health systems, hospitals, health plans, HISPs, providers not connecting through a community or organizational HIE, and other entities. Individual providers that are connected to a community or

organizational HIE or health care system would not directly pay into the statewide services. Subscription fees in other states are often proportional to the size of the organization (e.g., PMPM for health plans, number of beds for hospitals, etc.).

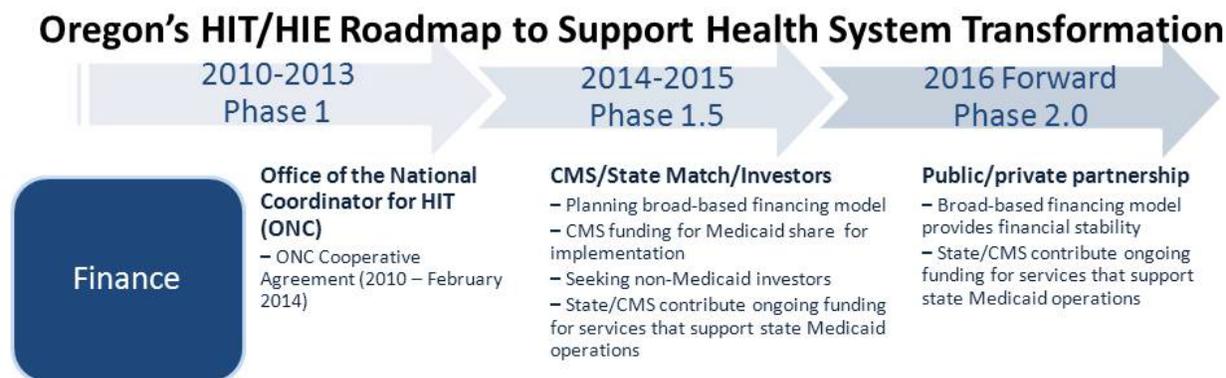
- State agencies using enabling infrastructure services should participate in funding their share of the costs.
- Transaction or per-use fees are ineffective for statewide enabling infrastructure services. Transaction and per-use fees could discourage utilization of State HIT/HIE resources and reduce user value.

Recommendations for Next Steps

The Task Force identified steps the State should take to pursue a public/private partnership to support sustainable financing:

- Seek CMS approval for the Medicaid share of implementation costs and Medicaid financing for ongoing operations for components used for Medicaid operations purposes.
- Seek non-Medicaid partners, including non-Medicaid state agencies and private entities who would benefit from HIT/HIE services, and reach out to communities and organizations engaging in HIT/HIE efforts. Build off successful partnerships such as EDIE and common credentialing.
- Work closely with CCOs to ensure they see the value of investments in statewide Phase 1.5 services.
- Define and seek legislative authority to set and charge fees for statewide enabling infrastructure services.

Phasing for Financing



VII. Conclusion

The work of creating HIT-optimized health care is not easy. As the many stakeholders who have contributed to this report have observed, challenges exist – from the burdens on providers struggling to meet multiple HIT changes in a short time, to the misaligned incentives still embedded in fee-for-service models, to the danger of unintended consequences such as “alert fatigue” resulting from an overwhelming volume of incoming information.

The benefits of achieving HIT-optimized health care, however, will be great. In some areas, these benefits already are beginning to be seen, as improved information sharing supports better care coordination and reduced costs. As the right HIT/HIE services become more ubiquitous and coordinated across Oregon, more Oregonians will experience the advantages of health care that is supported by timely access to patient information. Providers will find it easier to deliver whole person care. Systems will have the clinical outcomes data to enable quality improvement, population management and incentives for health promotion. Policymakers will be able to use clinical data for transparency and policy development. Oregonians and their families will access and use their own health information to be informed and engaged in their own health care.

Providers, systems and individuals all have a stake in making this vision a reality. This report outlines steps for the State, health plans, CCOs, community and organizational HIEs, health systems, providers and individuals. With all stakeholders working together, Oregon can achieve a transformed health care system that is optimized by HIT.

Appendix A: 2013 Stakeholder Listening Sessions and HIT Task Force

Listening Sessions

In Spring/Summer of 2013, OHA staff met with CCOs and other key stakeholders to identify HIT/HIE needs to support health system transformation efforts. These listening sessions included input on the appropriate role for the State and for statewide services in meeting the HIT/HIE needs.⁷

Health Plans	Hospitals/Health systems/Providers	
<ul style="list-style-type: none"> CareOregon Kaiser Permanente MODA (ODS) 	<ul style="list-style-type: none"> PacificSource Providence Regence 	
<ul style="list-style-type: none"> Asante Health System Health Futures CIO Council (Independent Hospitals) Independent Providers 	<ul style="list-style-type: none"> OHSU Providence Tuality Salem Health 	
Medicaid Coordinated Care Organizations	Local/Community Health Information Exchanges:	
<ul style="list-style-type: none"> AllCare Columbia Pacific CCO Eastern Oregon CCO FamilyCare Health Share of Oregon Intercommunity Health Network CCO Jackson Care Connect PacificSource Community Solutions CCO, Central Oregon Region 	<ul style="list-style-type: none"> Bay Area Community Informatics Agency (BACIA) Central Oregon HIE Gorge Health Connect Jefferson HIE 	
<ul style="list-style-type: none"> PacificSource Community Solutions CCO, Columbia Gorge Region Primary Health of Josephine County Trillium Community Health Plan Umpqua Health Alliance Western Oregon Advanced Health Willamette Valley Community Health Yamhill County Care Organization 	<th>Other Key Partners</th>	Other Key Partners
	<ul style="list-style-type: none"> Cover Oregon OCHIN Oregon Health Leadership Council (OHLC) Oregon Public Employees Benefit Board (PEBB) Oregon's HIT Oversight Council (HITOC) Oregon Health Care Quality Corporation 	
	<th>Associations</th>	Associations
	<ul style="list-style-type: none"> Association of Oregon Community Mental Health Programs Oregon Association of Hospitals and Health Systems Oregon Medical Association Oregon Primary Care Association 	

Health Information Technology Task Force

In July and August of 2013, the Oregon Health Authority (OHA) sought nominations for the Health Information Technology Task Force. OHA sought a diversity of stakeholders, including, but not limited to, health plans/payers, health systems, hospitals, providers, local HIE efforts, public sector, advocates/consumers and HITOC members. The Task Force met five times between September and November 2013, with some members participating in additional ad hoc meetings to inform staff work.

⁷ The full listening session report is available at http://healthit.oregon.gov/Initiatives/Documents/Stakeholder_ListeningSession_Summary_2013-08-25.pdf

Appendix B: Background

Oregon's Health System Transformation and Coordinated Care Organizations (CCOs)

Oregon is a national leader and undergoing a multi-dimensional effort to bring the triple aim of better health, better care and lower costs to Oregonians. In particular, Oregon has implemented new coordinated care organizations (CCOs) under an unprecedented Medicaid 1115 waiver and significant federal financial support, including a \$1.9 billion Centers for Medicare & Medicaid Services (CMS) investment over five years and a CMS Center for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) grant. In particular, through the SIM grant, Oregon is working to accelerate and spread the coordinated care model beyond the Medicaid population to public employees, Medicare, and private payers.

The coordinated care model encompasses the following principles and attributes. Many of these principles rely on access to the right patient information at the right time, which can be supported by HIT/HIE infrastructure and efforts.

Utilization of best practices to manage and coordinate care:

- Creating a single point of accountability
 - Providing patient and family-centered care
 - Using team-based care across appropriate disciplines
 - Managing the care for the 20 percent of the population driving 80 percent of the costs
 - Addressing prevention and wellness, including disparities among populations served
 - Broad adoption and use of electronic health records (EHRs)
- 6 Principles of Health Systems Transformation**
- Use of best practices to manage and coordinate care
 - Shared responsibility for health
 - Measured performance
 - Payment based on outcomes and health
 - Information provided
 - Sustainable rate of growth

Shared responsibility for health:

- Shared decision-making for care among patients and providers
- Consumer / patient education and accountability strategies
- Consumer / patient responsibility for personal health behaviors

Measured performance:

- Demonstrated understanding of population served
- Quality, cost and access metrics
- Strategies for targets and improvement

Payment based on outcomes and health:

- Payments aligned to outcomes, not volume
- Incentives for prevention and improved care of chronic illness

Information provided:

- Readily available, accurate, reliable and understandable cost and quality data
- Price and value for payers, providers and patients

Sustainable rate of growth:

- Focused on preventing cost shift to employers, individuals and families
- Reduced utilization and cost trend

Over 90 percent of Oregon's Medicaid population is now enrolled in 16 community-based CCOs, which cover all regions of the State. While there are similarities between CCOs and Medicare Accountable Care Organizations (ACOs), Oregon's CCOs are:

- Full risk-bearing entities operating within a global budget designed to move to payment based on outcomes.
- Responsible for physical, behavioral and oral health care for CCO members.
- The single point of accountability for health quality and outcomes in the population they serve and emphasize a community responding to its unique health needs.
- Rewarded for performance, via quality incentive payments based on performance on 17 key metrics, including three clinical quality measures found in certified electronic health records (EHRs).

- Provided the flexibility, within model parameters, to institute their own payment and delivery reforms that achieve the best possible outcomes for their membership.

Oregon is working to expand the coordinated care model beyond Medicaid to public employees covered through the Public Employees Benefit Board (PEBB), Medicare for individuals who are dually eligible for Medicaid and Medicare, and commercial payers purchasing plans in Cover Oregon, the State health insurance exchange.

Oregon State Innovation Model (SIM) Grant

In 2013, Oregon was one of six states to be awarded a SIM grant from the CMS Center for Medicare and Medicaid Innovation (CMMI) for up to \$45 million for three and a half years. The SIM grant, which provides funding for testing innovative approaches to improving health and lowering costs across the health care system, including Medicaid, Medicare, and the private sector, supports ongoing health system transformation and provides opportunities for Oregon to share what it learns with other states.

The SIM grant funds a number of efforts, including a new Transformation Center within OHA, which:

- Provides resources and technical assistance to Oregon's CCOs.
- Facilitates learning collaborative, rapid improvement cycles.
- Promotes health equity across sectors and payers.
- Evaluates methods of integration and coordination between primary, specialty, behavioral health and oral health.
- Improves community health through promotion and prevention activities.
- Supports CCOs' collaborations with long-term care, community health and social services.
- Tests new payment models.

ONC Cooperative Agreement for HIE and Oregon's Health Information Technology Oversight Committee (HITOC)

In 2009, Oregon's Health Information Technology Oversight Council (HITOC) was legislatively created to set goals, monitor progress in achieving those goals and provide oversight of HIT development and operations. Shortly after HITOC was established, Oregon applied for a four-year State HIE Cooperative Agreement from the Office of the National Coordinator for HIT (ONC). To meet the terms of the cooperative agreement, OHA and HITOC engaged in an intensive strategic planning effort, involving more than 100 Oregonians through eight workgroups, subcommittees, and ad hoc groups, to develop Oregon's HIE Cooperative Agreement Strategic and Operational Plans in 2010. HITOC also provides ongoing oversight and input for the Medicaid EHR Incentive Program and the CareAccord® HIE program.

Currently, the State Coordinator for HIT serves as the Director of HITOC. The State Medicaid director and a State public health representative serve as ex-officio members of HITOC. In addition, Oregon's HIE and Medicaid HIT planning teams are essentially merged under the auspices of OHA's Office of Health Information Technology (OHIT). OHIT staff collaborate with partners from programs in OHA and the Department of Human Services on such issues as physician outreach and communications, long-term care, behavioral health provider concerns and public health HIT/HIE initiatives, among others.

EHR Adoption, Medicaid/Medicare EHR Incentive Programs and Meaningful Use

The Medicare and Medicaid EHR Incentive Programs provide financial incentives for the Meaningful Use of certified EHR technology to improve patient care. To receive an EHR incentive payment, providers must show they are meeting a number of objectives. The Medicaid program provides incentives to eligible professionals and hospitals to adopt, implement or upgrade to certified EHR technology and demonstrate meaningful use. The Medicare EHR Incentive Program provides incentives only for demonstrating meaningful use. Eligible professionals can receive up to \$44,000 through the Medicare EHR Incentive Program and up to \$63,750 through the Medicaid EHR Incentive Program.⁸

Meaningful Use

Meaningful Use is the set of objectives and measures defined by the Centers for Medicare and Medicaid Services (CMS) that governs the use of electronic health records. Eligible providers and hospitals who meet Meaningful Use requirements can receive federal incentive payments. Generally, the requirements for meeting Meaningful Use increase as a provider progresses through the three stages.

Consumer engagement and health information exchange (from a provider to another provider, their patients, pharmacies, labs and public health) are a key focus in Stage 2, and 2014 EHR certification standards support those enhanced EHR functions. For example, to meet the Stage 2 Transitions of Care Objective, 2014 certified EHR technology must be able to electronically send and receive transition of care/referral summaries in accordance with the Direct standard.

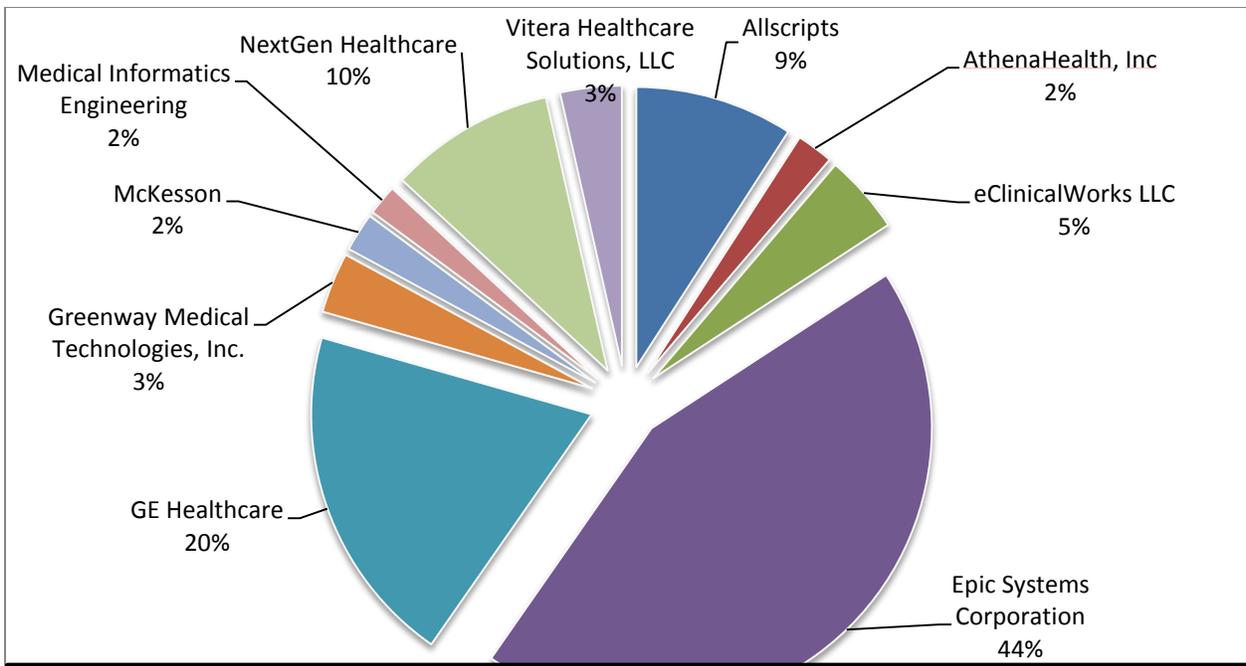
Starting in 2014, all providers must adopt or upgrade to 2014 certified EHR technology, regardless of their individual Meaningful Use stage.

Between January 2011 and September 2013, Oregon providers received \$109 million in Medicare EHR incentives. During the same period, Medicaid paid \$80.4 million to 2,145 providers for a total of \$189.4 million paid to 6,402 Oregon providers through both incentive programs.⁹

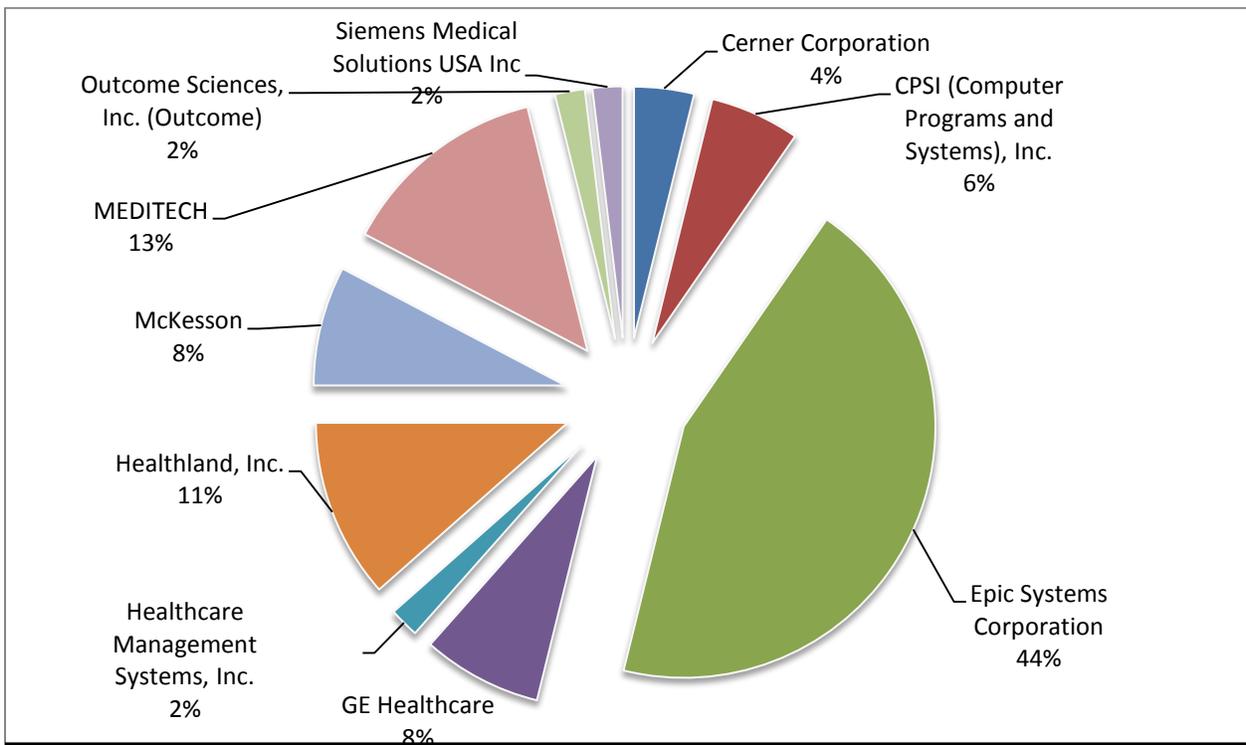
Analyzing the data on EHR incentives paid provides a view into EHR adoption rates in Oregon. Oregon is in the top tier for incentives paid at 42% of all physicians (MDs), physician assistants, and nurse practitioners. Oregon's EHR vendor landscape is varied (see below), with Epic dominating some regions and the hospital environment.

⁸ <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html>

⁹ http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/September2013_PaymentsbyStatebyProgram.pdf



Top 10 EHR vendors in use by Oregon providers receiving either a Medicare or Medicaid EHR incentive payment (2011–Aug 2013). About 83% of providers used one of these 10 vendors. A total of 97 EHR vendors were represented across all providers receiving an incentive.



EHR Vendors in use by Oregon hospitals receiving EHR Incentives (2011-2013). Includes 52 out of 59 hospitals

Statewide and Local HIE Environment

In response to local connectivity needs, local HIEs have developed across the state to facilitate exchange of patient information between providers. Some are organizational centric and some are community based. Significant “white space” exists due to geographic and/or service gaps. Oregon’s current HIE environment includes the following.

CareAccord®:

- Operated by OHA, serving providers statewide.
- Participants include ambulatory providers, long term care, behavioral health, a CCO, and OHA Medicaid and public health programs. As of February 2014, CareAccord® had over 1,000 registered accounts from 117 organizations.
- Vendor: Harris (systems integrator) and MirthMail.
- Services: Direct secure messaging, connecting to other HISPs through DirectTrust accreditation and connecting to California and Alaska providers through NATE membership.

Bay Area Community Informatics Agency (BACIA):

- Based out of Coos Bay, serving the Southern Oregon coast.
- Participants include Bay Area Hospital, North Bend Medical Center, Bay Clinic, Southwest Oregon Independent Practice Association and Western Oregon Advanced Health. Soon to include other local health care entities such as South Cost Orthopedics and Waterfall Clinic.
- Vendor/Services: BACIA acts as the governance and policy-making body, while technology is delivered through the hospital and CCO as follows:
 - Bay Area hospital is implementing Mobile MD, which will offer a number of enhancements to their provider workflow, as well as a patient portal for their EHR. Mobile MD provides a full HIE component as well.
 - Western Oregon Advanced Health (WOAH) is the regional CCO and is implementing an AT&T/Covisint/Milliman solution, providing secure collaboration platform for use by WOAH providers, with predictive modeling and business intelligence tools and analytics. This solution will be based on encounter data and is anticipated to add clinical health information to include mental and behavioral health, medical laboratory, and pharmacy features.

Central Oregon Health Information Exchange:

- Based out of Bend, serving Central Oregon.
- Participants include hospitals, labs, X-ray facilities, and the majority of clinics in the Bend area.
- Vendor: Relay Health.
- Services: Community health record.

Gorge Health Connect:

- Based out of The Dalles, serving the greater Mid-Columbia River Gorge region and supplying Jefferson HIE subscribers with Direct secure messaging services and referrals.
- Participants include Mid-Columbia Medical Center and Clinics, North Central Public Health, Gorge Urology, Mid-Columbia Surgical Specialists. Gorge Health Connect currently serves 9 organizations and 32 providers.
- Vendor: Medicity.
- Services: Direct secure messaging and referrals.

Jefferson Health Information Exchange:

- Based out of Medford, serving Southern Oregon.
- Participants include investments from all four CCOs in the region, Asante Health System, Providence Medford Medical Center, Sky Lakes Medical Center, Mid Rogue IPA and PrimeCare. JHIE currently serves 336 providers in 58 clinics/practices across Southern Oregon. Twenty seven additional clinics/practices are in the enrollment process, and 139 new clinics are in the JHIE pipeline for enrollment in 2014.
- Vendor: Medicity.
- Services: JHIE went live in January 2013 with Direct secure messaging and a closed-loop referral network where users of JHIE can send and receive clinical referrals and communicate with one another about the patient in a secure environment (Phase I). In 2014, JHIE will implement “Phase II” functions to include:
 - Patient search and discrete data (clinical reports and results) retrieval.
 - EHR integration with JHIE will allow for one interface for all results and reports (including discrete data) to be delivered into the EHR from all participating data sources; EHR participants also will be able to send summary documents to JHIE as well as to other HIE participants via their EHR.
 - Alerts will become available through JHIE from hospitals and urgent care facilities (e.g., emergency admit, discharge summaries, etc.) to support care coordination among providers and CCO care management teams.

Organizational HIEs:

- A number of the larger health systems in Oregon have built organizational HIEs. These solutions are often driven by business needs to establish laboratory or other referrals with community partners.

EHR and HISPs for Direct secure messaging:

- Oregon health systems, hospitals and providers seeking to meet Meaningful Use requirements are working now and over the next year or two to establish Direct secure messaging functionality within their EHRs by procuring HISP services. For a more complete discussion on Direct secure messaging, see the Technology chapter.

Behavioral Health and Long Term Care Providers

Behavioral health and long-term care providers face special challenges regarding adoption of EHRs and use of HIT. Most of these providers are not eligible for payments under the Medicare and Medicaid EHR incentive programs.

The engagement of long term care facilities is critical as EPs and EHs seek to address transitions of care and continuity of care records. The State’s HIT/HIE efforts will include connecting long term care facilities to health care teams through Direct secure messaging, including through increasing use of CareAccord® among long term care providers. CareAccord® participants already include long term care and behavioral health providers. The CareAccord® infrastructure supports patient information sharing within the physical health care system (labs, radiology, problem lists/allergies, medication lists, referrals, etc.) and across care teams (long term care, behavioral health, social services, criminal justice, etc.).

Behavioral health:

In 2012, OHA's Addictions and Mental Health Division (AMH) launched a project called COMPASS that includes a comprehensive behavioral health electronic data system to improve care, control cost and share information. This new data system will allow AMH to meet business needs and requirements and will provide data that more readily supports the ability to track:

- Performance outcomes associated with services
- Who accesses services, what services are provided, where and when
- Improvement in the health of Oregonians through better quality and availability of healthcare, and cost effectiveness of services.

One component of COMPASS is [OWITS](#), which was implemented in July 2011. OWITS provides a web-based, 2011-certified EHR for mental health and addiction services community-based programs that allows for the exchange of patient data between community providers. OWITS is available to all publicly funded behavioral health providers or required reporters (ex: DUII, methadone or detox providers). The OWITS application also provides a secure, central location for meeting reporting requirements, so that agencies will no longer need to submit the required client data to AMH. AMH will automatically pull all required data from the system and ensure that all data requirements are included within the system. Continuing support for OWITS is funded through the end of Oregon's biennial budget cycle in June 2015.

Long Term care:

The recent Oregon report: [Study Group Report on the Integration of Long Term Care Services into the Global Budgets of Oregon's Coordinated Care Organizations](#) noted that long-term services and supports (LTSS) and medical systems have different information systems and face interoperability barriers. The Study Group expects the integration of LTSS services into CCOs to increase strategies for information sharing. In the Study Group's view, "an effective system of care coordination required better access to real-time data across providers, better access to Medicare data, and strong consumer protections against inappropriate data sharing. Data analysis in an effective system of care coordination would underscore better care coordination for high cost consumers, better preventative planning at the aggregate level, and stronger predictive modeling for improving the overall care coordination system."

[Oregon Health Information Technology Extension Center \(O-HITEC\)](#)

As Oregon's Regional Extension Center (REC), O-HITEC has worked with stakeholders throughout the state to provide education, outreach and technical assistance to help providers select, implement and meaningfully use certified EHR technology to improve the quality and value of health care and meet the federal requirements for the Medicaid and Medicare EHR Incentive Programs. O-HITEC received the federal ONC REC contract for Oregon. As of September 2013, O-HITEC had helped 2,674 eligible physicians and clinicians "go live" on certified EHRs, with 1,621 of those providers and clinicians achieving Stage 1 Meaningful Use requirements.

[Oregon Broadband through the Oregon Health Network \(OHN\)](#)

Oregon Health Network is a non-profit, membership-based organization that was created in 2007 after the organization was awarded a \$20.2 million federal subsidy through the Federal Communications Commission (FCC) Rural Health Care Pilot Program. As of October 2013, OHN had more than 229 provider participants, including 46 hospitals. OHN's federal FCC subsidy is for deploying middle and final mile connectivity to infrastructures across Oregon, focusing on rural areas.

Appendix C: Acronyms and Glossary

All Payers All Claims Reporting Program (APAC): Oregon state program administered by the Oregon Health Authority (OHA) to collect data on all paid claims from commercial health insurance carriers, licensed third party administrators, pharmacy benefits managers, Medicaid managed care organizations, Medicaid fee-for-service and Medicare parts C and D.

American Recovery and Reinvestment Act of 2009 (ARRA): Economic stimulus package which included the HITECH Act.

CareAccord®: Oregon's statewide Health Information Exchange, administered by the Oregon Health Authority (OHA). CareAccord® facilitates the secure exchange of health information between Oregon's health care organizations and providers, enabling the coordination of care for better health, better care and lower cost.

Center for Medicare and Medicaid Innovation (CMMI): Established in the Affordable Care Act, CMMI was created for the purpose of testing innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality for individuals receiving Medicare, Medicaid or Children's Health Insurance Program (CHIP) benefits.

Centers for Medicare and Medicaid Services (CMS): A federal agency within the Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid.

Clinical Quality Metrics Registry (CQMR): Oregon registry used to track and report key healthcare quality measures.

Coordinated Care Organization (CCO): Local health entities that deliver health care and coverage for people eligible for the Oregon Health Plan (Medicaid), including those also covered by Medicare. CCOs are accountable for health outcomes of the population they serve. They have one budget that grows at a fixed rate for mental, physical and ultimately dental care. CCOs will bring forward new models of care that are patient-centered and team-focused. They have flexibility within the budget to deliver defined outcomes. Each CCO is governed by a partnership among health care providers, community members, and stakeholders in the health systems that have financial responsibility and risk.

Cross-enterprise Document Reliable Exchange (XDR): A secure, web services-based mechanism specified by Integrating the Healthcare Enterprise (IHE) that enables a document source to "push" documents and metadata to a specified recipient. XDR can be used as part of an IHE-based HIE and also as a standard way to connect EHR systems to Direct-enabled Health Information Service Providers (HISPs).

Direct secure messaging: A HIPAA-compliant way to safely and securely send encrypted electronic health information to specified recipients using Direct Project specifications (i.e., "Direct").

DirectTrust: DirectTrust is an independent non-profit trade association created by and for participants in the Direct community, with the goal of establishing and maintaining a national Security and Trust Framework in support of Direct exchange. DirectTrust is a trust community that provides

interoperability and security standards for exchanging Direct secure messages. To see a complete list of accredited HISPs, see: <http://www.directtrust.org/accreditation-status/>.

Electronic Health Records (EHRs): Records that contain medical and clinical data, and are designed to contain and share information from the various providers involved in a patient’s care. EHR data can be created, managed and consulted by authorized providers and staff from across more than one health care organization. A single EHR can bring together information from a wide variety of sources, such as current and past doctors, emergency facilities, school and workplace clinics, pharmacies, laboratories, and medical imaging facilities. Certified EHRs meet federal standards established by the ONC. Providers seeking Medicare or Medicaid EHR incentives must use certified EHRs. A complete up-to-date list of certified EHR systems can be found on the [ONC Certified HIT Product List \(CHPL\)](#).

Emergency Department Information Exchange (EDIE): An emergency department care coordination service that enables care providers to develop and implement effective care coordination guidelines for high-utilization and special-needs patients.

Enabling infrastructure services: Technology services that facilitate or directly enable the effective use of HIT and information exchange across organizational boundaries.

Enabling protocols: A term of convenience that refers to the various mechanisms for interaction supported by enabling infrastructure services components.

Health Information Exchange (HIE):

- VERB – HIE allows providers, patients, and other participants to appropriately access and securely share a patient’s health information electronically. Efficient HIE relies on interoperability and standards across technologies. Once standardized, the information shared can integrate into the recipients' Electronic Health Records (EHRs), further enhancing the usability of patient data and improving patient care. See Primer on HIE on page 12.
- NOUN – An HIE is an organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards. See also: Health Information Organization (HIO)

Health Information Organization (HIO): An organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards. See also Health Information Exchange (HIE).

Health Information Service Provider (HISP): A third-party that offers Direct and supporting services to members. HISPs may offer their members various ways to communicate using Direct, including web portals and EHR integration, and may or may not store data on behalf of their members.

Health Information Technology (HIT): is a broad concept that encompasses an array of technologies to store, share, and analyze health information. HIT includes electronic health records, personal health records, health information exchange systems, clinical data repositories, and many other technologies.

The Health Information Technology for Economic and Clinical Health (HITECH) Act: Part of the 2009 American Recovery and Reinvestment Act (ARRA), the HITECH Act seeks to improve American health care delivery and patient care through an unprecedented investment in health information technology. The provisions of the HITECH Act are specifically designed to work together to provide the necessary

assistance and technical support to providers, enable coordination and alignment within and among states, establish connectivity to the public health community in case of emergencies, and assure the workforce is properly trained and equipped to be meaningful users of EHRs. Combined, these programs build the foundation for every American to benefit from an electronic health record, as part of a modernized, interconnected, and vastly improved system of care delivery.

Health Information Technology Oversight Council (HITOC): As part of Oregon's 2009 state health reform law, Oregon's legislature created HITOC to coordinate Oregon's public and private statewide efforts in HIT. HITOC members, who are appointed by the Governor and confirmed by the Senate, bring a wide range of experience in health and HIT and represent the geographic diversity of Oregon. Among HITOC's goals are encouraging the adoption of electronic health records, developing a strategic plan for a statewide system for electronic health information exchange (HIE), setting technology standards, ensuring privacy and security controls and developing a sustainable business plan to support meaningful use of HIT to lower costs and improve quality of care. HITOC also provides oversight of the Medicaid EHR Incentive Program, which provides federal stimulus funds for eligible professionals and hospitals to adopt and meaningfully use certified EHR systems.

Health Insurance Portability and Accountability Act (HIPAA): The HIPAA Privacy Rule protects personal health information while still allowing the flow of health information for treatment, payment or operations. Provider and other entities that access health information can only share information as outlined in the rule, or with the written permission of the person.

Healthcare Effectiveness Data and Information Set (HEDIS): A tool set of 75 measures across 8 domains of care used by health plans to measure healthcare performance.

ICD-10: The 10th revision of the International Statistical Classification of Disease and Related Health Problems (ICD), a medical classification list by the World Health Organization. ICD codes are used worldwide for morbidity and mortality statistics, reimbursement systems, and automated decision support in health care. All HIPAA-covered entities (e.g., health care providers) must adopt ICD-10. In March 2014, Congress delayed the deadline for adoption changed from October 2014 to October 2015. Not only must new software be installed and tested, but medical practices must provide training for physicians, staff members, and administrators. They will also need to develop new practice policies and guidelines, and update paperwork and forms.

Integrating the Healthcare Enterprise (IHE): An initiative by healthcare professionals and industry to improve interoperability by promoting the use of established standards.

Interoperability: Interoperability is generally accepted to mean the ability of two or more systems or components to exchange information and *use* the information that has been exchanged. That means that there are two steps to interoperability: 1) the ability to *exchange* information; and 2) the ability to *use* the information that has been exchanged.

Meaningful Use: Meaningful Use is the set of objectives and measures defined by the Centers for Medicare and Medicaid Services (CMS) that governs the use of electronic health records. Eligible providers and hospitals who meet Meaningful Use requirements can receive federal EHR incentive payments. Generally, the requirements for meeting Meaningful Use increase as a provider progresses through the three stages. See Primer on page 16.

National Association for Trusted Exchange (NATE): Originally a project supported by the Office of the National Coordinator for Health Information Technology (ONC), NATE is a trust community that provides interoperability and security standards for exchanging Direct secure messages.

Office of Health Information Technology (OHIT): The Oregon Health Authority office responsible for HIT/HIE planning, coordination, policy and development.

Office of the National Coordinator for Health Information Technology (ONC): The principal federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information. The position of National Coordinator was created in 2004, through an Executive Order, and legislatively mandated in the HITECH Act of 2009.

Oregon Health Authority (OHA): The state agency charged with lowering and containing costs, improving quality and increasing access to health care in order to improve the lifelong health of Oregonians. Its mission is helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care.

Oregon Health Information Technology Extension Center (O-HITEC): Oregon's Regional Extension Center provides education, outreach and technical assistance to help providers select, implement and meaningfully use certified EHR technology to improve the quality and value of health care and meet the federal requirements for the Medicaid and Medicare EHR incentive programs.

Oregon Health Leadership Council (OHL): A collaborative organization that brings together health plans, hospitals and physicians to identify and act on cost-saving solutions that maximize efficiency while delivering high quality patient care.

Oregon Health Network (OHN): A non-profit, membership-based organization that was created in 2007 and funded by federal funding from the Federal Communications Commission (FCC) for deploying middle and final mile connectivity to infrastructures across Oregon, focusing on rural areas.

Patient-Centered Primary Care Home (PCPCH) Program: Oregon's medical home model, the PCPCH Program is administered by the Oregon Health Authority (OHA). The program is designed to reward clinics that demonstrate certain practices associated with quality and best practices for coordinated care.

Patient/provider attribution service: In integrated care delivery models, attribution is the process of assigning members to a provider or providers. Attribution establishes provider accountability, where the organization deems one individual or a group of individuals responsible for efficiency, quality and cost, regardless of which providers actually provide the services. The attribution service is a database used to safely and securely store patient identifying information and links patients to the providers on their care team. Given a particular patient's demographics or other identifying information, the service identifies the providers on that patient's care team.

Pay for performance (P4P): Programs where providers are paid for meeting established health targets (outcomes) rather than being compensated per service.

Privacy and security: Privacy and security are protected in part by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. HIPAA regulates the use and disclosure of protected health information. Without patient consent, covered entities may use protected health information only to conduct treatment, payment and healthcare operations activities.

Push: A method of health information exchange whereby information is sent (“pushed”) by one party to one or more specified recipients. The Direct Project specifications (i.e., “Direct”) offers a simple, scalable and secure form of push-based exchange.

Quality Reporting Document Architecture (QRDA): A standard document format for the exchange of clinical quality measures data. QRDA reports contain data extracted from electronic health records and other information technology systems. QRDA reports are used for the exchange of clinical quality measures data between systems for a variety of quality measurement and reporting initiatives, such as the Meaningful Use Stage 2.

Query: Query or “pull” refers to a messaging pattern in which a query is initiated from one participating health information organization to another, meeting the given query parameters for a particular patient for later retrieval.

State Accident Insurance Fund (SAIF): Oregon’s not-for-profit, state-chartered workers’ compensation insurance company.

State Innovation Model (SIM) Grant: Nationally, CMMI provided \$250 million in SIM grants to support development and testing of state-based models for multi-payer payment and health care delivery system transformation. In 2013, Oregon received a SIM grant of \$45 million to support health system transformation and the acceleration and spread of the coordinated care model.

Appendix 9

CCO Health Information Technology Efforts

Appendix X

Oregon Coordinated Care Organizations'

Health Information Technology Efforts

Oregon Health Authority, Office of Health Information Technology

June 30, 2015

Office of Health Information Technology



Executive Summary

This Executive Summary provides an overview of the June 30, 2015 report on the health information technology (HIT) initiatives underway in Oregon's 16 Medicaid coordinated care organizations (CCOs).

Health Information Technology (HIT) and the Coordinated Care Model

Oregon's coordinated care model is designed to improve health, improve care, and lower costs (the "Triple Aim"). HIT plays a critical role in realizing each of these goals of transforming Oregon's health care delivery system. The collection, sharing, and use of health information can facilitate improved:

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

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

Overview of CCO HIT Efforts

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

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

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

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

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

CCO Approaches to Developing and Implementing HIT Efforts

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

- Implementing a coordinated care management system for CCO staff including utilization, disease, and case management which integrates data from disparate sources.
- Providing a community-wide EHR operating as a community health record, which includes data on over 85% of the CCO's members and is available to both physical and behavioral health providers.
- Leading the collaborative development of a regional health information exchange tool, which will collect patient data from various sources and make it accessible to providers at the point of care.
- Pursuing a Community Data Warehouse pilot project to develop and implement a population health management, data aggregation, and analytics tool.
- Investing in a tool that allows for gathering/aggregating/sharing of clinic-level EHR data to identify gaps in care and specific health data points in the population.

Changing Approaches and Next Phases for CCO's HIT Efforts

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

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

CCOs' various investments in telehealth include:

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

New Relationship to Data

CCOs are committed to increasing the efficacy of available data. They are using data to support their healthcare transformation efforts as well as to support their providers, by furnishing them with data. Many CCOs are distributing regular reports to their providers which might include a variety of information on the provider's patient panel, such as:

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

Barriers to HIT Effectiveness

CCOs discussed various barriers encountered in the CCOs' implementation of their HIT initiatives (see table for a summary of the top barriers). Examples of specific barriers reported include: the use of disparate EHRs and challenges with EHR interoperability; limitations of time, resources, and capacity; change fatigue; clinic reluctance to make workflow changes; lack of access to clinical data; providers reliance on their EHR vendors; pressure to meet diverging regulatory and reporting requirements; and challenges with obtaining accurate and complete data.

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

Barriers to Behavioral Health Information Sharing

Most CCOs also reported significant concerns regarding behavioral health information sharing including: confusion over compliance with state or federal laws, concerns over privacy and confidentiality protection for the patient, technology systems that do not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data), and concerns over liability if information shared is later improperly shared. Ensuring the exchange of information with behavioral health providers is a priority for the CCOs, many of whom are exploring ways to increase the sharing of this data.

Oregon Coordinated Care Organizations' Health Information Technology Efforts

This summary describes the health information technology (HIT) initiatives underway in Oregon's 16 Medicaid coordinated care organizations (CCOs), based on information collected in summer/fall 2014 and revised in spring 2015. This summary is intended to inform Oregon Health Authority's (OHA) HIT planning efforts and the policy and strategic planning work of Oregon's HIT Oversight Committee (HITOC) through HITOC's monitoring of the status of major HIT efforts across the state, and the barriers and challenges faced in Oregon's communities around HIT. In addition, this summary may provide useful information to CCOs, providers, accountable care organizations, health plans, and other stakeholders as they pursue HIT efforts to support new expectations for care coordination and accountability.

Introduction

Health Information Technology (HIT) and the Coordinated Care Model

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

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

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

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

The Three Goals of HIT-Optimized Health Care

The vision for Oregon is a transformed health system where HIT and health information exchange (HIE) efforts ensure that the care all Oregonians receive is optimized by HIT. In an HIT-optimized health care system:

1. Providers have access to meaningful, timely, relevant, and actionable patient information at the point of care including information about the whole person, including information pertaining to relevant physical, behavioral, social and other needs.
2. Systems (health plans, CCOs, health systems, and providers) have the ability to effectively and efficiently use aggregated clinical data for quality improvement, population management and incentivizing value and outcomes. In turn, policymakers use aggregated data and metrics to provide transparency into the health and quality of care in the state, and to inform policy development.
3. Individuals, and their families, can access and engage with their clinical information and are able to use it as a tool to improve their health and engage with their providers.

Role of Health System Transformation Funds in Investments in HIT

In 2013, the Oregon Legislature approved \$30 million in Health System Transformation Funds. The OHA Transformation Center awarded \$27 million in Transformation Fund Grant Awards to help CCOs launch innovative projects aimed at improving integration and coordination of care for Medicaid patients. Specifically, the Legislature directed the funds to be used for projects that would create services targeting specific populations or disease conditions, enhance the CCO's primary care home capacity, and invest in information technology and electronic medical records. Almost all of the CCOs invested a portion of their grant funds in HIT initiatives,

including electronic health records, health information sharing and exchange, data aggregation tools for population health, metrics collection, and telemedicine.

All 16 CCOs agreed to support OHA's plan to use the remaining \$3 million to leverage and secure significant federal matching funds for investing in statewide HIT infrastructure. These funds are being used to support OHA's vision of a statewide approach for achieving HIT-optimized health care. OHA-supported HIT infrastructure will connect and support community and organizational HIT and HIE efforts where they exist, fill gaps where these efforts do not exist, and ensure all providers on a care team have a means to participate in basic sharing of information needed to coordinate care. The CCO HIT Advisory Group (HITAG) guides OHA's use of the \$3 million. OHA's commitment to the CCOs in state-level HIT infrastructure includes:

- A statewide Provider Directory, critical to supporting health information exchange, analytics and population management, accountability efforts, and operational efficiencies.
- Statewide Direct secure messaging and CareAccord, offer a standards-based, HIPAA-compliant, common method of health information exchange, leveraging new requirements for certified EHRs and for hospital and providers seeking to meet meaningful use.
- Notifications of hospital events, via a subscription-based product called PreManage that would allow CCOs to access this data as real-time notifications when their member has a hospital event (emergency department or inpatient admission, transfer, discharge).
- A Clinical Quality Metrics Registry to capture clinical quality metrics from electronic health records (see below for CCO reporting requirements).
- Technical assistance to support Medicaid providers with the adoption and meaningful use of certified EHR technology as well as support providers in submitting their clinical quality metrics electronically from providers' EHRs to meet meaningful use and OHA's CCOs clinical quality metrics reporting requirements.

Role of CCO Clinical Quality Metrics (CQM) Reporting Requirements

In 2012, as part of Oregon's 1115 waiver agreement with CMS, Oregon committed to an extensive plan of measurement and monitoring, including quarterly and annual reporting on a number of performance metrics at the CCO and state levels. This was to allow CMS to ensure that cost savings were not being realized by withholding needed care or degrading quality. CCOs have been encouraged to meet a number of quality metrics by being offered a financial incentive for achieving performance benchmarks.

Under OHA's waiver with CMS, CCOs are eligible to receive incentive payments (3 percent of their budgets in 2014) associated with their performance on 17 outcome and quality measures. Four of the 17 measures are directly related to HIT. One of the incentive metrics is EHR adoption and three others are clinical quality metrics (CQMs; hypertension, diabetes poor control, and depression screening) that require the CCOs to extract data directly out of EHRs.

To meet benchmarks and receive quality pool funding in 2014 and 2015 (for their 2013 and 2014 reporting years), CCOs had to submit technology plans to OHA, describing the EHR and HIT environment in their service areas, their HIT efforts, and their proposal for collecting sample data for the three clinical quality metrics. The sample size for these three metrics increases over time – emphasizing an expectation that CCOs would work with an increasing number of their key practices to collect these data. The plans for future years involves moving from technology plans and sample data to obtaining more robust data from EHRs, using it for measurement, and paying incentives for performance based on this data. CCOs have therefore been indirectly incentivized to pursue HIT initiatives that would support and facilitate their collection of clinical quality metrics data from providers' EHRs. As discussed further below, CCOs chose to pursue a variety of approaches to this end.

CCO Deeper Dive Sessions

In the summer and fall of 2014, OHA's Office of HIT conducted in-person "Deeper Dive" meetings with each of the CCOs. The overall objective of these meetings was to gain a deeper understanding of each CCO's HIT initiatives and coordinate around OHA's HIT infrastructure in development at the state level. The aim was to ensure that (1)

the state's HIT services support CCO investments; (2) CCO and state efforts remain aligned; and (3) CCOs have a clear understanding and expectations for what state-level services will include.

Following these in-depth meetings, in the winter of 2014-15, Office of HIT produced CCO profile documents (see Appendix B) summarizing each CCO's HIT initiatives including information sharing and care coordination; quality improvement, population management, and data and analytics tools; clinical quality metrics collection and reporting; technical assistance to practices for EHRs and Meaningful Use; patient engagement; and telehealth.

CCOs were given two opportunities to review and update their draft profiles; all CCOs responded to the review request and profiles were edited accordingly. In some cases, the CCO HIT efforts changed since our Deeper Dive meetings. The profiles represent the CCOs' HIT status at a point-in-time. Though we have made every effort to ensure that they are accurate and up-to-date, HIT efforts may have continued to evolve and some information may therefore be out-of-date.

Overview of CCO HIT Efforts

All 16 CCOs have made an investment in HIT in order to facilitate healthcare transformation in their community. These efforts have been supported, in part, by the transformation funds described above. CCOs have invested in helping their provider communities implement and make effective use of various HIT tools intended to improve their patients' health and their patients' care, as well as manage their costs. Various factors have influenced the unique paths each chose to take (see below).

Each CCO had to assess their circumstances and determine their best path forward, given their unique characteristics. Although no two paths were exactly the same, nearly all CCOs are pursuing and/or implementing both a health information exchange/case management/care coordination tool as well as a population management/metrics tracking/data analytics tool. Even with those similarities, each of the 16 CCOs chose to invest in a different set of HIT tools.

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

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

CCO Context for HIT Development

CCOs reported a number of factors that have influenced their approach to HIT development in support of healthcare transformation in their community, such as:

- The types of organizations from which they evolved, and thus their organizational structure (physician-owned/Independent Practice Association-based, health system-based, commercial health plan-based, community/county led, etc.)
- Community and governance factors
 - The already existing (community) efforts, including existing governance structures, they evolved from and therefore whose support they had from the beginning
 - The degree of already existing (community) support for initiatives like HIT at the time of establishment, and the degree of HIT infrastructure that was already in place
- Provider environments
 - The extent of variation in EHRs implemented across their provider community
 - Partnerships with hospital systems
 - The size and type of community members they support
 - The number, type, and size of key practices
 - Concentration of Medicaid patients among primary care clinics
 - Regions with multiple hospitals vs. relatively closed systems where one hospital system dominates care in the area
- The geography of their community
 - Southern Oregon has the most concentrated presence of CCOs: 4 CCOs across 4 counties
 - Eastern Oregon CCO service area covers 12 counties (over 50% of Oregon's land mass)

Role of Community Support

A factor that seems particularly relevant to both a CCO's approach to HIT development and the pace of their progress is the extent to which they began with an already established collaboration in the community. As one engaged stakeholder said during one of the Deeper Dive meetings *"Building the trust and shared commitment is foundational"*. Several CCOs had pre-established community governance and shared commitment to work collaboratively on common goals. Some communities had already come together specifically around HIT efforts, such as Southern Oregon's Jefferson HIE and Central Oregon's Central Oregon Health Connect. Having the support of a collaborative community can facilitate the many challenging discussions involved in making decisions

about shared HIT tools, helping to advance the significant process. In community-based HIT efforts, CCOs participated or led work to assess and pursue HIT tools which would most benefit their community, and which required buy-in and (in some cases) financial commitment from providers and hospitals and other stakeholders.

Impact of Geography and Size

A high concentration of CCO members across a small number of clinics/health systems implies there are fewer groups to bring into the conversation compared to areas where members are distributed across a large number of clinics. Having fewer entities involved in the pursuit of a new HIT tool can simplify and increase the efficiency of communication, making it easier to coordinate across groups more rapidly and effectively. According to one CCO, this has allowed them to “*make an impact quickly.*”

CCO communities with a greater concentration of Medicaid members within fewer providers/clinics may have less EHR variation to contend with and therefore fewer workflow modifications to support. In such communities, maintaining closer contact with each provider may be less burdensome. Additionally, CCOs report having greater influence on practices where their members make up a greater proportion of the patients.

Organizational Affiliations

Many CCOs are affiliated with a health plan that also serves the commercial or Medicare markets. In these cases, the HIT investments made to support CCO operations are often used for their commercial population as well. In other cases, three CCOs are affiliated with an IPA that provides a hosted EHR to practices. This resource can make a significant difference in (1) implementing changes to reporting data to the CCO, (2) supporting functionality within the hosted EHR that enables sharing patient information and care coordination across providers, and (3) providing technical assistance to providers around using their EHR and improving workflows, given their already established relationship.

CCO Approaches to Developing and Implementing HIT Efforts

Many CCOs reported experiencing challenges in setting their HIT strategy. Some CCOs found it challenging to piece together the complex puzzle of EHRs, HIT resources, and gaps in their region, and/or found the offerings from technology vendors complicated to navigate as well. In general, CCOs sought to (1) understand what HIT and EHR resources were in place in their community and provider environments, (2) identify what HIT capabilities were needed to support the CCO’s efforts, and (3) identify strategies to meet those needs, including leveraging existing resources or bringing in new HIT tools to fill priority needs. In some cases, CCOs invested in consultants to support their HIT strategic planning and project development efforts. Several CCOs expressed an interest in learning from other CCOs and regional efforts – unsure of whether they selected the best approach, or were making as much progress as their CCO peers, and were interested to learn from other’s successes.

Ultimately, the combination of different CCO community, organizational, geographic and provider contexts as well as the variation in EHR and existing HIT resources led to a number of differing approaches to HIT. Some examples of HIT approaches CCOs have taken include:

- A focus on improving CCO case management of their members leveraging a module in their existing administrative software.
- Implementing a coordinated care management system for CCO staff including utilization, disease, and case management which integrates data from disparate sources and combines it into a single, member-centric workflow which enables use of one system in managing the health needs of each member.
- Launching a care management tool that includes actionable clinical information and psychosocial risk factors in support of behavioral health integration and perinatal programs to be used both by CCO staff and provider partners.
- Providing a community-wide EHR operating as a community health record, which includes data on more than 85% of the CCO’s members and is available to both physical and behavioral health providers.
- Leading the collaborative development of a regional health information exchange tool, which will collect patient data from various sources, organize it, and make it available and easily accessible to providers at the point of care.

- Supporting local entities that have developed their own HIT tools, while also developing and implementing centralized tools to support care management, population management, utilization and analytics, with a long-term vision for an integrated solution for sharing clinical information with the provider network to support patient care and population health.
- Implementing a comprehensive tool that includes predictive analytics/risk assessment, care coordinator and PCP/Provider management reports, quality metrics and care gaps information, and business intelligence tools.
- Coordinating across local entities that have developed their own HIT tools while also developing and implementing centralized HIT including a data aggregation, analysis, and reporting solution.
- Pursuing a Community Data Warehouse pilot project to develop and implement a population health management, data aggregation, and analytics tool that integrates hospital, ambulatory EHR, pharmacy, and claims data.
- Investing in a tool that allows for gathering/aggregating/sharing of clinic-level EHR data to identify gaps in care and specific health data points in the population (e.g., members in need of screening), as well as produce the three CCO clinical quality metrics.

Changing Approaches and Next Phases for CCO's HIT Efforts

In some cases, CCOs faced unexpected challenges, which caused them to alter their HIT efforts. Some CCOs reported changing course after facing: vendor limitations and mergers, unanticipated prohibitive costs, challenges with community support and buy-in, longer than anticipated development periods, and/or other issues. Some degree of flexibility has been critical given the realities of an ever-changing landscape.

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

- Connecting providers to HIT/HIE through integration within their EHR workflows
- Moving from administrative/claims-based case management and analytics to incorporating and extracting clinical data from provider's EHRs
- Working with providers and providing technical assistance to establish clinical data reporting
- Supporting providers in new ways by providing data and dashboards back to them
- Investing in new tools for patient engagement and telehealth

New Relationship to Data

A consistent theme across all CCOs' efforts to use HIT to improve healthcare delivery, is their commitment to increase the efficacy of available data. They have developed and fostered new ways of using data to support their healthcare transformation efforts, and supporting their providers by furnishing them with data. CCOs report that they have become more sophisticated with data, and, in some cases, have supported a culture change with their provider networks who are also learning to become more sophisticated with data. The CCOs support providers using data in a variety of ways including:

- Collecting data (e.g., providing assistance to shift burden for collecting data from providers to other staff)
- Compiling, interpreting, understanding data (e.g., prioritizing care coordination, identifying high utilizers and missing screenings, incentive metric progress monitoring, identifying populations to target for complex case management and disease management, tracking clinical quality metrics performance). One CCO described that their HIT tool *"takes a haystack and pull[s] a few needles out."*
- Ensuring credibility of data (e.g., working with clinics to understand and mitigate quality issues)
- Educating and evolving the delivery system to use the data
- Refining how to meaningfully present and effectively communicate the data

Though this is an evolving process in which both CCOs and providers will continue to learn new ways to maximize the value of data, CCOs report that significant progress has already been made in using data to improve care.

Many CCOs are distributing regular reports to their providers which might include a variety of information on the provider's patient panel, such as: risk scores, quality metrics, top utilizing members, patients in need of screenings, basic emergency department and inpatient utilization, top 10% members at risk for poor outcomes, diagnoses, and prescription drug use. One CCO describe themselves as an 'information company' as they "*have information coming in and better information going out*".

Also of note, providers and healthcare systems have demonstrated an increased interest in metrics and are becoming accustomed to reflecting on their data and its implications. Some have changed their approach to patient care management and have newly begun accessing, examining, and utilizing their data for the purpose of population management, decreasing their reliance on the CCO to fulfill this role. Some providers have become increasingly involved with and invested in their data and outcomes, which has fostered a healthy competition and incentive to improve their metrics. This has been reinforced by the requirement that CCOs distribute quality pool earnings to their provider networks. Several CCOs have implemented their own quality pool/pay for performance programs across their provider network, which incentivizes provider investment and commitment to make improvements.

Workflow Changes

Some CCOs are actively engaged in helping providers make workflow changes to accommodate the implementation of HIT tools and/or data needed by the CCO. For example, providers need assistance modifying their workflows to ensure they are accurately capturing the depression screening data required for CQM reporting. Some CCOs are adding staff to conduct training, selecting best practices for workflow, and/or finding provider champions.

Access to Clinical Data

CCOs are all either currently able to access clinical data or are actively pursuing access, in a variety of ways. Some CCOs are working to extract clinical data from their providers' EHRs. Some CCOs are building a process to store and analyze clinical information. One CCO described their interest in moving toward clinical data for population management, metrics, etc., as being related to the lag time with claims data which can make those data not actionable: "*We want to get [data] further upstream to be able to impact care.*" Another CCO has piloted a tool that pulls clinical data out of EHRs and integrates it into their case management tool. In the case of regional HIEs with a community health record model, interfaces are established with hospitals, laboratories, and provider EHRs to collect clinical data using standards-based formats like HL7, etc.

Moving beyond Primary Care and Physical Health Information

Though CCOs have focused their efforts largely on primary care providers and physical health information, they are interested in incorporating behavioral health information in order to increase care coordination across different provider types. Most CCOs, however have significant concerns regarding the security and privacy issues surrounding behavioral health information sharing. Some CCOs have invested funds and significant effort into overcoming barriers and taking steps toward increasing behavioral health information sharing.

CCOs expressed that exchanging information across the full care team involved in their members' care is an area of priority. For example, some CCOs are taking steps to electronically share information and coordinate care with long-term care and social services. One CCO has expressed interest integrating information from social services, non-emergency medical transportation, residential care settings, schools and school-based health centers, in addition to behavioral health and long-term care.

Summary of CCO-Specific HIT Investments

See Appendix A and Appendix B for further details. Note that the categories used below are not necessarily mutually exclusive, as tools can be used to serve more than one function (and often do). The HIT tools are grouped based on their primary function.

	# of CCOs	Overview	Details
Health Information Exchange	13	2 active HIEs (6 CCOs)	Medicity: Jefferson HIE (5 CCOs) RelayHealth: Central Oregon Health Connect
		2 HIEs in development	InterSystems: Care Team Link (Regional Health Information Collaborative; RHIC) Bay Area Community Informatics Agency (BACIA)
		1 Community-wide EHR	GE Centricity: Umpqua One Chart
		Hospital Notifications (4 CCOs are live, 3 CCOs are in discussion)	Collective Medical Technologies: PreManage
Case Management and Care Coordination	10	1 Social Services -focused tool (2 CCOs)	VistaLogic: Community Connected Network
		Case Management Tools (9 CCOs)	Essette: Case Management
			PopIntel Care Coordination Registry
			InterSystems: Care Team Link
			McKesson: VITAL
			The Advisory Board: Crimson CM (2 CCOs)
			Milliman: Patient Relationship Manager
IMA Technologies: CaseTrakker (2 CCOs)			
Population Management, Metrics Tracking, Data Analytics	15	Population Management tools (9 CCOs)	Milliman: MedInsight (2 CCOs)
			Optum: Impact Intelligence
			The Big Kahuna
			Arcadia: Community Data Warehouse
			Crimson Population Risk Management
			Milliman: Patient Relationship Manager
		Business Intelligence (BI) tools (6 CCOs)	SAS BI (3 CCOs)
			IBM Cognos BI
			Microsoft BI (2 CCOs)
		Health Analytics tools (11 CCOs)	Intelligenz: CCO Metrics Manager (2 CCOs)
			Truven Health Analytics (2 CCOs)
			Inovalon Indices
			SAS Data Store
			IBM: SPSS
			SAS
Tableau (2 CCOs)			
IBM Cognos Query Studio			
PopIntel			
EHR Hosting via Affiliated IPA	3		DCIPA: Umpqua One Chart
			MVIPA: NextGen
			MRIPA: Greenway PrimeSuite

Health Information Exchange

CCO health information exchange investments include a variety of tools and services each intended to securely share health information electronically between providers and across organizations. There are two health information exchanges currently in use in Oregon including Jefferson HIE in use by five CCOs and Central Oregon Health Connect in use by one CCO, and two that are in development including IHNCCO's Care Team Link (Regional Health Information Collaborative; RHIC) and an effort in Coos Bay lead by BACIA (Bay Area Community Informatics Agency). Umpqua One Chart is a community wide EHR which has been adopted by over 85% of providers in the area. Finally, four CCOs have gone live with a PreManage subscription, which provides them with hospital event (emergency department admission, inpatient, and discharge) notification. Some are opting for the 'complete' PreManage package, which makes the notifications available to their key practices in their provider network.

Case Management and Care Coordination

CCOs have implemented a range of case management and care coordination tools. One of the tools, Community Connected Network supported by two CCOs, is a social service-based tool which is expected to include data for the entire patient population across a variety of social service agencies. There are seven case management tools in use by nine CCOs. They differ in the data that is incorporated into the tool and made available as well as the tool functionality. Some are intended to be used only by CCO staff (e.g., case managers) and others are intended to be used across providers. CCO staff use case management tools for various tasks including: to record assessments; develop care plans; record tasks, notes, correspondence; and get daily email alerts/reports for important events such as surgery. Case management tools may allow case managers to set goals, identify interventions and assign members to care teams, support coordination around transitions of care, and identify barriers for managed patients that need to be addressed.

Population Management, Metrics Tracking, and Data Analytics

CCOs reported implementing and/or using seven population management tools, three Business Intelligence (BI) tools, and nine health analytics tools. Some CCOs have developed and/or implemented claims-based analytic reporting via BI software. This type of reporting might include aggregate reporting for CCO-, provider-, and member-level data for demographics, utilization, and gaps in care.

EHR Hosting via Affiliated IPA

Three Independent Practice Associations (IPAs) host EHRs for some of their member clinics: Douglas County IPA hosts Umpqua One Chart (Umpqua Health Alliance CCO), Mid Valley IPA hosts NextGen (Willamette Valley Community Health), and Mid Rogue IPA hosts Greenway PrimeSuite (AllCare CCO).

Other HIT efforts: Technical Assistance, Patient Engagement, and Telehealth

Many CCOs offer technical assistance to their provider network including assistance in support of workflow modifications (e.g., effective handoff protocols), HIE connectivity, and Direct secure messaging. Other types of assistance has included training about meaningful use as well as IT and analytic resources to help providers set up reporting tools needed to pull relevant information out of their own EHRs and IT systems.

Several CCOs expressed support for increasing patient engagement and access to specialty care through HIT and telehealth. CCOs mentioned supporting the use of patient portals that include access to medical records, scheduling, and secure correspondence with primary care providers and/or supporting the OpenNotes movement, which makes full clinician notes available to patients via their provider's EHR patient portal.

Several CCOs have made an investment in various telehealth efforts including:

- Tele-dermatology
- Genetic counseling via telehealth
- Tablet/laptop-based needs and health risk assessments
- Behavioral health telemedicine/tele-mental health
- Virtual Provider Triage (supports delivery of care in the most appropriate setting)
- Gladstone by Kannact (providing high-risk individuals with tablets to facilitate remote patient monitoring)
- Provision of post-hospital discharge tablet/laptop by which member can contact care support
- Telementoring
- Tablet-based CAHPS survey
- Text4Baby

Barriers and Challenges

During the Deeper Dive conversations, CCOs discussed a variety of barriers that they themselves and/or their clinics encountered in the process of the CCOs' implementation of their HIT initiatives. OHA staff categorized the information into various barrier types and then tallied the frequency with which the information was discussed across CCOs. The results are reported below in three sections: (1) *Top Barriers to HIT Implementation* includes the six most frequently discussed barrier categories, (2) *Additional Barrier Categories* lists the four barrier categories mentioned by only 2-3 CCOs each, and (3) *Other Barriers* lists five barriers that were each mentioned by only one CCO. As the CCOs were not specifically asked about each of the various barrier categories, the frequency of the barriers reported is not representative of all the CCOs who are experiencing each barrier. Rather, the frequency represents for whom the barrier was reported during the Deeper Dive meetings or included in the CCO HIT Profiles. Lastly, the final section included below summarizes the barriers CCOs have experienced with behavioral health information sharing.

Top Barriers to HIT Implementation

Top Barriers to HIT Implementation	CCOs Who Discussed Barriers in the Category (n=16)
EHR, Technology, and Interoperability	88%
Workflows, Staffing, and Training	81%
Clinical Data Collection and Reporting	75%
Data Analysis, Processing, and Reporting	44%
HIPAA, Privacy, and Security	31%
Metrics	31%

EHR, Technology, and Interoperability Barriers

The top barriers to HIT implementation discussed by the CCOs include issues specific to technology constraints, interoperability challenges, and EHR limitations. Though the overall EHR adoption rate in Oregon is high, there remain some rural areas where the rate is lower contributing to a variety of challenges. In addition, providers have implemented over 100 different EHR systems across the state, leaving most CCO regions to grapple with the challenges associated with having numerous systems with which to interact. Disparate EHR systems complicate interoperability and information exchange as well as the collection of clinical data.

CCOs reported experiencing various interoperability challenges across systems. Bringing systems together across a common platform requires significant investments of time, effort, and testing. In addition, providers are at the mercy of their EHR vendors for the development and expansion of interoperability capabilities. Also, some providers have implemented out-of-the-box EHR systems (without enhancements), which are often quite costly to expand or customize.

All CCOs have a vision of the role they plan HIT to play in their health care transformation efforts. Many expressed some frustration regarding the slower than expected pace of development among their technology vendors/partners, as they had hoped for additional capabilities to be more (broadly) available sooner. Additionally, CCOs reported challenges with (or lack of) EHR interoperability with other systems.

The following were also mentioned as barriers in the area of technology and interoperability:

- Lack of a standardized and central data repository for patient health information
- Cumbersome to retool each EHR interface when new CQMs are released
- Challenges with Direct secure messaging as implemented within certain EHRs
- Concerns about making significant investment in HIE given interoperability challenges (e.g., integration of care summaries in CCD format, limits on some EHRs regarding message delivery via Direct secure messaging)

Workflows, Staffing, and Training Barriers

Most CCOs reported that they have received push-back from clinics regarding workflow requirements. Some clinics do not see value in changing workflows to accommodate CQM reporting requirements, for example. Clinics report challenges related to limited time, resources, and bandwidth given the numerous competing demands. Many are also experiencing change fatigue due to the unremitting requests for changes across various aspects of clinic functions.

Training needs identified include:

- assistance with making workflow adjustments to allow for properly collecting/reporting depression screening data
- greater knowledge and understand regarding Direct secure messaging
- implementation training and technical assistance related to all aspects of data (e.g., collection, use, coordination)

Clinical Data Collection and Reporting Barriers

Another top category of HIT implementation barriers is specific to the collection and reporting of clinical data. As mentioned above, CCOs are incentivized to collect clinical quality metrics data (for an increasing percentage of their member population) in order to qualify for incentive payments. In addition, CCOs are all keenly aware of the need for access to clinical data in order to maximize the utility of available data; that is, the extent to which the data are actionable. CCOs are therefore highly interested in and actively pursuing HIT initiatives to collect clinical data. These efforts have not been without challenge.

CCOs noted that EHR usability is a barrier to data entry and thus accurate reporting, with many providers at the mercy of vendors for CQM reporting. CCOs spoke of challenges with data collection consistency across providers, with CQM data quality and reporting being limited by workflow. Obtaining CQMs is often experienced as tedious and/or challenging due to data extraction issues. Some organizations are hesitant or reluctant to share clinical data for purposes of CQM reporting creating an additional layer of challenges.

Additional barriers to clinical data collection and reporting include:

- Doubts about relying on new CQM reporting formats in EHRs such as QRDA
- Financial burden on smaller practices to configure their system to produce CQMs
- Requiring CQM data transmission to multiple CCOs could increase costs for providers, which may deter treatment of Medicaid patients

Data Analysis, Processing, and Reporting Barriers

More than a third of the CCOs described data analysis, processing and reporting barriers. Core issues include difficulties obtaining clean and complete data, with some providers unable to share data in standardized formats (e.g., HL7), as well as challenges with performing data verification. CCOs discussed experiencing challenges with meeting diverging regulatory and reporting requirements. In addition, CCOs have received pushback from clinics with many of them struggling to meet the various reporting requirements. The demand on providers to collect and enter data is a major barrier due to growing and conflicting requirements. Finally, with respect to data analysis, CCOs reported that practices lack the necessary resources to develop improved analytic capabilities resulting in a dependence on the functionalities inherent in their EHR.

HIPAA, Privacy, and Security Barriers

About a third of the CCOs discussed barriers related to HIPAA, privacy, and security (including issues with FIRPA, federal privacy requirements related to education). More specifically, CCOs expressed concerns about data sharing policies and adequate consent procedures to allow for the sharing of data. There are concerns among providers regarding correct business agreements that identify who has access to data and a lack of clarity about what information is acceptable to share.

Metrics Barriers

About a third of the CCOs discussed metrics-related challenges. For example, there are metrics data being collected in non-primary care environments (e.g., schools, behavioral health, dental), but there are no means by which to capture these data. Also, providers have expressed frustration regarding some metrics not being relevant to specific providers (e.g., some providers may order a mammogram, but not perform them); providers are requesting that the metrics by which they are being evaluated are credible and valid.

Additional Barrier Categories (each identified by two to three CCOs):

- Data Access
 - Questions about the management of access to patient information and how case managers would coordinate data
- Vendors
 - Waiting on 2014 updates (to support meaningful use Stage 2) from EHR vendors
 - Difficulty in engaging EHR vendors about getting certain information into the standardized care summary format (CCDA)
- Patient Attribution
 - Challenges with managing patient attribution
 - Some challenges with ensuring information only goes to right health plan
 - Patient attribution challenges: PCP reconciliation between the plan, provider records, and provider providing services
- Dental
 - Lack of EHR adoption among dental providers
 - Uncertain of when dental providers must meet meaningful use and other HIT goals/metrics

Other Barriers (each reported by one CCO)

- Broadband connectivity issues in some rural areas
- Challenges with logistical and geographical technology capabilities
- Lack of provider understanding or interest of available HIT tools (e.g., Epic CareEverywhere for providers with Epic EHRs)
- Ongoing changes with provider networks
- Lack of CCO technology/analytics staff

Barriers to Behavioral Health Information Sharing:

The draft CCO HIT Profiles included a survey asking that each CCO identify which of the listed barrier to behavioral health information sharing they have experienced. Thirteen of the CCOs completed the survey. The table below summarizes the responses, in order from most to least frequently experienced.

Barriers to Behavioral Health Information Sharing	CCOs Reporting Experiencing Barrier (n=13)
Confusion over compliance with state or federal laws	77%
Concerns over privacy and confidentiality protection for the patient	77%
Technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data).	62%
Concerns over liability if information you share is later improperly shared	62%
Lack of proper consent forms from the patient	38%
State or federal laws prohibit the type of sharing I want/need to do	23%

Interest in OHA’S HIT Initiatives

As mentioned above, OHA’s Office of HIT is pursuing five statewide HIT initiatives: (1) a Statewide Provider Directory; (2) PreManage hospital event notifications; (3) a Clinical Quality Metrics Registry; (4) Technical Assistance to Medicaid practices; and (5) CareAccord providing Direct secure messaging. All of these initiatives were discussed with each CCO at the Deeper Dive meetings. Below is a tally of the level of interest reported by all 16 CCOs in each of the five initiatives.

OHA’s HIT Initiatives	CCO Interest Level		
	Using or expect to use	Considering	Not currently interested
Statewide Provider Directory	69%	31%	0%
PreManage – hospital event notifications	50%	44%	6%
Clinical Quality Metrics Registry*	38%	38%	25%
Technical Assistance on EHRs and Meaningful Use for Medicaid Practices	25%	75%	0%
CareAccord Direct secure messaging	16%	69%	19%

*All CCOs will need to report to the Registry – the interest level reflected here is whether the CCO is considering having any of their providers submit clinical quality metrics directly to the Registry.

Overall, the CCOs expressed the most interest in the Statewide Provider Directory and the PreManage hospital notifications. The CCOs had the most questions about whether or how they would use Technical Assistance for Medicaid practices and CareAccord Direct secure messaging. In terms of technical assistance, some CCOs reported experiencing a variety of challenges in their previous efforts to deliver technical assistance to providers. CCOs reported being uncertain regarding what the assistance would include and therefore to what extent it would benefit their providers when it becomes available. In terms of CareAccord, CCOs varied in their understanding and approach to Direct secure messaging. Most reported that many providers remain unaware of or confused by Direct secure messaging. Some providers are taking advantage of Direct secure messaging capability available via their EHRs. Several CCOs are invested in a regional HIE that includes Direct secure messaging capability. Some CCOs are exploring the use of Direct secure messaging as a means for communicating securely with non-health entities such as law enforcement and education (e.g., early learning hubs).

As noted above, four CCOs have gone live with a PreManage subscription as of June 2015, which provides them with hospital event (emergency department admission, inpatient, and discharge) notification. One has opted for the ‘complete’ PreManage package, which includes the availability of PreManage subscriptions for the key practices in their provider network. Three additional CCOs are in discussions with CMT about purchasing PreManage.

Appendix A: Summary of CCO HIT Investments

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

Appendix B: CCO HIT/HIE Profiles

(In alphabetical order)

1. AllCare Health Plan
2. Cascade Health Alliance
3. Columbia Pacific CCO
4. Eastern Oregon CCO
5. FamilyCare, Inc.
6. Health Share of Oregon
7. Intercommunity Health Network CCO
8. Jackson Care Connect
9. PacificSource Community Solutions CCO, Central Oregon Region
10. PacificSource Community Solutions CCO, Columbia Gorge Region
11. PrimaryHealth of Josephine County
12. Trillium Community Health Plan
13. Umpqua Health Alliance
14. Western Oregon Advanced Health
15. Willamette Valley Community Health
16. Yamhill Community Care Organization

AllCare CCO HIT/HIE Profile

Southern Oregon, 47,805 members¹

CCO Description:

- Mid Rogue AllCare Health Assurance, Inc. owns AllCare CCO, Inc.
- Medicaid members who reside in Jackson, Josephine, Curry and Southern Douglas Counties.
 - Includes more than 8,500 new enrollees for 2014 through the ACA Medicaid expansion. Majority of new enrollees reside in Jackson County.
 - Medicare Advantage plan, CareSource, serves 2,100 Members who reside in Jackson and Josephine Counties, of which about 800 are dually eligible.
- Network of providers exceeds 1400 primary care and specialty care providers with an extensive network of behavioral health and dental health providers. AllCare has a varied provider network and doesn't rely as heavily on FQHCs as other CCOs. AllCare's network has grown considerably with the ACA expansion population.
- Mid Rogue AllCare Health Assurance, Inc, AllCare's owner, owns AllCare eHealth Services, an EMR company that provides Greenway's PrimeSuite EHR solution to a number of clinics in AllCare's network. They also own Mid Rogue Independent Physicians Association, a contracting entity for the Josephine County Providers.
- AllCare is one of 4 Southern Oregon CCOs participating in the Jefferson Health Information Exchange (JHIE).
- AllCare is also supporting Community Connected (C2) Network – led by the county agency, in partnership with 2 CCOs, education and social services stakeholders, to develop a database and system for coordinating and integrating information related to social services assessment and delivery in Jackson County

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination			Quality Improvement, Population Management, Data and Analytics Tools
Status	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input type="checkbox"/> Currently supporting <input checked="" type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing
Vendor Name	Medicity	Essette	Vistalogic	Milliman
Product Name				MedInsight
Version		2013		
Comment	Provided by Jefferson HIE	Case management software	Provided by Community Connected Network for social service delivery	Predictive Modeling, assist in population management through our case management team

¹As of 10/01/2014

www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

Description of HIT/HIE Initiatives

<p>Information Sharing and Care Coordination</p>	<p>AllCare is participating in the Jefferson Health Information Exchange (JHIE) which aims to provide the care team with access to patient-centered health information at the time and place of care to improve timeliness, quality and coordination of care. JHIE covers a three county region in Southern Oregon inclusive of Jackson, Josephine, and Klamath Counties, and recently added partnerships with a 5th CCO and providers in the Columbia River Gorge area.</p> <p>Health Information Exchange:</p> <ul style="list-style-type: none"> • JHIE currently offers Direct secure messaging and a provider-to-provider closed-loop referral system through its technology vendor Medicity. These features support health information exchange and referrals among behavioral, physical, and dental health providers and with CCO Care Coordinators. • JHIE is in the process of implementing “phase 2” to include additional functions/services including clinical alerts, 30-day readmission alerts, patient search, and a consolidated clinical inbox to be accessible to any enrolled provider or CCO with a patient/member relationship. Patient matching and record location supports patient/provider attribution. EHR integration and connectivity will be supported as well, including single sign on for patient search of HIE, results delivery to the EHR and receipt of CCD/care summary to the EHR. <p>AllCare is also supporting Community Connected (C2) Network – a committed group of organizations working together to change the way individuals access and receive social service support in Jackson County; startup funding supported by county and 2 CCOs; other partner organizations from social services, education sectors. Launch expected in 2015. Intersections with JHIE are under discussion.</p> <ul style="list-style-type: none"> • Goals include: to support sharing of information and coordination of services amongst community partners, to provide tools to help integrate and coordinate the existing social service delivery infrastructure including identifying service providers for common clients, and to provide a mechanism to connect existing systems within social service, health care, and education sectors. • C2 database will include centralized contact registry, resource/referral module, onboarding tool, release of information module, record capabilities, survey/assessment module, auto-populating forms/summary sheets, integrated calendar and discussion forum, aggregate data reporting. <p>Direct Secure Messaging²:</p> <p>AllCare sees value in getting their case managers signed up with and using JHIE, specifically the Direct secure messaging feature.</p> <ul style="list-style-type: none"> • JHIE offers Direct secure messaging and a provider-to-provider closed-loop referral system through its technology vendor Medicity. • The JHIE Medicity HISP is DirectTrust accredited, and thus interoperable with CareAccord and other Direct secure messaging users across the state. JHIE participates in the flat file directory sponsored by OHA, to share Direct secure messaging addresses across Oregon organizations using accredited HISPs to support cross-organizational exchange • AllCare is interested in communicating securely with non-health entities such as law enforcement and education (e.g., early learning hubs), and is therefore exploring the use
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² Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

	<p>of CareAccord as a service for those entities to use for that purpose, if these organizations do not become part of JHIE.</p> <ul style="list-style-type: none"> • AllCare clinics using AllCare eHealth Services’ Greenway EHR will have access to Direct secure messaging. Greenway’s preferred HISP is Updocs. • AllCare notes that clarification and information about Direct secure messaging and JHIE would be helpful for communicating with provider network and affiliates including about the value and need for health information exchange. <p>Hospital Notifications³:</p> <ul style="list-style-type: none"> • JHIE will include hospital event notifications from its member hospitals (Asante, Providence, Sky Lakes, Mid-Columbia Medical Center) to JHIE members as part of “phase 2” and is contemplating connecting to PreManage to enable its members to send and receive hospital alerts from hospitals beyond the JHIE region across the state. • AllCare case managers will use JHIE as well for referrals, hospital event notifications, etc. They used to receive hospital event (ADT) information which made a big difference in behavior health/physical health integration. Looking forward to having that info again. <p>Care Management and CCO-Provided Information to Providers/Care Teams:</p> <ul style="list-style-type: none"> • AllCare uses Essette case management system for members who need case management and/or do not have care managed by a PCPCH. AllCare case management staff use Essette to record assessments; develop care plans; record tasks, notes, correspondence; and get daily email alerts/reports for important events such as surgery. The care plan allows case managers to set goals, identify interventions and assign them to care teams, supports coordination around transitions of care, and identifies barriers for managed patients that need to be addressed. AllCare case management teams are organized to support groups of patients such as those needing disease management, exceptional needs care coordination, community health worker assistance, etc. • AllCare case managers will use JHIE as well for referrals, hospital event notifications, etc. AllCare would like to add lab, hospital data for case managed members integrated into the Essette dashboard. • Many AllCare members have their care coordinated within a PCPCH. AllCare provides member information to their PCPCHs to support care management and care coordination, including including provider specific lists of their, CMHPs a list of their members diagnosed with Severe and Persistent Mental Illness (SPMI) and Diabetes who have not had the appropriate lab monitoring (LDL and HgbA1C testing).
<p>Quality Improvement, Population Management, Data and Analytics Tools</p>	<p>AllCare is anxious to better leverage the data they have, and add new data to the mix. They have staffed a data team.</p> <ul style="list-style-type: none"> ▪ Roll-out of new compensation formulas and incentives will require better use of data and provide the opportunity to strengthen the health plan’s ability to collect and report on specific quality measures in a standardized, replicable, and comparable format. <ul style="list-style-type: none"> ○ As part of their OHA Transformation Grant, AllCare created new provider incentive compensation plan for its primary care providers that commenced on January 1, 2014. ○ Quarterly, the team distributes quality dashboard reports for each provider, focusing on access, number of member in practices, compensation capitation tied to acuity, then adding basic ED and inpatient utilization and primary care data, and third are 17 measures for PCPs.

³ Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

	<ul style="list-style-type: none"> ○ The team has developed a Specialty incentive compensation plan this is in a pilot phase as of the end of 2014. ○ The team has developed a Dental and a Behavioral Health incentive compensation plan which are in the final phases of development. <p><u>Incorporating clinical data:</u></p> <ul style="list-style-type: none"> ● AllCare will also need to access utilization and clinical quality data within a provider’s EHR system in order to manage the new provider compensation formulas real time. ● Defining tools for data analytics and population health management are anticipated for 2015 with services available in 2016 through participation with JHIE. ● In addition, AllCare anticipates it might need to implement or develop its own data warehouse & database management system in the future for clinical data for analytics and metrics (e.g., JHIE data, HL7 messages, CCDs, etc.). Particularly interested in getting lab data – potentially through JHIE, which is needed for multiple reporting requirements including HEDIS.
Clinical Quality Metrics (CQM) Collection and Reporting	<p>Current CQM Strategy:</p> <ul style="list-style-type: none"> ● AllCare providers largely use 3 different 2014 CCHIT certified electronic medical record systems (Epic, Greenway, and NextGen). The three software systems have the capacity to report electronic clinical quality measures per Meaningful Use Stage 1 requirements and are working towards those criteria for Meaningful Use Stage 2. (See update under “Other” below for the Greenway solution.) ● AllCare reports it will need some of the smaller (1 to 2 doc practices) with EHRs to participate in order to achieve the Year 2 population % CQM requirements. The clinics on Greenway will not be enough to meet these requirements. <p>Longer term CQM Strategy: Utilizing JHIE is part of the CCO’s long-term strategy for CQM reporting. JHIE member CCOs will be able to collect CQMs from providers using JHIE and are exploring using JHIE to submit data to the CQMR.</p>
Technical Assistance to Practices for EHRs and Meaningful Use	<p>AllCare eHealth Services, an EMR company that provides Greenway’s PrimeSuite EHR solution to a number of clinics in AllCare’s network, provides technical assistance and support to those clinics related to using the EHR and meeting Meaningful Use.</p> <p>AllCare found many providers faced challenges in 2013 for recording depression assessments in EHRs – didn’t know where to put the assessments in the EHR. AllCare provides training to providers to ensure they are putting the data in the right place.</p>
Telehealth and Patient Engagement through HIT	<ul style="list-style-type: none"> ▪ In the fall 2014, AllCare worked with Providence for eHealth Express, which offers “virtual provider triage” to support delivery of care in the most appropriate setting, including identifying non-emergent issues. ▪ AllCare is interested in texting initiatives for telehealth. Have been doing Text 4 Baby for about 4-5 years. Interested in moving into disease management.
Other	<p>EHR Hosting</p> <ul style="list-style-type: none"> ● AllCare eHealth Services (hosting Greenway’s PrimeSuite EHR) – upgraded to 2014 version in fall 2014; fully integrated practice management and EMR; includes a meaningful use dashboard for providers monitoring their metrics and CQMs. The dashboard is great for meaningful use, but not the best for other metrics like the PCPCH metrics, since meaningful use dashboard is set for a calendar year. Can export meaningful use CQMs. <p>Local Provider Directories:</p> <ul style="list-style-type: none"> ● AllCare maintains a provider directory within their administrative systems including within Essette case management; and AllCare eHealth Services (hosting Greenway’s

	<p>PrimeSuite EHR). JHIE includes a provider directory based on user enrollment and clinical results attribution expected to be compliant with anticipated HPD standards.</p>
<p>Barriers to Implementation of HIT Tools/ Services</p>	<ul style="list-style-type: none"> • Lack of EHR adoption with some private solo and small practice sites. Certain providers and clinics that serve as key access points for patients to the care system have not yet adopted EHRs and it's unclear if they will be doing so in the future. • Many smaller offices are struggling with reporting burden and meeting PCPCH, PQRS, meaningful use, and other requirements. Concerned that burden will become a barrier to achieving or maintaining PCPCH status. Our AllCare eHealth Services spends plenty of time supporting EHR and pulling reports – some small practices just may not have sophistication to do it or the time to deal with upgrading EMR, and it is frustrating for them when we keep pushing in that direction when they don't have the resources to do those things. One-stop reporting for providers would be helpful. • Providers want credible metrics – some metrics aren't credible, such as holding a PCP accountable for mammograms, when the PCP orders but doesn't perform them. The certified EHR system doesn't account for that. • AllCare is experiencing some pushback from clinics because of all of the reporting/workflow requirements placed on them. Some clinics are averse to becoming primary care homes because of the reporting burden (e.g., NQF measures). AllCare is using its case management staff to fill some of the gaps in care coordination experienced by practices in its network. • For C2 and sharing individual-level data between non-health providers – many issues around FIRPA (laws regulating sharing of student data within the education system) and HIPAA arise. C2 and JHIE sharing HIPAA resources. • JHIE and its partners would like to include access to the Prescription Drug Monitoring Program data to support efforts to reduce inappropriate prescribing and abuse of prescription drugs.
<p>Barriers to Behavioral Health Information Sharing</p>	<p>JHIE and its partner CCOs would like mental health agencies in their network to be able to contribute data to JHIE's community health record for patient search, but data management concerns resulting from the sensitivity of mental/behavioral health information (and the potential co-mingling of that information with physical health data) present challenges.</p> <p>Barriers/challenges experienced in sharing behavioral health data (including mental health, substance abuse, and addictions) include:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Confusion over compliance with state or federal laws <input type="checkbox"/> State or federal laws prohibit the type of sharing we want/need to do <input type="checkbox"/> Our organization's technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data). <input checked="" type="checkbox"/> Concerns over privacy and confidentiality protection for the patient <input type="checkbox"/> Concerns over liability if information you share is later improperly shared <input type="checkbox"/> Lack of proper consent forms from the patient

CCO Provider Environment:

Hospital Engagement in HIT

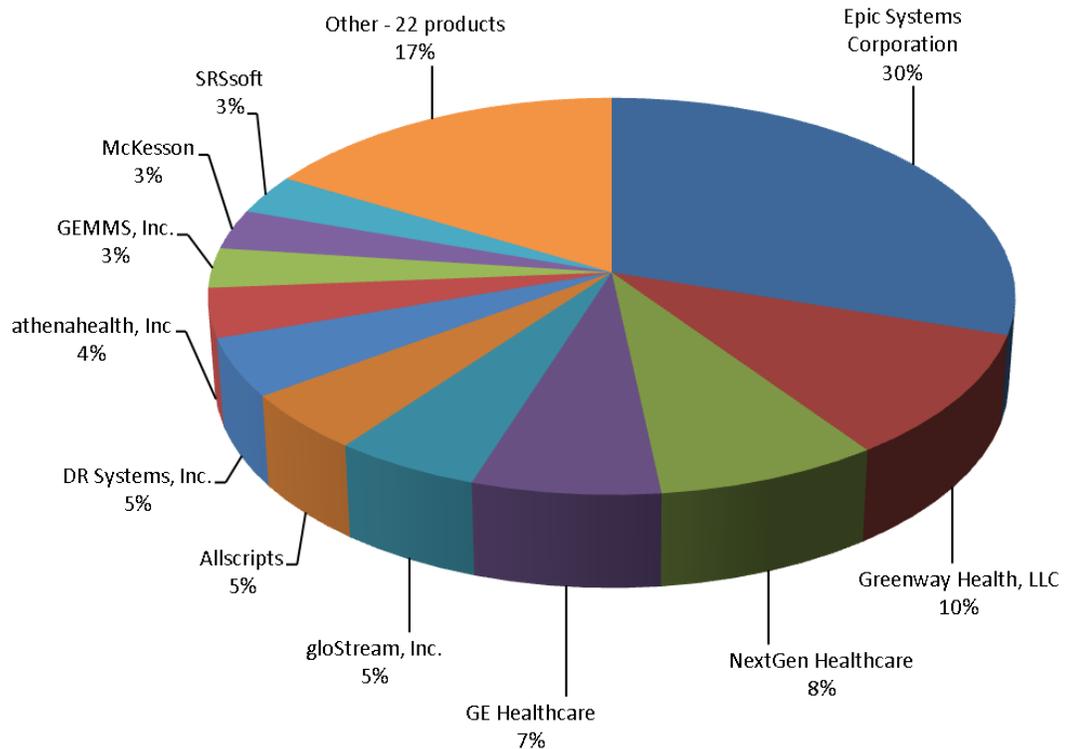
Hospital Name	EHR Vendor	Stage of Meaningful Use*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Asante Three Rivers Medical Center	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Asante Ashland Community Hospital	N/A	N/A	Feed is live for ED and inpatient data—receiving notifications to EMR.
Asante Rogue Regional Medical Center	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Curry General Hospital	CPSI	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Providence Medford Medical Center	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.

*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top Certified EHR Technology Products for AllCare

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 400 unique providers affiliated with AllCare CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, EHR represented in data is based on the most recent information. There are a total of 32 different EHRs in use within the CCO. The top 11 products are represented in the chart, which are in use by 334 unique providers.



Cascade Health Alliance CCO HIT/HIE Profile

17,125 members¹

CCO Description:

- 9 primary care clinics and 45 primary care providers, with 75 local IPA specialists and 1 hospital.
- 3 largest clinics are assigned approximately 25% of membership each. As of December 2013, the largest 4 clinics (two of which are pediatric clinics) made up a total of 91.82% of membership.
- Cascade Health Alliance is one of 4 Southern Oregon CCOs participating in the Jefferson Health Information Exchange (JHIE).

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination	Quality Improvement, Population Management, Data and Analytic Tools
Status	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input type="checkbox"/> Currently supporting <input checked="" type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing
Vendor Name	Medicity	
Comment	Provided by Jefferson HIE	Pursuing new case management software

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	<p>Cascade Health Alliance is participating in the Jefferson Health Information Exchange (JHIE) which aims to provide the care team with access to patient-centered health information at the time and place of care to improve timeliness, quality and coordination of care. JHIE covers a three county region in Southern Oregon inclusive of Jackson, Josephine, and Klamath Counties, and recently added partnerships with a 5th CCO and providers in the Columbia River Gorge area.</p> <p>Health Information Exchange:</p> <ul style="list-style-type: none"> • JHIE currently offers Direct secure messaging and a provider-to-provider closed-loop referral system through its technology vendor Medicity. These features support health information exchange and referrals among behavioral, physical, and dental health providers and with CCO Care Coordinators. • JHIE is in the process of implementing “phase 2” to include additional functions/services including clinical alerts, 30-day readmission alerts, patient search, and a consolidated clinical inbox to be accessible to any enrolled provider or CCO with a patient/member relationship. Patient matching and record location supports patient/provider attribution. EHR integration and connectivity will be supported as well, including single sign on for patient search of HIE, results delivery to the EHR and receipt of CCD/care summary to the EHR. <p>Direct Secure Messaging²:</p> <ul style="list-style-type: none"> • JHIE offers Direct secure messaging and a provider-to-provider closed-loop referral system
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¹As of 10/01/2014

www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

² Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

	<p>through its technology vendor Medicity.</p> <ul style="list-style-type: none"> The JHIE Medicity HISP is DirectTrust accredited, and thus interoperable with CareAccord and other Direct secure messaging users across the state. JHIE participates in the flat file directory sponsored by OHA, to share Direct secure messaging addresses across Oregon organizations using accredited HISPs to support cross-organizational exchange. <p>Hospital Notifications³:</p> <ul style="list-style-type: none"> JHIE will include hospital event notifications from its member hospitals (Asante, Providence, Sky Lakes, Mid-Columbia Medical Center) to JHIE members as part of “phase 2” and is contemplating connecting to PreManage to enable its members to send and receive hospital alerts from hospitals beyond the JHIE region across the state. <p>Care Management and CCO-Provided Information to Provider/Care Teams: CHA is heavily involved in providing case management to their members. EZCap, their practice management software, has a case management module that is in use by the CCO. MedImpact (Atrio’s chosen reporting software) and MedOptimize (Pharmacy) are used for running reports from Atrio for dual eligible population.</p> <p>The CCO is exploring the possibility of implementing a new case management application, which would have the ability to ingest data from the state, interface with practices and/or the JHIE platform, and access claims data from EZCap.</p>
<p>Quality Improvement, Population Management, Data and Analytics Tools</p>	<p>CHA has a focus on claims analytic capabilities and report preparation. A key barrier to improved analytics is the lack of access to EHR clinical data.</p> <p>Incorporating Clinical Data:</p> <ul style="list-style-type: none"> Expecting significant growth in the capacity to report clinical metrics internally with the advent of JHIE tools for data analytics and population health management. Defining tools for data analytics and population health management are anticipated for 2015 with services available in 2016 through participation with JHIE. Additional opportunities exist for future alternate data collection. In time, these may be the best opportunities because they are less dependent on clinic personnel resources. <ul style="list-style-type: none"> Utilize JHIE for the majority of clinical data reporting. Looking forward to using JHIE to get aggregate data. The CCO expects to rely on report from their anticipated (new) care coordination software integrated with clinic EHRs. This will depend on the software’s ability to integrate effectively, but will serve a dual purpose – more real time data as well as faster turnaround for clinical reports because of direct access.
<p>Clinical Quality Metrics (CQM) Collection and Reporting</p>	<p>Current CQM Strategy:</p> <ul style="list-style-type: none"> As in year 1, CHA plans to utilize aggregate-level data provided by OCHIN for year 2 CQM reporting. One of CHA’s larger clinics, Klamath Open Door, has recently implemented Greenway EHR technology, which is currently only capable of reporting on one of the three CQMs. Klamath Open Door is providing data generated from internal reporting for all three CQMs. Despite the new EHR not having canned reports, the data desired is in the system and can be extracted. <p>Longer term CQM Strategy: Utilizing JHIE is part of the CCO’s long-term strategy for CQM reporting. JHIE member CCOs will be</p>

³ Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

	able to collect CQMs from providers using JHIE and are exploring using JHIE to submit data to the CQMR.
TA to Practices for EHRs and MU	CHA provides Technical Assistance to practices for EHR adoption/workflow optimization, but uptake has been limited. JHIE is providing some assistance in HIE connectivity and Direct.
Other	<p>Local Provider Directory:</p> <ul style="list-style-type: none"> • JHIE includes a provider directory based on user enrollment and clinical results attribution expected to be compliant with anticipated HPD standards. • CHA maintains a provider directory within EZCap
Barriers to Implementation of HIT Tools/ Services	<ul style="list-style-type: none"> • Use of disparate EHRs within the CCO. • Lack of access to clinical data, needed for analytics and care management. • Ongoing changes within CHA, including training and setup of new employees (primarily case managers) on JHIE. Case managers access a variety of tools (dual eligible tools through Atrio, etc.) and need 3 monitors to do so. • Pushback from practices due to drastic workflow changes associated with implementing a new application. • JHIE and its partners would like to include access to the Prescription Drug Monitoring Program data to support efforts to reduce inappropriate prescribing and abuse of prescription drugs.
Barriers to Behavioral Health Information Sharing	<p>JHIE and its partner CCOs would like mental health agencies in their network to be able to contribute data to JHIE's community health record for patient search, but data management concerns resulting from the sensitivity of mental/behavioral health information (and the potential co-mingling of that information with physical health data) present challenges.</p> <p>Identify the barriers/challenges CHA experiences in sharing behavioral health data (including mental health, substance abuse, and addictions):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Confusion over compliance with state or federal laws <input type="checkbox"/> State or federal laws prohibit the type of sharing I want/need to do <input type="checkbox"/> Our organization's technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data). <input checked="" type="checkbox"/> Concerns over privacy and confidentiality protection for the patient <input checked="" type="checkbox"/> Concerns over liability if information you share is later improperly shared <input type="checkbox"/> Lack of proper consent forms from the patient

CCO Provider Environment:

Hospital Engagement in HIT

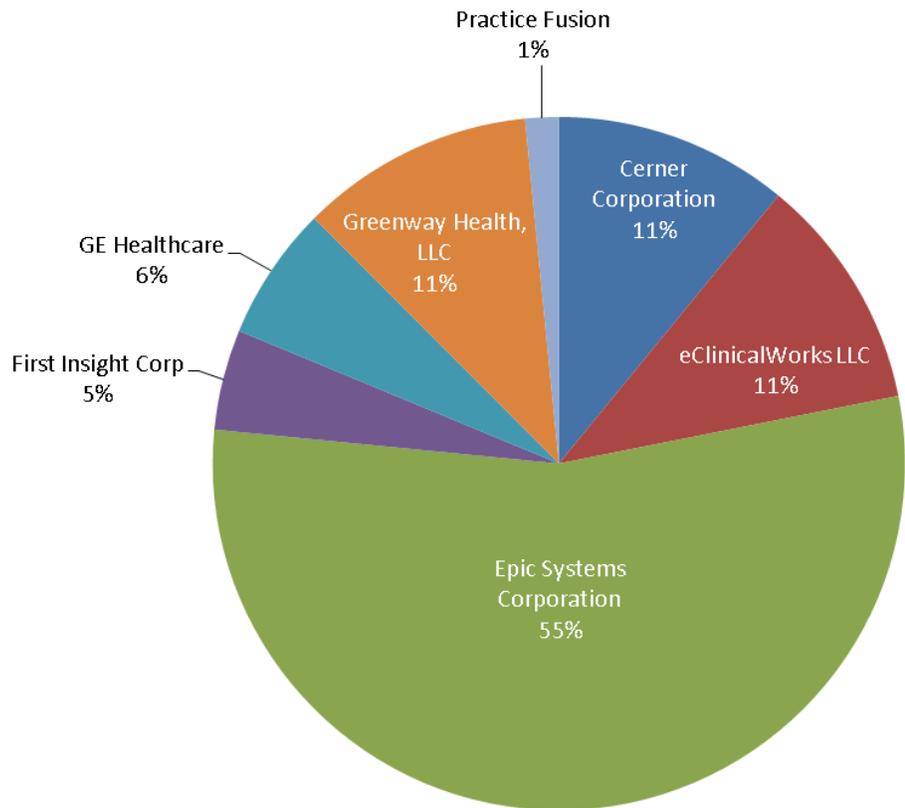
Hospital Name	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Sky Lakes Medical Center	Meditech	Stage 1	Feed is live for ED and inpatient data—receiving notifications to printer.

*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Certified EHR Technology Products Cascade Health Alliance

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 64 unique providers affiliated with Cascade Health Alliance CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 7 different EHRs in use within the CCO.



Columbia Pacific CCO HIT/HIE Profile

28,850 members¹

CCO Description:

- Services members in Tillamook, Clatsop, Columbia and five zip codes in Douglas County
- 29 contract primary care clinics sites, 13 mental health/addictions sites, and 4 hospitals within its service area
- Majority of primary care clinics are licensed FQHCs or RHCs; a smaller proportion of the Medicaid population is served by small clinics and independent practitioners within the CCO
- Over 40% of members are empaneled to two clinics: OHSU Scappoose and Coastal Family Health Center
 - Both clinics are PCPCH Tier 3 clinics and have OCHIN's Epic certified electronic health record (EHR) and participate in Meaningful Use
- Due to the Affordable Care Act and Medicaid expansion, Columbia Pacific CCO (CPCCO) grew 70%.

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination	Quality Improvement, Population Management, Data and Analytic Tools
Status	<input type="checkbox"/> Currently supporting <input checked="" type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing
Vendor Name	CareAccord	
Product Name		SAS Business Intelligence Software
Comment	Exploring pilot projects with CareAccord	Claims-based analytic reporting, ideally expanding to incorporate clinical information

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	<p>Overall, Columbia Pacific anticipates leveraging state HIT/HIE efforts and expects to work toward a CCO-specific technology roadmap.</p> <p>Health Information Exchange:</p> <ul style="list-style-type: none"> • Patient information is shared across physical health care teams that are using Epic EHR (including FQHCs using OCHIN's Epic) via Epic CareEverywhere. • Columbia Pacific is interested in exploring approaches for supporting information sharing with behavioral health providers and other members of the care team including with their behavioral health partner, the Great Oregon Behavioral Health Inc. (GOBHI) (see Direct secure messaging below). <p>Direct Secure Messaging²:</p> <p>Columbia Pacific is considering how to support and facilitate the use of Direct secure messaging,</p>
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¹As of 10/01/2014

www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

² Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

	<p>including considering Direct secure messaging pilots around physical and behavioral health information sharing using CareAccord.</p> <p>Hospital Notifications³: CPCCO has a strong interest in EDIE and PreManage, as it has patients that seek care at hospitals outside of the CCO network, including OHSU and hospitals in Washington state. The CCO has been engaged in some ad hoc notifications of providers related to ED follow up, which PreManage would replace.</p> <p>Care Management and CCO-Provided Information to Provider/Care Teams: The CCO is interested in supporting transitions of care workflow with primary care providers, when their patients are discharged from the hospital, for example. The CCO plans to utilize the hospital notifications obtained via PreManage to assist with care management, including its care coordination efforts and support for providers.</p> <p>CPCCO would like to be able to provide clinics with reports that would allow for follow-up with specific patients. Patient-level information would need to be extracted from the EHRs in order to be actionable, rather than current aggregate metrics reporting.</p>
Quality Improvement, Population Management, Data and Analytics Tools	<ul style="list-style-type: none"> • CareOregon supports Columbia Pacific CCO with claims-based analytic reporting through SAS Business Intelligence software, using data warehouse to store claims and administrative data. <ul style="list-style-type: none"> • In 2013, GOBHI mental health claims were incorporated into the data warehouse and made available in SAS BI. • Current reporting capability includes aggregate reporting for CCO level data, provider level data, and member level data for demographics, utilization, and gaps in care • Partnership with OCHIN to report capability for clinical data
Clinical Quality Metrics (CQM) Collection and Reporting	<p>Current CQM Strategy: The high penetration of Epic and use of OCHIN’s Epic installation in particular, has allowed for the reliance on OCHIN as the current strategy.</p> <p>Longer-term CQM Strategy: The CCO intends to utilize the statewide CQMR service for Medicaid reporting instead of standing up its own comparable technology.</p>
Technical Assistance to Practices for EHRs and Meaningful Use	<p>CPCCO is currently providing EHR technical assistance to clinics through our PC3 collaborative as well as when the practice coach provides one-to-one assistance as well. When working on clinical process and workflow improvement, how to document and code the activity in the EHR is always one aspect of the process we discuss and guide clinics through.</p> <p>We are currently looking into Scribes however no firm decision has been made yet.</p>
Patient Engagement through HIT	<p>Supporting clinic-based initiatives to encourage the use of MyChart.</p>
Telehealth	<p>Interested in and exploring various telehealth opportunities including specialty apps (e.g., tele-dermatology), virtual specialists, telemedicine after hours care, and Project ECHO (tele-mentoring).</p>
Other	<p>Local Provider Directory: CareOregon maintains a provider directory in its internal administrative systems.</p>

³ Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

Barriers to Implementation of HIT Tools/ Services	<ul style="list-style-type: none"> • Providers in rural areas are serving many more of the CCO’s members due to Medicaid expansion, and layering changes or new expectations (such as new metrics) on top of this much new growth is difficult for providers. • HIT tools for providers, such as PreManage hospital notifications, are more likely to be used if a clinic’s entire patient panel is supported by the HIT tool. • A lack of access to clinical data. In need of patient-level actionable information. • A number of additional small practices use other (non-Epic) EHR systems that do not have the same HIE capabilities • Current lack of understanding among clinics/providers in optimal use of Epic’s CareEverywhere.
Barriers to Behavioral Health Information Sharing	<p>Integration of Behavioral Health clinical data with physical health clinical data will be an ongoing challenge as the county Mental Health providers use differing software/ EHR platforms.</p> <p>Identify the barriers/challenges Columbia Pacific experiences in sharing behavioral health data (including mental health, substance abuse, and addictions):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Confusion over compliance with state or federal laws <input checked="" type="checkbox"/> State or federal laws prohibit the type of sharing I want/need to do <input checked="" type="checkbox"/> Our organization’s technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data). <input checked="" type="checkbox"/> Concerns over privacy and confidentiality protection for the patient <input checked="" type="checkbox"/> Concerns over liability if information you share is later improperly shared <input checked="" type="checkbox"/> Lack of proper consent forms from the patient

CCO Provider Environment:

Hospital Engagement in HIT

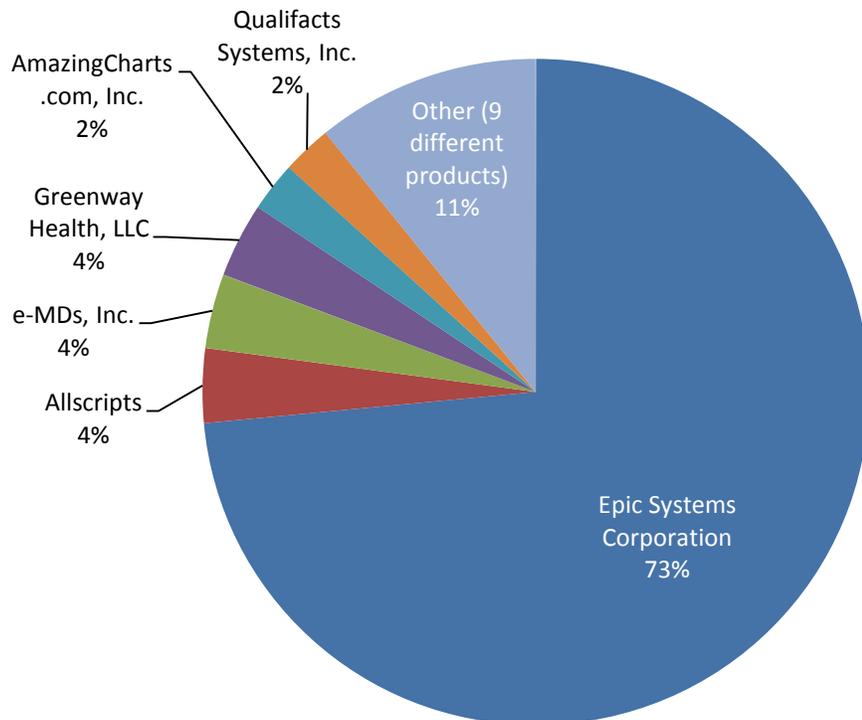
Hospital Name	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Columbia Memorial Hospital	CPSI	Stage 1	Feed is live for ED and inpatient data—receiving notifications to fax.
Providence Seaside Hospital	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Lower Umpqua Hospital	Healthland	Stage 1	Feed is live for ED and inpatient data—receiving notifications to printer.
Tillamook Regional Medical Center	Cerner	Stage 1	Feed is live for ED data—receiving notifications to fax.

*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top Certified EHR Technology Products for Columbia Pacific CCO

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 83 unique providers affiliated with Columbia Pacific CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 15 different EHRs in use within the CCO. The top 6 products are in use by 74 unique providers.



Eastern Oregon CCO HIT/HIE Profile

46,701 members¹

CCO Description:

- Service area covers 12 counties in rural eastern Oregon, the land mass of which is more than 50,000 square miles, representing over 52% of the land area in the State of Oregon.
- There are 57 widely dispersed clinics and individual providers: 24 are certified as Rural Health Clinics (RHCs), 6 as Federally Qualified Health Centers (FQHCs). Twenty-four of EOCCO's contracted clinics within the 12 counties of EOCCO are PCPCHs. An additional Twenty-two (22) clinics that border the EOCCO geography are certified.

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination	Quality Improvement, Population Management, Data and Analytic Tools	
Status	<input type="checkbox"/> Currently supporting <input checked="" type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input type="checkbox"/> Currently supporting <input checked="" type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing
Vendor Name			SAS
Product Name		Provider Portal	Data Store
Comment	Exploring how to support clinics with Direct secure messaging	Being developed/offered by Moda Health (Q2 2015). Reporting: quality, utilization, rosters, etc.	Includes risk analysis tool

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	<p>EOCCO has developed a regional HIT/HIE strategy that focuses on leveraging state HIT/HIE services and otherwise relies largely on technology resources developed and provided by Moda Health. EOCCO plans to contract with a vendor to provide technical assistance, who would work in conjunction with the Innovator Agent as needed to engage providers around HIT efforts.</p> <p>Health Information Exchange: (see Direct secure messaging, below)</p> <p>Direct Secure Messaging²: The CCO sees significant value in getting providers and other care team members (e.g., public health, social services, corrections, etc.) in their network enrolled in CareAccord or other Direct secure messaging so they can exchange information and communicate amongst themselves. The CCO is interested in pilot testing use cases across a diverse care team. The CCO itself uses Moda Health's own secure email service and does not currently intend on utilizing Direct secure messaging separately.</p>
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¹As of 10/01/2014

<http://www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf>

² Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

	<p>Hospital Notifications³: Hospitals in the EOCCO service area are providing hospital notifications directly to many key CCO practices. EOCCO is considering whether PreManage would provide added value for their CCO or practices.</p> <p>Care Management and CCO-Provided Information to Provider/Care Teams: EOCCO plans to utilize a provider portal (expected in 2015) which is currently being developed and offered by Moda Health. It will provide reporting, including quality and utilization metrics, and patient rosters to providers. Currently this information is being provided via secure email.</p>
<p>Quality Improvement, Population Management, Data and Analytics Tools</p>	<ul style="list-style-type: none"> • EOCCO/Moda’s analytical capacity includes the ability to extract, transform and load data into a data store for analytic and reporting functions. This data store provides the foundation for the analytic team to assess information quickly and run various analytics against information about members and providers and to make recommendations surrounding members’ care. • EOCCO Leverages the analytics capabilities of Moda Health who supplies: <ul style="list-style-type: none"> ○ a dedicated analyst ○ ad-hoc support from the larger Moda analytical team as needed ○ support by the full portfolio of Moda analytical tools and organizational knowledge • With Moda resources, the CCO is able to generate timely reports on cost, utilization, quality and trends and gaps in care (e.g., patients in need of screening). EOCCO produces reporting packages tailored for individual counties or provider groups to assist in finding opportunities to improve care and eliminate waste, for example. • EOCCO currently sends out provider report cards tracking performance by secure email. Moda is planning to distribute these provider report cards via their provider portal.. • Moda is considering expansion of their risk score tool to allow for the identification of members whose utilization rate they could influence. They are interested in becoming more sophisticated with respect to the stratification of their population. • In 4th quarter 2014 EOCCO began providing primary care practices a report of their top 15 utilizing members which includes the members prospective risk score. This information is provided with the report cards. This new report is an additional tool for providers to use to help manage the most costly members assigned to their clinic/practice. <p>Incorporating Clinical Data:</p> <ul style="list-style-type: none"> • EOCCO is highly interested in extracting clinical data from their providers’ EHRs and are therefore in discussion with a vendor for these services, potentially in early 2015. • Building a process to store and analyze clinical information. It is anticipated that providers will deliver information in standard HL7 data format, which would allow for consistency and efficiency in information processing. EOCCO will then be able to run analytics against this information and validate the data against the utilization in claims data.
<p>Clinical Quality Metrics (CQM) Collection and Reporting</p>	<p>Current CQM Strategy:</p> <ul style="list-style-type: none"> • EOCCO continues to express concern about being able to meet the Year 2 depression screening CQM target. This is not due a technical barrier, but a workflow-related one, as many practices have not yet implemented the depression screening process into their clinical workflow. • The CCO is currently performing outreach to practices in an attempt to get them to incorporate proper depression screening processes into their EHR workflows. The focus

³ Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

	<p>has been on the larger practices in order to ensure collection of sufficient data.</p> <ul style="list-style-type: none"> EOCCO is pursuing the collection of clinical and other HEDIS data for the purpose of expanding their data repository and improved reporting as well as providing practices with more meaningful and actionable reports. <p>Longer-term CQM Strategy:</p> <p>The CCO and Moda are in discussions regarding their strategy for addressing the CCO incentive measures moving forward, which includes contracting with an outside vendor to provide analytics tools/capabilities and/or guidance around collecting and reporting on CQM data.</p> <ul style="list-style-type: none"> EOCCO is in discussions with vendors who could access various systems, review and assist with adjusting workflows, and collect clinical data directly out of the EHRs. Note: any vendor solution will also be expected to support Moda performance/quality related initiatives outside of the CCO, e.g., HEDIS reporting.
Technical Assistance to Practices for EHRs and MU	CCO is embarking on a technical assistance program, which may include staff that goes out to support practices. Providing assistance with workflow modifications to facilitate the collection of clinical data is a priority. EOCCO plans to begin TA to assist with CQMs at their high-priority practices in early 2015.
Patient Engagement through HIT	EOCCO plans to expand the use of the MyModa member portal to the EOCCO population. The MyModa portal provides members customized on-line access to real time health information such as claims, eligibility, current PCP/Medical home assignment, the ability to search for network providers along with other health related tools and resources. We expect the portal to be available to the EOCCO population in 2015.
Telehealth	EOCCO providers have telehealth equipment and technology, but lack an implementation partner. They are very interested in telehealth and requested access to the OHA-sponsored telehealth inventory, once compiled.
Other	Local Provider Directory: EOCCO maintains a provider directory within their administrative systems.
Barriers to Implementation of HIT Tools/ Services	<p>EOCCO's provider network contains many small practices. This presents challenges on multiple levels. Having many small practices on disparate systems complicates efforts to implement HIE or collect clinical data. This also makes the CCO's process of providing practice-level assistance around EHR workflows longer and more complex.</p> <ul style="list-style-type: none"> Small practice size is a barrier to increasing CQM collection. EOCCO is finding it challenging to get clinical data out of EHRs effectively, particularly with its rural providers. There are over 25 different EHRs being used by practices in the CCO's region, and a lack of EHR interoperability. Challenges related to geographical and logistical technology capabilities. Some providers are waiting on vendors for needed MU Stage 2 updates, while those owned by hospitals/health systems are relying on their parent organization to proceed. <p>EOCCO is finding it challenging to distribute provider report cards to practices and providers., It is difficult to get accurate, up-to-date e-mails for secure email distribution. Having an email address does not ensure distribution to the correct individual.</p>
Barriers to Behavioral Health Information Sharing	<p>Barriers/challenges experienced in sharing behavioral health data (including mental health, substance abuse, and addictions) include:</p> <p><input checked="" type="checkbox"/> Confusion over compliance with state or federal laws</p> <p><input type="checkbox"/> State or federal laws prohibit the type of sharing I want/need to do</p> <p><input checked="" type="checkbox"/> Our organization's technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not</p>

segment or separate data).

- Concerns over privacy and confidentiality protection for the patient
- Concerns over liability if information you share is later improperly shared
- Lack of proper consent forms from the patient

CCO Provider Environment:

Hospital Engagement in HIT

Hospital Name	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Blue Mountain Hospital	Healthland	Stage 1	Feed is live for ED and inpatient data—receiving notifications to fax.
Good Shepherd Medical Center	Meditech	Stage 1	Feed is live for ED and inpatient data—receiving notifications to fax.
Grande Ronde Hospital	McKesson	Stage 1	Feed is live for ED and in patient data—receiving notifications to fax.
Harney District Hospital	McKesson	Stage 2	Feed is live for ED and inpatient data—receiving notifications to fax.
Lake District Hospital	CPSI	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Pioneer Memorial Hospital	Healthland	Stage 1	Feed is live for ED and inpatient data—receiving notifications to fax.
St. Alphonsus Medical Center – Baker City	Cerner	AIU	Contract with vendor has been signed.
St. Alphonsus Medical Center – Ontario	Cerner	Stage 1	Contract with vendor has been signed.
St. Anthony Hospital	Meditech	AIU	Feed is live for ED and inpatient data—receiving notifications to fax.
Wallowa Memorial Hospital	Healthland	Stage 1	Feed is live for ED and inpatient data—receiving notifications to printer.

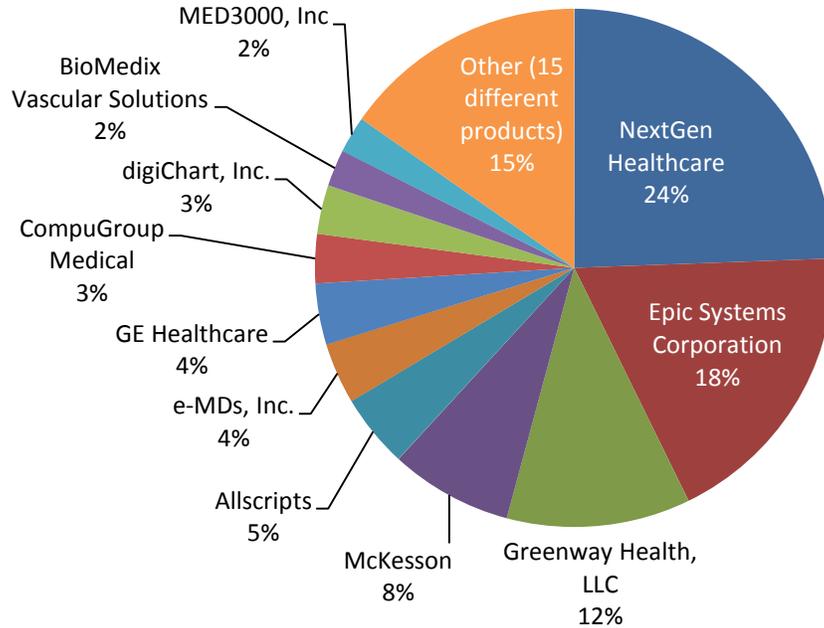
*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top Certified EHR Technology Products for EOCCO

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 131 unique providers affiliated with EOCCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 26 different EHRs in use within the CCO. The top 11 products are in use by 111 unique providers.

EOCCO Certified EHR Technology products



FamilyCare CCO HIT/HIE Profile

117,316 members¹

CCO Description:

- Services Medicaid members in Clackamas, Multnomah, and Washington counties, and a small number in Marion.
- Primary care network providers are generally PCPs in small to medium-sized group practices and within FQHCs throughout the tri-county area (pre-2014 enrollment was 70% children).
- 74% of patients are assigned to Tier 3 Patient Centered Primary Care Homes (PCPCH).
- A significant number of FamilyCare providers' compensation will be tied to outcomes in 2015.
- Technology strategy involves supporting local entities that have developed their own HIT/HIE tools, while also developing and implementing centralized tools in two phases
 - Based on a gaps assessment, quickly procured best of breed tools to support care management, population management, utilization and analytics,
 - Longer term strategy – in 2015, select an integrated solution for sharing clinical information with the CCO's provider network to support patient care and population health

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination			Quality Improvement, Population Management, Data and Analytic Tools	
Status	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input type="checkbox"/> Currently supporting <input checked="" type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing
Vendor Name	McKesson	CMT	TBD	Milliman	Inovalon
Product Name	VITAL	PreManage		MedInsight	Indices
Version	7.2	Complete		10.3	4.04
Comment	Care management system; attributes available clinical data with individual member records	Provider clinics have begun to establish direct connections with CMT for ED and inpatient notifications	Pursuing an integrated solution for sharing member information to support care delivery with the CCO's provider network	Analytics tool for utilization management and quality improvement; has ability to benchmark and compare performance from provider and population perspectives	Quality analytics platform with Medicare HEDIS tracking/reporting; will have ability to track many CCO measures

¹As of 10/01/2014

www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

Description of HIT/HIE Initiatives

<p>Information Sharing and Care Coordination</p>	<p>Overall approach:</p> <ul style="list-style-type: none"> • FamilyCare has reported a trend in their region of provider groups (e.g., IPAs, ACOs) taking the lead in investing in, designing, and developing certain HIT/HIE-related tools and services on their own. These groups want to be able to assume risk and need the tools to support care and manage risk, and are thus investing in HIT/HIE. <ul style="list-style-type: none"> ○ Two major examples - an organization representing 22 pediatric practices and an association of large adult care practices outside of health systems have each invested in population management platforms, and want to connect to patient information within other provider, hospital, and CCO/health plan systems. • FamilyCare’s strategy is to track such investments to understand providers’ needs and the expectations or opportunities for FamilyCare to support provider groups and facilitate access to important member-level data for providers. Providing the right patient information to support practices and groups accepting risk is part of FamilyCare’s strategy to recruit and retain providers. • In 2015, FamilyCare will select an integrated solution for care management and sharing member information to support care delivery with the CCO’s provider network. An ideal solution would simplify data exchange (HIE) with providers and integrate information with the CCO’s care management activities. Tools for member engagement will be part of this solution as will additional analytics and population health capabilities. <p>Health Information Exchange: FamilyCare CCO’s overall HIT/HIE strategy includes taking a decentralized approach, by supporting the development/adoption/use of HIT/HIE at the provider-level, and being a conduit of information to providers, but not serving as a central consolidator of information or services related to HIE.</p> <p>FamilyCare is an early adopter of the Emergency Department Information Exchange (PreManage) and will facilitate provider access to this information and integrate the data into care management and other operational processes.</p> <p>Direct Secure Messaging²: FamilyCare is interested in supporting the use of Direct secure messaging for sharing patient information between physical health providers and others such as CCO case management, home health, developmental screenings happening outside of pediatric practices, etc.</p> <p>Hospital Notifications³: FamilyCare has implemented the PreManage solution from CMT comprising both ED and inpatient notifications. As part of this service, provider clinics in FamilyCare’s network have begun to establish direct connections with CMT for this data.</p>
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² Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

³ Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

	<p>Care Management and CCO-Provided Information to Provider/Care Teams:</p> <p>In March 2013, FamilyCare licensed and implemented McKesson’s VITAL system, for use internally by the CCO’s care management teams. VITAL is a coordinated care management system for utilization, disease and case management. It includes clinical data and decision support tools integrating data from disparate sources and combining it into a single, member-centric workflow which enables use of one system in managing the health needs of each member. The tools support emergency room follow up and help reduce readmissions for hospital care:</p> <ul style="list-style-type: none"> • The assessment tool supports case management staff working with the member to create a care plan and goals. • The disease monitoring tool sends alerts to care managers based on needs or gaps in care for members within certain chronic conditions.
<p>Quality Improvement, Population Management, Data and Analytics Tools</p>	<p>FamilyCare has two tools for analytics, quality improvement, and population management (in addition to VITAL, described above):</p> <ul style="list-style-type: none"> • In 2014, FamilyCare began implementing the Milliman MedInsight platform as an internal analytics tool for utilization management and quality improvement, which includes consolidated medical and pharmacy claims, prospective risk scoring, and CCO metrics tracking for provider performance. • Inovalon Indices is an analytics platform that FamilyCare will utilize for HEDIS tracking/reporting for their Medicare population, which may be applicable to other populations/initiatives in the future (e.g., quality reporting for Medicaid). This is a sophisticated tool that helps to identify gaps in care and prompt care teams when interventions are needed. • Longer term strategy – as described above, FamilyCare is pursuing an integrated HIT/HIE/analytics solution that can support shared care management/planning, clinical information sharing, member engagement and analytics, etc. <p>Incorporating Clinical Data:</p> <ul style="list-style-type: none"> • FamilyCare develops or participates in data warehousing initiatives to enable aggregation of clinical and claims information to inform conversations about quality, cost and value. FamilyCare has programmers on staff who develop point-to-point data sharing, although this is labor intensive. • FamilyCare has engaged a handful of labs, and is pursuing additional ones, in data sharing arrangements. One of their long-term goals is for lab data to be fed directly into VITAL and Inovalon where it can be used for analytics and CQMs.
<p>Clinical Quality Metrics (CQM) Collection and Reporting</p>	<p>Current CQM Strategy:</p> <ul style="list-style-type: none"> • For its OCHIN clients FamilyCare utilizes OCHIN-supplied aggregated data for CQM reporting. However, FamilyCare sees the most value reporting patient-level, actionable data. • For non-OCHIN clients, FamilyCare is pursuing a strategy of developing individual connections/interfaces to enable the collection of (individual-level) clinical data. The CCO commented that this process can be a tedious one-by-one effort to set up the customized connections, and perform the necessary patient attribution processes once the data is flowing. • As described above, FamilyCare is bringing lab data into VITAL and Inovalon for CQMs, and is developing the ability to obtain clinical quality data from the provider network. However practices have varying capacity to send clean, structured clinical quality information for state quality measures.

	<p>Longer-term CQM Strategy: Investigating market options (as described above), and considering the state clinical quality metrics registry for data collection from providers.</p>
Technical Assistance to Practices for EHRs and MU	OCHIN supports some key FamilyCare practices. FamilyCare is considering using OHA-sponsored technical assistance, however the amount of assistance available does not address the needs of FamilyCare’s relatively large provider network.
Patient Engagement through HIT	FamilyCare is pursuing strategies for connecting with members and engaging them in improving their health through HIT. This includes short-term implementation of stand-alone services for member communication and medium-term implementation of systems for members integrated with CCO databases. Longer-term solutions will be tightly connected with the care management system as part of the larger integrated systems strategy.
Telehealth	Lots of interest in telehealth, but no current activities. FamilyCare would like clarification on operational issues around telehealth such as billing, what constitutes a visit, etc.
Other	<p>PH Tech, FamilyCare’s third-party claims administrator (TPA), offers web-based tools through the Clinical Information Manager “CIM” system for FamilyCare practices related to eligibility and prior authorization requests.</p> <p>Local Provider Directory: FamilyCare maintains a provider directory (Applied Statistics & Management, Inc.’s “MDStaff”) within their administrative systems, and provider information is included in their case management program, McKesson VITAL. An online provider directory is also available to all members and providers on FamilyCare’s website.</p>
Barriers to Implementation of HIT Tools/ Services	<ul style="list-style-type: none"> • Challenging to identify when and what are the right investments for the CCO to make related to supporting health information exchange, given the investments that local provider groups and health systems are making. • FamilyCare’s network is changing – more adult-focused practices. Providing the right patient information to support practices and groups accepting risk is part of FamilyCare’s strategy to recruit and retain providers. • Obtaining clinical quality metrics data is tedious, and there are challenges with managing patient attribution for the provider, because in some cases their EHR is not linked to their practice management system, and assigned PCP is not tracked in EHRs. Some complexity around providers ensuring that submitted information only goes to the appropriate health plan. Providers will want more automated (and reliable) patient attribution once they are taking on risk. • Some providers do not utilize EHR technology, and/or are not able to share patient information outside their organization or connect to an HIE. FamilyCare faces challenges related to assisting providers to become ready and willing to participate in HIE. • Difficult for some clinics to see the value of altering their workflows to accommodate CQM reporting requirements. • Providers are being asked to consume and share data with payers, hospitals, peers, government, and an increasing number of complex risk sharing entities. In the Portland Metro area, providers frequently work with multiple CCO’s. Coupled with what is expected to be relatively low Meaningful Use Stage 2 technology adoption, requiring them to transmit CQM data to multiple CCO’s could increase overhead even further and make caring for Medicaid patients less attractive.
Barriers to	Barriers /challenges experienced in sharing behavioral health data (including mental health, substance abuse, and addictions) include:

Behavioral Health Information Sharing	<input checked="" type="checkbox"/> Confusion over compliance with state or federal laws <input type="checkbox"/> State or federal laws prohibit the type of sharing I want/need to do <input type="checkbox"/> Our organization's technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data). <input type="checkbox"/> Concerns over privacy and confidentiality protection for the patient <input checked="" type="checkbox"/> Concerns over liability if information you share is later improperly shared <input type="checkbox"/> Lack of proper consent forms from the patient
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CCO Provider Environment:

Hospital Engagement in HIT

(Hospitals in the CCO's service area)

Hospital Name	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Adventist MC	Cerner	Stage 1	Feed is live for ED data—receiving notifications by fax.
Kaiser <ul style="list-style-type: none"> • Sunnyside MC • Westside MC 	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Legacy <ul style="list-style-type: none"> • Emanuel MC • Good Samaritan MC • Meridian Park MC • Mount Hood MC 	Epic	Stage 2	Feed is live for ED and inpatient data—receiving notifications to EMR.
Oregon Health & Science University	Epic	Stage 1	Feed is live for ED data—receiving notifications to EMR.
Providence <ul style="list-style-type: none"> • Milwaukie MC • Portland MC • St. Vincent MC • Willamette Falls MC 	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Tuality <ul style="list-style-type: none"> • Forest Grove Hospital • Healthcare 	Cerner	Stage 2	Feeds are live for ED and inpatient data—receiving notifications by Fax.

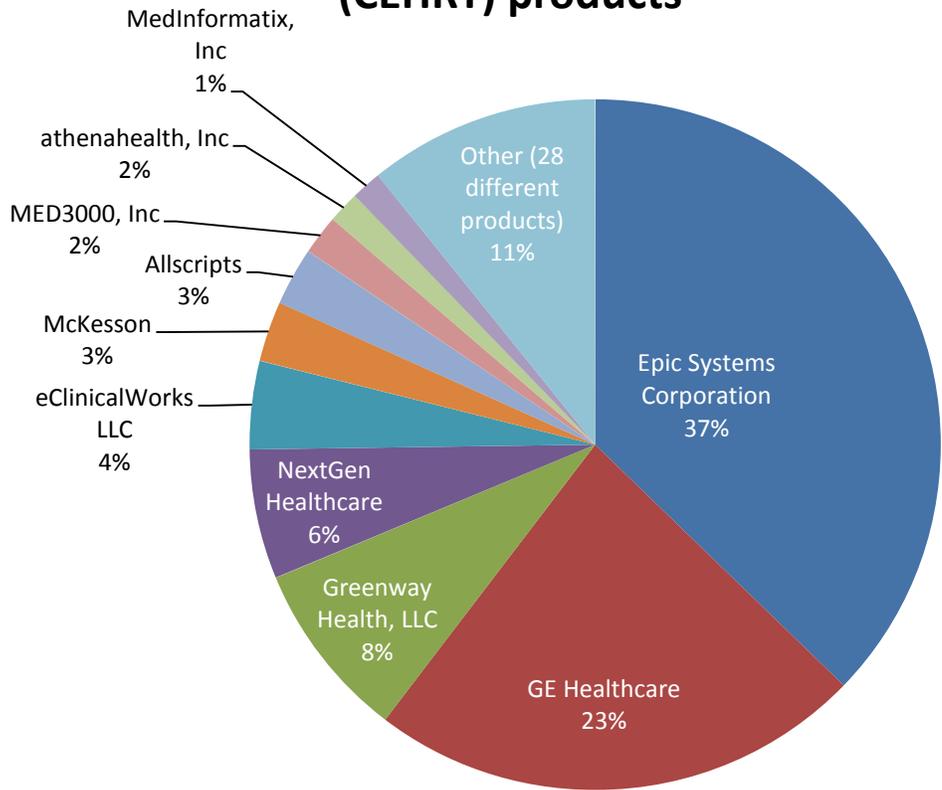
*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top 10 Certified EHR Technology Products for FamilyCare

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 1138 unique providers affiliated with FamilyCare that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 38 different EHRs in use within the CCO. The top 10 products are represented in the chart, which are in use by 1015 unique providers.

FamilyCare Certified EHR Technology (CEHRT) products



Health Share CCO HIT/HIE Profile

238,517 members¹

CCO Description:

- The state’s largest CCO serving members in Clackamas, Multnomah, and Washington counties.
- Delivers services through its risk accepting entities (RAEs) and partners including the following: CareOregon, Kaiser Permanente, Providence Health Plan, Tuality Health Alliance, Clackamas County Mental Health, Multnomah County Mental Health, Washington County Mental Health, Access Dental Care, Capital Dental Care, CareOregon Dental, Family Dental Care, Kaiser Permanente Dental, Managed Dental Care of Oregon, ODS Community Health Dental Plan, Willamette Dental Group, and Access2Care. Health Share’s contracted provider network exceeds 17,000 providers.
- More than 60% of Health Share’s members receive physical health care services from one of 11 provider organizations, all of which have implemented Meaningful Use certified EHRs: Adventist Health, Clackamas County Health Department, Kaiser Permanente, Legacy Health System, Multnomah County Health Department, Neighborhood Health Center, OHSU, Providence Health and Services, Tuality Healthcare, and Virginia Garcia Memorial Health Center in the context of more than 120 related practices, most of which are PCPCH certified.
- Technology strategy involves coordinating across local entities that have developed their own HIT/HIE tools, while also developing and implementing centralized HIT including
 - an electronic data interchange infrastructure supporting the bi-directional secure exchange of data between OHA, Health Share, and its partners,
 - a Provider Portal enabling web-based and programmatic member eligibility inquiries, and
 - a robust data aggregation, analysis, and reporting solution (“the Big Kahuna”).

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination		Quality Improvement, Population Management, Data and Analytic Tools	
Status	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input type="checkbox"/> Currently supporting <input checked="" type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing
Vendor Name	RAEs employ Epic, Certify, Medicity, Cerner*	Collective Medical Technologies	Internally/Self-developed	
Product Name		EDIE, PreManage, PopIntel	The Big Kahuna, PopIntel	
Comment	*In addition to developing and leveraging its centralized HIT solutions, Health Share supports and facilitates alignment across the HIT tools that its partners and providers use. Examples include standardized or aligned configuration and use of Epic CareEverywhere, Epic MyChart OpenNotes, EHR-agnostic Discharge Summaries, etc.			

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	Health Information Exchange: <ul style="list-style-type: none"> • For organizations using Epic EHR, CareEverywhere has been configured to enable optimal health information exchange (HIE) among providers using Epic EHRs. • Supports private enterprise HIEs. Most hospital-based delivery systems contracted with
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¹ 9/15/2014 www.oregon.gov/oha/healthplan/DataReportsDocs/September2014CoordinatedCareServiceDeliverybyCounty.pdf

	<p>Health Share have implemented private, enterprise HIEs such as Certify, Medicity, and Cerner while some rely upon interface engines such as Mirth, Cloverleaf, and eGate to exchange health information between internal and external systems for the benefit of related stakeholders.</p> <ul style="list-style-type: none"> • Patient information is shared across physical health care teams that are either using Epic EHR and/or within a hospital-based delivery system, as described above. • Health Share is exploring approaches for supporting information sharing with behavioral health providers and other members of the care team. <p>Direct Secure Messaging²: Some providers utilize Direct secure messaging to exchange secure messages with other providers as well as patients. Health Share is considering how to support and facilitate this more broadly, including considering Direct secure messaging pilot around behavioral health information sharing potentially using CareAccord.</p> <p>Hospital Notifications³: As is true in other parts of the State, Health Share providers are beginning to leverage EDIE and many expect to use Pre-Manage when available.</p> <p>Care Management and CCO-Provided Information to Provider/Care Teams: One of Health Share RAEs, CareOregon, shares information with relevant providers and intervention teams about Health Share members engaged in one or more intervention programs aimed at high utilizers of health care services in order to better coordinate and manage care. In this context, information is shared via PopIntel, an internally developed web-based centralized care coordination registry for teams to manage their intervention cohort and collect relevant data about intervention processes and outcomes.</p>
<p>Quality Improvement, Population Management, Data and Analytics Tools</p>	<p>The “Big Kahuna”: Health Share’s data aggregation, analysis, and reporting solution , known as the “Big Kahuna,” aggregates and correlates information at a member-level sourced from 32 distinct data feeds, maintaining more than 500 data elements per member, totaling more than 100,000,000 data elements refreshed monthly within a data warehouse. The solution has been in use for 16 months and sheds light on: Health Share’s members: demographics, RAE assignment, chronic conditions, their utilization of healthcare services and related costs; providers’ performance; prescribed medications; Quality Improvement Project (QIP) and Performance Improvement Project (PIP) outcomes; and key performance indicators. Forty distinct “slicers” predicated on member-specific attributes enable analysis of sub-populations. Member-level data enables population risk management, health management, and care coordination.</p> <ul style="list-style-type: none"> • The solution offers a variety of functions, including, but not limited to: receiving and reporting on CQM data, risk-stratifying and tracking member populations, and managing population health. It <ul style="list-style-type: none"> ○ is based on administrative data and CQM data ○ can drill down to member-level details

² Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

³ Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

	<ul style="list-style-type: none"> ○ identifies CCO metrics ○ allows for sub-population analysis and drill-down ● This solution will provide CQM reporting capabilities for year 2 and beyond, and also give providers the ability to track practice-level CQM scores. ● <u>Clinical data</u>: the Big Kahuna incorporates data from a variety of sources, including clinical metrics data aggregated at the provider level (see below). <p>PopIntel (described under “Information Sharing” above) supports analysis and evaluation of targeted interventions.</p>
Clinical Quality Measure (CQM) Collection and Reporting	<ul style="list-style-type: none"> ● Health Share looks forward to receiving and aggregating data for the CQMs through the QRDA standard, as it will enable the CCO to calculate the actual CQM measures in-house instead of at the actual practices themselves. ● For Year 1 CQM reporting, Health Share utilized aggregate practice level data (Numerator/Denominator), in structured, CSV format from 11 organizations. ● Health Share is concerned that the opportunity costs of further expanding the infrastructure to collect and report on CQMs using new technology (i.e., requiring organizations to report CQM data using QRDA standards) may disrupt providers’ efforts to achieve MU stage 2. To that end, Health Share does not plan to implement any new technologies/methods for reporting Year 2 metrics
Technical Assistance to Practices for EHRs and MU	OCHIN is providing technical assistance to some Health Share providers with OCHIN Epic EHR. Partner organizations and larger integrated health systems are providing technical assistance support to practices.
Patient Engagement through HIT	<ul style="list-style-type: none"> ● Most large provider organizations actively participate in the NW OpenNotes Consortium sponsored by We Can Do Better and either have or will shortly enable OpenNotes features within their respective patient portal solutions – e.g. Epic MyChart. ● Interested in leveraging a “backbone” similar to CareEverywhere for consumer access across the Health Share population – currently My Chart is a portal tethered to a single clinic or practice. Would like a single point of consumer access facilitated through Epic Lucy.
Telehealth	<p>Project ECHO: Expanding Primary Care Capacity with Telementoring</p> <ul style="list-style-type: none"> ● Focused on management of psychiatric meds in primary care for adults. ● Lead: OHSU dept. of psychiatry. Partnering with OHSU telemedicine ● Implementation to date enthusiastically embraced by contracted healthcare providers
Other	<ul style="list-style-type: none"> ● Health Share provides an internal electronic data interchange infrastructure supporting the bi-directional secure exchange of member-related data between OHA, Health Share, and its numerous partners including RAEs. ● Health Share provides a Provider Portal enabling web-based and programmatic member eligibility inquiries ● Health Share and its RAEs maintain provider directories within their administrative systems, EHRs and private enterprise HIEs, and a provider directory for analytics exists within the Big Kahuna
Barriers to Implementation of HIT Tools/ Services	<ul style="list-style-type: none"> ● Health Share has opted to table certain discussions for HIT/HIE enhancements at the community level in order to avoid disrupting efforts happening at the individual entity/organization level (e.g., coordinating EDIE Plus/PreManage implementation, or building connections between private enterprise HIEs and/or EHR systems). ● Difficulty for the provider community to understand what the common credentialing database is. Health Share suggested that more visible marketing efforts towards providers

	be launched in parallel to the development of the service itself.
Barriers to Behavioral Health Information Sharing	<p>Barriers are limited to 42 CFR Part 2 restrictions governing PHI related to substance abuse treatment. However, challenges regarding the electronic sharing of behavioral health information are numerous including:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Confusion over compliance with state or federal laws <input checked="" type="checkbox"/> State or federal laws prohibit the type of sharing I want/need to do <input checked="" type="checkbox"/> Our organization’s technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data). <input checked="" type="checkbox"/> Concerns over privacy and confidentiality protection for the patient <input checked="" type="checkbox"/> Concerns over liability if information you share is later improperly shared <input checked="" type="checkbox"/> Lack of proper consent forms from the patient

CCO Provider Environment

Hospital Engagement in HIT

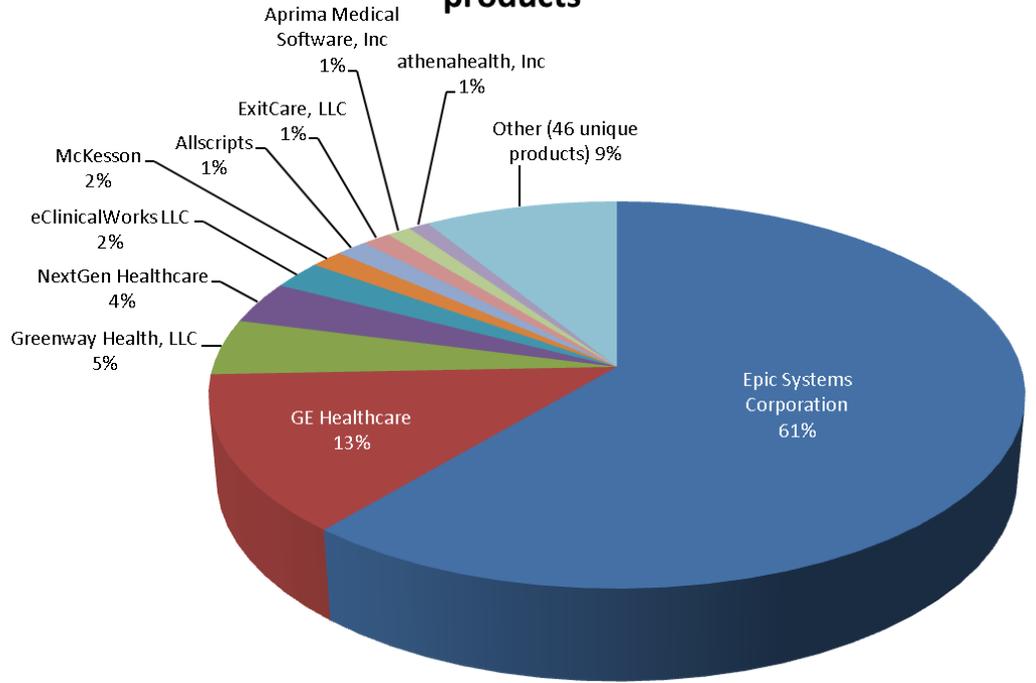
Hospital Name	Direct Secure Messaging Flat File Participation (as of 12/2014)	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Adventist MC	Anticipated	Cerner	Stage 1	Feed is live for ED data—receiving notifications by fax.
Kaiser <ul style="list-style-type: none"> • Sunnyside MC • Westside MC 		Epic	Stage 1	Feed is live for ED inpatient data—receiving notifications to EMR.
Legacy <ul style="list-style-type: none"> • Emanuel MC • Good Samaritan MC • Meridian Park MC • Mount Hood MC 	Currently participating	Epic	Stage 2	Feed is live for ED inpatient data—receiving notifications to EMR.
Oregon Health & Science University	Currently participating	Epic	Stage 1	Feed is live for ED data—receiving notifications to EMR.
Providence <ul style="list-style-type: none"> • Milwaukie MC • Portland MC • St. Vincent MC • Willamette Falls MC 		Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Tuality <ul style="list-style-type: none"> • Forest Grove Hospital • Healthcare 	Currently participating	Cerner	Stage 2	Feeds are live for ED and inpatient data—receiving notifications by Fax.

*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top 10 Certified EHR Technology Products for Health Share CCO
 (in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 2,553 unique providers affiliated with Health Share that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 56 different EHRs in use within the CCO. The top 10 products are represented in the chart, which are used by 2,328 unique providers.

Health Share Certified EHR Technology (CEHRT) products



Intercommunity Health Network (IHNCCO) HIT/HIE Profile

57,132 members¹

CCO Description:

- InterCommunity Health Network CCO was formed in 2012 by local public, private, and non-profit partners to unify health services and systems for Oregon Health Plan (Medicaid) members in Benton, Lincoln, and Linn Counties.
- Samaritan Medical Clinics provide primary care services to 70% of CCO membership. Other providers in the IHNCCO primary care network include IPAs, FQHCs and several independent primary care clinics.
- IHNCCO is affiliated with Samaritan Health Services as its parent corporation which includes other health care providers via its hospital/health system.

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination	Quality Improvement, Population Management, Data and Analytic Tools
Status	<input type="checkbox"/> Currently supporting <input checked="" type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing
Vendor Name	InterSystems	IBM
Product Name	HealthShare	Cognos Data Marts, Business Intelligence, Query Studio
Version	Cache: 2014.1.3 HealthShare modules: Core: 12.07 Linkage/Index: 13.04 Clinical viewer: 12.0	
Comment	Regional Health Information Collaborative (RHIC) will collect patient data from various sources, organize it, and make it available to providers within a provider clinical viewer	Analytic solutions

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	<p>Health Information Exchange:</p> <ul style="list-style-type: none"> • IHNCCO is currently participating in the collaborative development of a regional health information exchange tool, known as the Regional Health Information Collaborative (RHIC). <ul style="list-style-type: none"> ○ RHIC will collect patient data from various sources (EHRs, claims, others), organize it, and make it available and easily accessible to providers at the point of care within a provider clinical viewer. The vision is for there to be a link within the EHRs to allow for single sign-on access into RHIC. ○ The clinical viewer will provide a quick overview of patient information (organized within specific categories, such as allergies, latest visits, etc.) with the ability to drill
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¹As of 10/2014

www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

down to the depth of detail the provider needs.

- IHNCCO selected InterSystems as the vendor at the end of May. IHNCCO developed an Implementation Project Plan in August 2014. Contract was signed on October 8th and IHNCCO expects to conduct a pilot in fall/winter 2014/5.
- Following a successful pilot, IHNCCO will add Epic data from Lincoln and Benton counties supplied by OCHIN, Linn county data from their Raintree EHR, and AllScripts data from The Corvallis Clinic into RHIC in early 2015.
- IHNCCO aims to bring myriad data into RHIC to support care coordination
 - IHNCCO has assembled a Delivery System and Transformation committee within RHIC including members from long-term care, public health, county health, mental health community, and dental. They are using this forum to help identify the data needs that RHIC may be able to address.
 - IHNCCO is sponsoring a pilot with the long-term care communities across Linn, Benton, and Lincoln counties including all 5 hospitals. It involves LTC partners providing follow-up care for members discharged from any participating hospital within 24 hours. Several issues have come to light including a lack of information regarding when the member is going to be discharged and their insurance (e.g., only 25% were IHNCCO members who are the only patients for whom IHNCCO can pay). The plan is to have all of the data feed into RHIC. The hospitals that have been successful in implementing this program have documented particularly low readmission rates as well as a lower risk across their population.
- Samaritan Health Services has promoted the use of Epic CareLink with its participating providers.
 - Several providers have begun to use the product; future efforts will focus on expanding the use of this product.
 - All IHNCCO Case Managers have been trained and use Epic CareLink. Plans are in development for case managers to educate providers on ways to access available information within Epic CareLink.

Direct Secure Messaging²:

- IHNCCO's major provider partners will have Direct secure messaging in their EHRs (e.g., OCHIN, Samaritan).
- RHIC could have Direct capabilities, but IHNCCO has not yet determined when they will initiate this.

Hospital Notifications³:

The IHNCCO reported that emergency departments in their region have faced some operational barriers in integrating EDIE capabilities into EHR workflows. The IHNCCO plans to have discussions about their potential use of PreManage after they have received and analyzed additional feedback from ED managers around the value of EDIE.

- Samaritan chose to receive EDIE notifications via fax. They are in the process of determining

² Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

³ Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

	<p>the utility of the information at the point of care.</p> <ul style="list-style-type: none"> IHNCCO met internally and with emergency departments to discuss leveraging EDIE and evaluate PreManage and it was found neither service would be beneficial to assisting with IHNCCO members. <p>Care Management and CCO-Provided Information to Provider/Care Teams:</p> <ul style="list-style-type: none"> (See RHIC description above)
<p>Quality Improvement, Population Management, Data and Analytics Tools</p>	<ul style="list-style-type: none"> IHNCCO has multiple analytical solutions available for in-house analytics staff (e.g., utilizing Cognos data marts, Business Intelligence, and Query Studio, as well as Crystal Reports server and reports). <ul style="list-style-type: none"> Currently have an analytics department of 5 staff, as well as access to Samaritan Health Services Information Services staff, for programming and development services, and occasionally work with contracted vendors to provide additional analytical capability. Future phases of the RHIC will support federal, state and local quality reporting initiatives as well as other population health analysis and reporting, evidence-based clinical notices and alerts, and improved population health management capabilities. Continuing work to expand internal analytic capabilities <ul style="list-style-type: none"> Staff recruiting and training, implementing procedures and policies to ensure data integrity, etc. IHNCCO is engaging in discussions with their community partners regarding the most meaningful way to risk-stratify their patient population. They have determined that one risk-stratification method will not suffice for their entire member population. IHNCCO is also interested in identifying the socio-economic factors they can affect. <p>Incorporating Clinical Data: RHIC integrates various types of data from numerous sources, including clinical data extracted from EHRs.</p>
<p>Clinical Quality Metrics (CQM) Collection and Reporting</p>	<p>Lack of HIE across the provider network makes it particularly complex and burdensome to collect CQM data.</p> <p>Current CQM Strategy:</p> <ul style="list-style-type: none"> IHNCCO leveraged the Samaritan Health Services system for reporting on CQMs in Year 1, and plans to do so again for Year 2. <p>Longer-term CQM Strategy:</p> <ul style="list-style-type: none"> RHIC may be used as a tool for reporting on CQMs in the future (beyond Year 2), but details around such functionality have not yet been envisioned.
<p>Technical Assistance to Practices for EHRs and MU</p>	<p>IHNCCO provider network may receive TA already from within their organizations - Samaritan supports its providers, as does OCHIN.</p>
<p>Telehealth</p>	<p>IHNCCO has a high interest in telehealth:</p> <ul style="list-style-type: none"> IHNCCO is in the early stages of a telehealth pilot implementing KANNACT at Corvallis clinic <ul style="list-style-type: none"> Involves giving tablets to high-risk individuals and surrounding them with 24/7 high-performance health team to improve their care. The goal of the program is to keep high-risk members out of the inpatient setting, if possible, to cut down those costs.

<p>Other</p>	<p>Local Provider Directory: IHNCCO maintains a provider directory within their administrative system and will include one in RHIC.</p>
<p>Barriers to Implementation of HIT Tools/ Services</p>	<ul style="list-style-type: none"> • Rural and diverse provider community. The hospital system, county health departments, and larger clinics manage data in disparate EMR systems. • Lack of a standardized and central data repository for patient health information across the provider network (RHIC is meant to address this, at least in part). • Some providers can only send and receive data files (e.g., Excel spreadsheets), unable to share data in HL7 standardized formats. • IHNCCO’s provider network has some clinics with broadband connectivity limitations in parts of their region, mainly in rural areas and away from the I-5 corridor (e.g., Lincoln county). • The CCO expressed some concerns about meeting the Year 2 (and beyond) for depression screening CQM requirements, indicating they’ve faced challenges getting providers to adjust their workflows to be able to properly collect/report on data for the depression screening measure. • The long-term governance model/strategy of the RHIC HIE system is under development. • IHNCCO is considering how to include important data in RHIC for the full care team, but is finding concerns/uncertainty about data sharing policies and adequate consent procedures to allow for the sharing of data: <ul style="list-style-type: none"> ○ Connecting homecare members into the remaining care community, ○ Connecting with the educational and penal systems. ○ Foster children are of significant concern; developmental screenings happening in multiple locations but not getting back to the PCP. • IHNCCO has been engaged in a pilot with Benton county involving the real-time connection of three facilities to allow for the monitoring of who is assigned to the members. PCP reconciliation between the plan, provider records, and provider providing services is only 33% correct. The goal of the pilot is to reconcile the information, for which they have found that member involvement is needed.
<p>Barriers to Behavioral Health Information Sharing</p>	<p>The IHNCCO identified a disconnect between behavioral/mental health EHRs and RHIC. CCO attributes challenges to differing incentives/motivations between the behavioral and physical medicine communities.</p> <p>Barriers/challenges experienced in sharing behavioral health data (including mental health, substance abuse, and addictions) include:</p> <ul style="list-style-type: none"> <u> X </u> Confusion over compliance with state or federal laws <u> X </u> State or federal laws prohibit the type of sharing I want/need to do <u> X </u> Our organization’s technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data). <u> X </u> Concerns over privacy and confidentiality protection for the patient <u> X </u> Concerns over liability if information you share is later improperly shared <u> X </u> Lack of proper consent forms from the patient

CCO Provider Environment:

Hospital Engagement in HIT

Hospital Name	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Samaritan <ul style="list-style-type: none"> • Albany General • Lebanon • North Lincoln • Pacific Communities • Samaritan Regional 	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to fax.

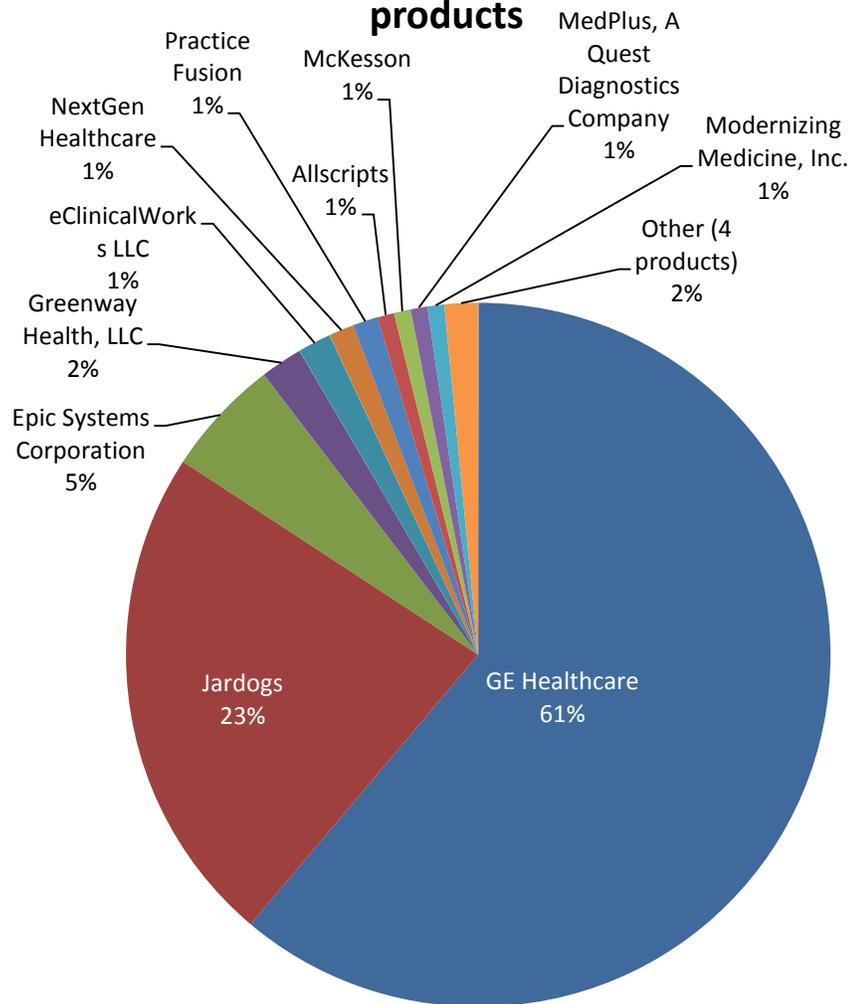
*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top Certified EHR Technology Products for IHNCCO

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

IHN Certified EHR Technology (CEHRT) products

There were 260 unique providers affiliated with IHN CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 15 different EHRs in use within the CCO. The top 11 products are represented in the chart, which are in use by 256 unique providers.



Jackson Care Connect CCO HIT/HIE Profile

31,054 members¹

CCO Description:

- 51 contract clinics and 2 hospital systems
- 2 primary care clinics are licensed FQHCs and the majority of the clinics are small private practices.
- Approximately 40% of JCC members are empaneled to the two FQHCs in Jackson County, La Clinica and Community Health Center. Both clinics are PCPCH Tier 3 clinics, have certified EHRs (OCHIN Epic) and participate in Meaningful Use.
- Jackson Care Connect is one of 4 Southern Oregon CCOs participating in the Jefferson Health Information Exchange (JHIE).
- Jackson Care Connect is also supporting Community Connected (C2) Network – led by the county agency, in partnership with 2 CCOs, education and social services stakeholders, to develop a database and system for coordinating and integrating information related to social services assessment and delivery in Jackson County

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination		Quality Improvement, Population Management, Data and Analytic Tools
Status	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing
Vendor Name	Medicity	Vistalogic	SAS
Product Name			Business Intelligence software
Comment	Provided by Jefferson HIE	Provided by Community Connected Network for social service delivery	Claims-based analytic reporting

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	<p>Jackson Care Connect is participating in the Jefferson Health Information Exchange (JHIE) which aims to provide the care team with access to patient-centered health information at the time and place of care to improve timeliness, quality and coordination of care. JHIE covers a three county region in Southern Oregon inclusive of Jackson, Josephine, and Klamath Counties, and recently added partnerships with a 5th CCO and providers in the Columbia River Gorge area.</p> <p>Health Information Exchange:</p> <ul style="list-style-type: none"> • JHIE currently offers Direct secure messaging and a provider-to-provider closed-loop referral system through its technology vendor Medicity. These features support health information exchange and referrals among behavioral, physical, and dental health providers and with CCO Care Coordinators. • JHIE is in the process of implementing “phase 2” to include additional functions/services including clinical alerts, 30-day readmission alerts, patient search, and a consolidated clinical inbox to be accessible to any enrolled provider or CCO with a patient/member relationship. Patient matching and record location supports patient/provider attribution.
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¹As of 10/01/2014

www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

	<p>EHR integration and connectivity will be supported as well, including single sign on for patient search of HIE, results delivery to the EHR and receipt of CCD/care summary to the EHR.</p> <ul style="list-style-type: none"> In addition, clinics who have implemented Epic have access to HIE through CareEverywhere. <p>Jackson Care Connect is also supporting Community Connected (C2) Network – a committed group of organizations working together to change the way individuals access and receive social service support in Jackson County; startup funding supported by county and 2 CCOs; other partner organizations from social services, education sectors. Launch expected in 2015. Intersections with JHIE are under discussion.</p> <ul style="list-style-type: none"> Goals include: to support sharing of information and coordination of services amongst community partners, to provide tools to help integrate and coordinate the existing social service delivery infrastructure including identifying service providers for common clients, and to provide a mechanism to connect existing systems within social service, health care, and education sectors. C2 database will include centralized contact registry, resource/referral module, onboarding tool, release of information module, record capabilities, survey/assessment module, auto-populating forms/summary sheets, integrated calendar and discussion forum, aggregate data reporting. <p>Direct Secure Messaging²:</p> <ul style="list-style-type: none"> JHIE offers Direct secure messaging and a provider-to-provider closed-loop referral system through its technology vendor Medicity. The JHIE Medicity HISP is DirectTrust accredited, and thus interoperable with CareAccord and other Direct secure messaging users across the state. JHIE participates in the flat file directory sponsored by OHA, to share Direct secure messaging addresses across Oregon organizations using accredited HISPs to support cross-organizational exchange. <p>Hospital Notifications³:</p> <ul style="list-style-type: none"> JHIE will include hospital event notifications from its member hospitals (Asante, Providence, Sky Lakes, Mid-Columbia Medical Center) to JHIE members as part of “phase 2” and is contemplating connecting to PreManage to enable its members to send and receive hospital alerts from hospitals beyond the JHIE region across the state. <p>Care Management and CCO-Provided Information to Provider/Care Teams: The CCO anticipates using JHIE data to inform care management and support provider information sharing through JHIE.</p>
<p>Quality Improvement, Population Management, Data and</p>	<ul style="list-style-type: none"> JCC and CareOregon have developed and implemented claims-based analytic reporting through SAS Business Intelligence software. Current reporting capability includes aggregate reporting for CCO level data, provider level data, and member level data for demographics, utilization, and gaps in care. Jackson County Mental Health shared behavioral/mental health data for members with SPMI in 2013; this will continue in 2014. In 2015, JCC plans to integrate mental health

² Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

³ Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

Analytics Tools	<p>claims for JCMH services into the JCC / CareOregon data warehouse which feeds into SAS BI.</p> <ul style="list-style-type: none"> • During the 2014 calendar year, JCC will continue to explore the ability to expand reporting to other clinics using Epic. <p>Incorporating Clinical Data:</p> <ul style="list-style-type: none"> • Defining tools for data analytics and population health management are anticipated for 2015 with services available in 2016 through participation with JHIE. • CareOregon is exploring a partnership with OCHIN to create reporting capability for claims and clinical data.
Clinical Quality Metrics (CQM) Collection and Reporting	<p>Current CQM Strategy: JCC has relied on OCHIN for their current CQM reporting strategy.</p> <p>Longer-term CQM Strategy: Utilizing JHIE is part of JCC’s long-term strategy for CQM reporting. JHIE member CCOs will be able to collect CQMs from providers using JHIE and are exploring using JHIE to submit data to the CQMR</p>
Technical Assistance to Practices for EHRs and MU	<p>JCC is currently assessing CareEverywhere use and identifying any clinics/provider training needs.</p>
Other	<p>Local Provider Directory: JHIE includes a provider directory based on user enrollment and clinical results attribution expected to be compliant with anticipated HPD standards. In addition, JCC maintains a provider directory within their administrative systems.</p>
Barriers to Implementation of HIT Tools/ Services	<ul style="list-style-type: none"> • Large number of private practices utilizing different EHRs and some without EHRs will continue to be a challenge until all providers are enrolled with JHIE. • Needing to educate providers on workflow and process changes needed to maximize effectiveness of current JHIE functionality. • Current lack of understanding among clinics/providers about optimal use of CareEverywhere. • Though metrics data are being collected in non-PCP environments (e.g., developmental screening (ASQ) data being collected within the educational environment), there is currently no EHR or other structured means by which to capture these data, particularly across the school-based health, behavioral health, and dental systems. This can lead to duplication of services (e.g., ASQ being collected numerous times across settings to meet assessment need and/or various agency or funder requirements) as well as underrepresented rates of achievement (e.g., ASQ being conducted on CCO member within school setting, but CCO metrics do not reflect this). • JCC has experienced challenges in getting some of the organizations in their region to share clinical (EHR) data for the purposes of CQM reporting. JCC perceives this to be primarily a political/relational barrier, and not necessarily a technical barrier. • For C2 and sharing individual-level data between non-health providers – many issues around FIRPA (laws regulating sharing of student data within the education system) and HIPAA arise. C2 and JHIE are sharing HIPAA resources. • JHIE and its partners would like to include access to the Prescription Drug Monitoring Program data to support efforts to reduce inappropriate prescribing and abuse of prescription drugs.
Barriers to Behavioral	<p>Uncertainty among JCC staff as to how to best address the HIT and analytics needs of their mental/behavioral health clinics.</p>

Health Information Sharing	<ul style="list-style-type: none"> • JCC experiences the disparity in EHRs for behavioral health as a challenge to population management, care coordination, and quality and analytics. In an effort to contribute to progress in this area, the CCO invested significant funds into an EHR for the two largest alcohol and drug treatment providers in their community. In addition, the CCO has requested TA for behavioral health EHRs, as not having TA support is a significant barrier. • JCC has requested guidance from the state regarding privacy, as its absence is a barrier to health information exchange and care coordination. They would like specific guidance regarding relevant state policies that could inform their efforts. • JHIE and its partner CCOs would like mental health agencies in their network to be able to contribute data to JHIE’s community health record for patient search, but data management concerns resulting from the sensitivity of mental/behavioral health information (and the potential co-mingling of that information with physical health data) present challenges.
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CCO Provider Environment:

Hospital Engagement in HIT

Hospital Name	EHR Vendor	Stage of Meaningful Use*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Asante Three Rivers Medical Center	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Asante Ashland Community Hospital	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Asante Rogue Regional Medical Center	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Providence Medford Medical Center	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.

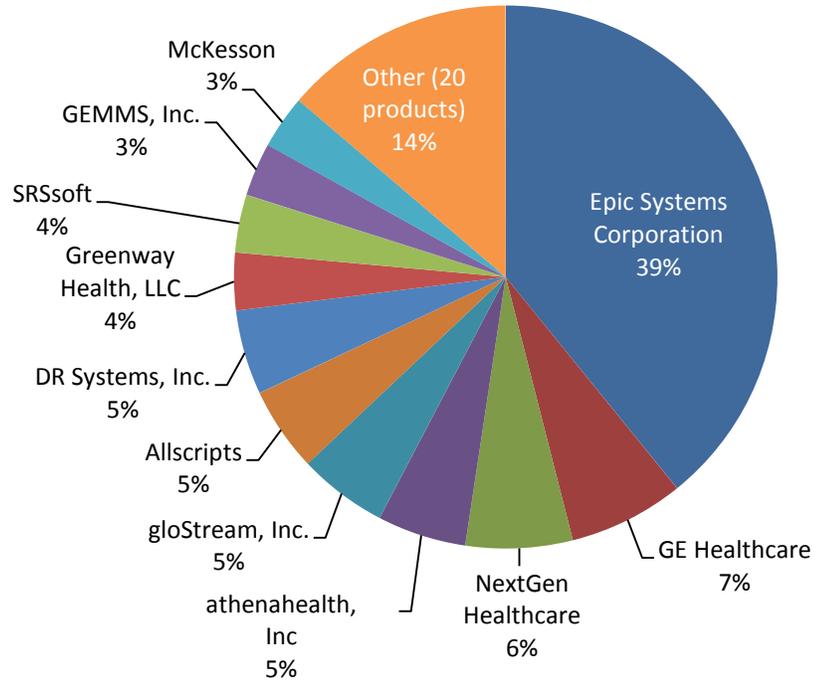
*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top Certified EHR Technology Products for Jackson Care Connect

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 378 unique providers affiliated with Jackson Care Connect CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 31 different EHRs in use within the CCO. The top 11 products, represented in the chart, are in use by 326 unique providers.

Jackson Care Connect Certified EHR Technology (CEHRT) products



PacificSource Central Oregon CCO HIT/HIE Profile

52,137 members¹

CCO Description:

- Services members in Crook, Deschutes, Jefferson and part of Klamath Counties.
- Majority of care takes place in the population hubs of Bend and Redmond.
- The region has a high rate of electronic health record (EHR) use in clinics and hospitals
- The CCO is supporting and planning to participate in Central Oregon Health Connect.

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination			Quality Improvement, Population Management, Data and Analytic Tools	
Status	<input type="checkbox"/> Currently supporting <input checked="" type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing
Vendor Name		Collective Medical Technologies	IMA Technologies	Truven Health Analytics	Internally developed tools, SAS, Tableau, Microsoft BI
Comment	Provided through Central OR Health Connect	PreManage hospital notifications for entire CCO population	CaseTrakker Dynamo	Analytic tool for population management, analytics, etc.	Data marketplace, analytic tools for population health and engagement

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	<p>Health Information Exchange:</p> <p>The CCO is supporting and planning to participate in CO Health Connect, which operates a community data repository CO Health Connect. The goal for CO Health Connect is to function as a clinical tool for providers, and ultimately to support the CCO needs for clinical data. CO Health Connect covers the central Oregon region inclusive of Crook, Deschutes, Jefferson and part of Klamath counties.</p> <ul style="list-style-type: none"> • COHIE's community data repository includes data from the majority of St. Charles medical groups and hospital, as well as lab and results data. • COHIE is in the process of working with its stakeholders to solidify its strategic plan and sustainable business model. • CO Health Connect is supported by partner organizations including: St. Charles Health System, PacificSource Community Solutions, Adaugeo Health Care, Central Oregon IPA, OCHIN, Mosaic medical clinic (an FQHC), and Bend Memorial Clinic. <p>Direct Secure Messaging²:</p> <ul style="list-style-type: none"> • CO Health Connect is considering options for Direct secure messaging, including potentially
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¹As of 9/15/2014 www.oregon.gov/oha/healthplan/DataReportsDocs/September2014CoordinatedCareServiceDeliverybyCounty.pdf

² Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

	<p>working with RelayHealth (their vendor for CO Health Connect, who also operates a HISP). [RelayHealth and CareAccord are both nationally accredited within the same trust bundle (DirectTrust), allowing for the secure exchange of information.]</p> <ul style="list-style-type: none"> • CareAccord would be available as an option for entities that are not using CO Health Connect. The CCO is interested in assisting long-term care organizations to get on CareAccord. <p>Hospital Notifications³: CO Health Connect is planning to include hospital event notifications from the St. Charles Health System to all CO Health Connect members. The CCO has implemented the PreManage solution from CMT comprising both ED and inpatient notifications for the entire CCO population, enabling its members to send and receive hospital alerts from hospitals beyond the CO Health Connect region across the state.</p> <p>Care Management and CCO-Provided Information to Provider/Care Teams:</p> <ul style="list-style-type: none"> • Primary care providers get care plan and progress/data, including information from the CCO. The CCO uses Truven for population management (see below), which informs the care management team within the CCO and supports the CCO connecting to the provider team. • In addition, CO Health Connect is working to establish the scope of work for supporting the CCO data needs for case management, operations management, and as a data source for analytics and population management efforts within the CCO's HIT tools (see description below).
<p>Quality Improvement, Population Management, Data and Analytics Tools</p>	<p><u>CCO-support for provider/network systems:</u> The CCO is working to support its provider groups by providing information on CCO members, referring high risk members for follow up, and supporting provider connections to CO Health Connect. Provider groups vary in their analytics capabilities:</p> <ul style="list-style-type: none"> • Provider groups with EHRs have analytic capacity of varying degrees and types—some use analytics to meet the standard business operations and finances needs, others use analytics for data-driven decision-making and informing planning of internal operations and programs. • Two key partners, St. Charles Health System and Mosaic Medical have robust technological infrastructure, tools and staff to extract and analyze data, as well as to create and run reports. • Adaugeo Healthcare, which is a PCPCH provider, has been successful in their transitional care management initiative which involves a data analyst sifting through ED discharge notifications and identifies cases needing to be referred to nursing resources. The nurse immediately arranges a Transitional Care Management visit. The goal is that these members are seen at a primary care office within 48 hours. Physicians and patients alike have expressed satisfaction with this program. • Regionally, the Central Oregon Independent Practice Association (COIPA) is an analytical asset for COIPA providers who are located in both Central OR and Gorge regions. Their Health Quality Program Director performs several analytical tasks in that role. <p><u>CCO internal systems:</u></p> <ul style="list-style-type: none"> • Supported by a team of database, IT, and data modeling specialists, PacificSource actively applies data analytics in numerous areas with a goal of improving population health and engagement. The Analytics Department is able to create and run routine and ad hoc data

³ Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

	<p>reports on member experiences, utilization and expenditure trends, and cost comparisons, as well as other data analyses. The IT department aims to enable self-service to allow end users to access a data marketplace, and quickly answer questions and gain insights into populations.</p> <ul style="list-style-type: none"> • Specific tools/capabilities include: <ul style="list-style-type: none"> ○ Data Marketplace includes various cubes of data on claims, members, prescriptions, etc. ○ Truven is used to identify high risk populations and then the PacificSource team outreaches and connects members to the health team. ○ Tableau supports data visualization ○ Suite of self-developed tools, SAS, Microsoft BI support metrics, self-service reports and population management, etc. A Member 360 module provides a complete view of members for use in predictive modeling and “micro –targeting” in achieving health outcomes. <p>Incorporating Clinical Data: PacificSource is seeking to incorporate clinical data in their internal analytics systems. In addition, the CCO is working with CO Health Connect to establish the scope of work for supporting the CCO data needs for case management, operations management, and as a data source for analytics and population management efforts within the CCO’s HIT tools.</p> <ul style="list-style-type: none"> • This will include role-based access to the community data repository in CO Health Connect, pushing hospital ADT data to the CCO, and providing the data to support the CCO’s analytic capabilities. • Using the HIE to supply clinical data provides the CCO a one-stop place for labs, hospital data, and other clinical information, reducing the administrative burden and duplication of effort on the part of the CCO that they would otherwise face, for example, by working to establish data feeds from each lab or entity directly.
<p>Clinical Quality Metrics (CQM) Collection and Reporting</p>	<p>Current CQM Strategy: PacificSource is working directly with practices to meet its CQM reporting requirements. They are able to leverage a small number of clinics to meet the population threshold, including their OCHIN clinics and other key practices.</p> <p>Longer-term CQM Strategy: The CCO is working with CO Health Connect to determine whether CO Health Connect is a viable and/or appropriate route for the management of clinical quality metrics.</p>
<p>Technical Assistance to Practices for EHRs and MU</p>	<p>Several of the key practices are supported already with technical assistance, such as OCHIN-supported practices, and the larger groups /health system practices. The CCO is interested in exploring state sponsored TA for practices.</p>
<p>Other</p>	<p>Local Provider Directory: PacificSource maintains a strong provider directory within their administrative systems; CO Health Connect includes a provider directory within its Relay Health platform.</p>
<p>Barriers to Implementation of HIT Tools/ Services</p>	<p>Data challenges:</p> <ul style="list-style-type: none"> • Pressure to meet diverging regulatory and reporting requirements that compete for priority, time, resources, and employee bandwidth. • Clinics/providers need implementation training and technical assistance to help them get the data, coordinate the data, find the data, as well as learn to use new systems. • Looking for clinical data integration solution and a solution to manage clinical data. PacificSource operates across commercial and Medicare lines of business, in multiple states with multiple HIEs, and would like to find one consistent way to bring clinical data in.

	<p>CQMs:</p> <ul style="list-style-type: none"> • Not sure a goal of CMQ reporting for 100% of CCO population is feasible in current EHR/HIE environment – very cumbersome to retool each EHR interface when new CQMs are released. Technology needs to become flexible to adapt to measurement changes. • CQM reporting opens up workflow and quality considerations. Data quality is limited by workflow. Data relying on lab values is easiest to get and use. • Will be challenging to get CQM reporting in place beyond leveraging OCHIN and a small number of key practices who overall cover 60-70% of the CCO population. • Experiencing difficulty in engaging EHR vendors about getting certain information into the CCDA, even if the vendor’s product is MU2 certified, causing concern regarding CQM reporting and effectiveness of relying on QRDA. EHR vendors “don’t think you need it”. <p>HIE:</p> <ul style="list-style-type: none"> • CO Health Connect and its partners identified several barriers or challenges relating to the following areas: interoperability and Meaningful Use, establishing an HIE business model, agreements/consent management, and Direct secure messaging. <p>Direct secure messaging:</p> <ul style="list-style-type: none"> • Many practices lack knowledge and understand regarding Direct secure messaging, the smaller of whom rely on their vendor to inform them. This is an opportunity for the state to support education and information about Direct secure messaging to providers.
<p>Barriers to Behavioral Health Information Sharing</p>	<p>Barriers/challenges experienced in sharing behavioral health data (including mental health, substance abuse, and addictions) include:</p> <p><input checked="" type="checkbox"/> Confusion over compliance with state or federal laws</p> <p><input type="checkbox"/> State or federal laws prohibit the type of sharing I want/need to do</p> <p><input checked="" type="checkbox"/> Our organization’s technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data).</p> <p><input checked="" type="checkbox"/> Concerns over privacy and confidentiality protection for the patient</p> <p><input checked="" type="checkbox"/> Concerns over liability if information you share is later improperly shared</p> <p><input type="checkbox"/> Lack of proper consent forms from the patient</p>

CCO Provider Environment:

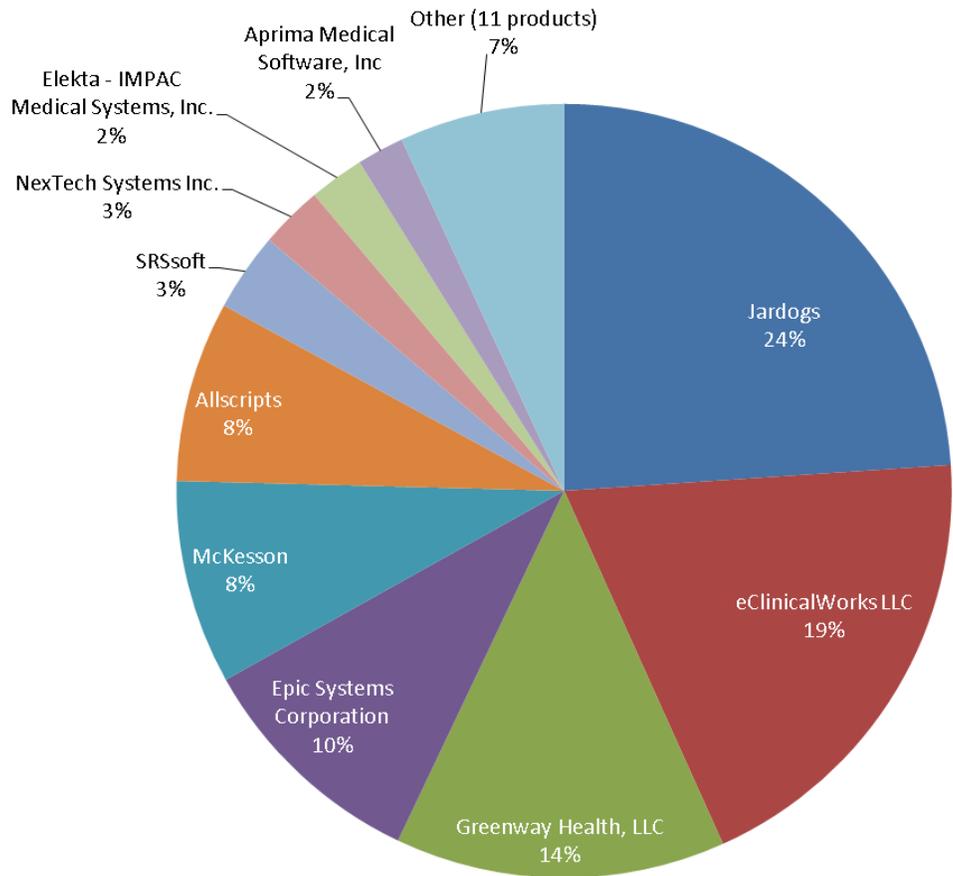
Hospital Engagement in HIT

Hospital Name	Direct Secure Messaging Flat File Participation (as of 12/2014)	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Pioneer Memorial Hospital – Prineville		McKesson	Stage 1	The St. Charles feeds are live, as is Prineville – both are sending both ED and inpatient data. All are receiving notifications by print with the exception of Redmond which is receiving fax notifications.
St. Charles Medical Center – Bend	Currently participating	McKesson	Stage 1	
St. Charles Medical Center – Madras	Currently participating	McKesson	Stage 1	
St. Charles Medical Center – Redmond	Currently participating	McKesson	Stage 1	

*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top 10 Certified EHR Technology Products for PacificSource Central Oregon CCO (in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 305 unique providers affiliated with PacificSource Central Oregon CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 21 different EHRs in use within the CCO. The top 10 products are in use by 284 unique providers.



PacificSource Columbia Gorge CCO HIT/HIE Profile

12,693 members¹

CCO Description:

- Services members in Wasco and Hood River Counties.
- The CCO is located in a small community with a history of partnerships across organizations.
- The majority of members receive their primary care in 4 organizations: Mid-Columbia, One Community Health (FQHC), Columbia Gorge Family Medicine, and Providence,
- Due to the varied terrain in this region, Broadband and cell service connectivity are barriers outside of Hood River/The Dalles. Providers largely provide services at practices in The Dalles and Hood River, however a large portion of the population lives outside the cities.
- Pacific Source Columbia Gorge CCO is joining the 4 Southern Oregon CCOs participating in the Jefferson Health Information Exchange (JHIE).

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination		Quality Improvement, Population Management, Data and Analytic Tools	
Status	<input type="checkbox"/> Currently supporting <input checked="" type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing
Vendor Name	Medicity	IMA Technologies	Truven Health Analytics	Internally developed tools, SAS, Tableau, Microsoft BI
Comment	Provided by Jefferson HIE	CaseTrakker Dynamo	Analytic tool for population management, analytics, etc.	Data marketplace, analytic tools for population health and engagement

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	<p>Health Information Exchange: The CCO is joining Jefferson Health Information Exchange (JHIE) which aims to provide the care team with access to patient-centered health information at the time and place of care to improve timeliness, quality and coordination of care. JHIE covers a three county region in Southern Oregon inclusive of Jackson, Josephine, and Klamath Counties, and recently added the Columbia River Gorge area.</p> <p>Health Information Exchange:</p> <ul style="list-style-type: none"> • JHIE currently offers Direct secure messaging and a provider-to-provider closed-loop referral system through its technology vendor Medicity. These features support health information exchange and referrals among behavioral, physical, and dental health providers and with CCO Care Coordinators. • JHIE is in the process of implementing “phase 2” to include additional functions/services including clinical alerts, 30-day readmission alerts, patient search, and a consolidated clinical inbox to be accessible to any enrolled provider or CCO with a patient/member
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¹As of 10/01/2014

www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

	<p>relationship. Patient matching and record location supports patient/provider attribution. EHR integration and connectivity will be supported as well, including single sign on for patient search of HIE, results delivery to the EHR and receipt of CCD/care summary to the EHR.</p> <p>The CCO is very interested in integrating and connecting social services and community health workers in a meaningful way, including DHS/local agencies, non-emergency medical transportation, long term care and behavioral health/DD residential care settings, schools and school based health centers, etc. Interested in understanding what systems may be in use by these organizations that could be leveraged by the CCO. The CCO has concerns around behavioral health information sharing (see barriers section below).</p> <p>Direct Secure Messaging²:</p> <ul style="list-style-type: none"> • JHIE offers Direct secure messaging and a provider-to-provider closed-loop referral system through its technology vendor Medicity. • The JHIE Medicity HISP is DirectTrust accredited, and thus interoperable with CareAccord and other Direct secure messaging users across the state. JHIE participates in the flat file directory sponsored by OHA, to share Direct secure messaging addresses across Oregon organizations using accredited HISPs to support cross-organizational exchange. • PS Columbia Gorge CCO is considering how to support and facilitate Direct secure messaging more broadly and expressed an interest in ensuring that non-medical members of care teams have the ability to securely exchange information and communicate using Direct secure messaging. CareAccord would be available as an option for entities that are not using JHIE. <p>Hospital Notifications³:</p> <ul style="list-style-type: none"> • JHIE will include hospital event notifications from its member hospitals (Asante, Providence, Sky Lakes, Mid-Columbia Medical Center) to JHIE members as part of “phase 2” and is contemplating connecting to PreManage to enable its members to send and receive hospital alerts from hospitals beyond the JHIE region across the state. • PacificSource Gorge has a strong interest in EDIE and PreManage, as it commonly has patients that seek care at hospitals outside of the CCO network, including OHSU and hospitals in Washington state. <p>Care Management and CCO-Provided Information to Provider/Care Teams:</p> <ul style="list-style-type: none"> • The CCO’s established community practices have care managers, so the primary care provider gets care plan and progress/data, including information from the CCO. The CCO uses Truven for population management (see below), which informs the care management team within the CCO and connecting to the provider team.
<p>Quality Improvement, Population</p>	<p><u>CCO-support for provider/network systems:</u> The CCO is working to support its provider groups by providing information on CCO members, referring high risk members for follow up, and supporting provider connections to JHIE. Provider groups vary in their analytics capabilities:</p>

² Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

³ Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

<p>Management, Data and Analytics Tools</p>	<ul style="list-style-type: none"> • The CCO’s board has been having discussions around providing centralized data analytics and reporting solution/support as opposed to having each organization/practice doing these tasks themselves, and is considering various options. • Provider groups with EHRs have analytic capacity of varying degrees and types, such as analytics to meet the standard needs for business operations and finances, for data-driven decision-making and/or for informing internal operations and program planning. • Regionally, the Central Oregon Independent Practice Association (COIPA) is an analytical asset for COIPA providers who are located in both Central OR and Gorge regions. Their Health Quality Program Director performs several analytical tasks in that role. • Both FQHCs also have analytic capacity through employees who are able to extract, summarize, and analyze EHR data on a routine and ad hoc basis; and, because both FQHCs are on OCHIN’s Epic platform, they benefit from having access to the reporting and analytic tools that OCHIN makes available to its users. <p><u>CCO internal systems:</u></p> <ul style="list-style-type: none"> • Supported by a team of database, IT, and data modeling specialists, PacificSource actively applies data analytics in numerous areas with a goal of improving population health and engagement. The Analytics Department is able to create and run routine and ad hoc data reports on member experiences, utilization and expenditure trends, and cost comparisons, as well as other data analyses. The IT department aims to enable self-service to allow end users to access a data marketplace, and quickly answer questions and gain insights into populations. • Specific tools/capabilities include: <ul style="list-style-type: none"> ○ Data Marketplace includes various cubes of data on claims, members, prescriptions, etc. ○ Truven is used to identify high risk populations and then the PacificSource team outreaches and connects members to health team. ○ Tableau supports data visualization ○ Suite of self-developed tools, SAS, Microsoft BI support metrics, self-service reports and population management, etc. A Member 360 module provides a complete view of members for use in predictive modeling and “micro –targeting” in achieving health outcomes. <p>Incorporating Clinical Data: PacificSource is seeking to incorporate clinical data in their internal analytics systems. In addition, defining tools for data analytics and population health management are anticipated for 2015 with services available in 2016 through participation with JHIE.</p> <p>The CCO is interested in moving more toward clinical data and away from claims/administrative data for population management, metrics, etc., especially given the lag time with claims data which can make those data not actionable. “We want to get [data] further upstream to be able to impact care.”</p>
<p>Clinical Quality Metrics (CQM) Collection and Reporting</p>	<p>Current CQM Strategy: The CCO expects to be able to meet the CQM reporting requirements using either the JHIE platform and/or OCHIN’s reporting solution with the One Community Health FQHCs (Hood River and The Dalles). Most key practices without current CQM reporting capabilities state that system upgrades have been scheduled and/or teams have been dedicated to develop clinical data reporting by the end of 2014.</p> <p>Longer-term CQM Strategy: Utilizing JHIE is part of the CCO’s long-term strategy for CQM reporting. JHIE member CCOs will be</p>

	able to collect CQMs from providers using JHIE and are exploring using JHIE to submit data to the CQMR.
Technical Assistance to Practices for EHRs and MU	CCO plans to assist with TA for HIE connectivity and Direct Secure messaging with funds from their transformation grant.
Telehealth	Interested in tracking telehealth opportunities. At least one hospital/health system in their area uses telemedicine and home health visits – where connectivity can be an issue. Like the idea of kiosks, which might work due to the concerns around Broadband connectivity in some parts of the Gorge.
Other	<p>EHR investment – the CCO is funding an EHR for one of the County health departments</p> <p>Local Provider Directory: PacificSource maintains a strong provider directory within their administrative systems; JHIE includes a provider directory based on user enrollment and clinical results attribution expected to be compliant with anticipated HPD standards.</p>
Barriers to Implementation of HIT Tools/ Services	<ul style="list-style-type: none"> • Clinics and providers across the network have a need for technical assistance to help them get, find, share, and use the information in the new system. • Looking for clinical data integration vendor and a solution to manage clinical data. PacificSource operates across commercial and Medicare lines of business, in multiple states with multiple HIEs, and would like to find one consistent way to bring clinical data in. • Change fatigue as a result of constant change in recent years and competing demands of multiple initiatives. • Provider organizations are at the mercy of their vendor for expanding interfaces, interoperability, and clinical quality reporting. Many have little or no influence in the direction the product goes. • Gorge CCO’s provider network has some clinics with broadband issues outside of their metro areas (Hood River and The Dalles). • JHIE and its partners would like to include access to the Prescription Drug Monitoring Program data to support efforts to reduce inappropriate prescribing and abuse of prescription drugs.
Barriers to Behavioral Health Information Sharing	<p>The CCO emphasized that behavioral health information should be shared as appropriate for care coordination. Concerns include providers focusing on metrics (including mental health assessment metric), misinformation about HIPAA/42 CFR Part 2.</p> <p>JHIE and its partner CCOs would like mental health agencies in their network to be able to contribute data to JHIE’s community health record for patient search, but data management concerns resulting from the sensitivity of mental/behavioral health information (and the potential co-mingling of that information with physical health data) present challenges.</p> <p>Barriers/challenges experienced in sharing behavioral health data include:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Confusion over compliance with state or federal laws <input type="checkbox"/> State or federal laws prohibit the type of sharing I want/need to do <input checked="" type="checkbox"/> Our organization’s technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data). <input type="checkbox"/> Concerns over privacy and confidentiality protection for the patient <input checked="" type="checkbox"/> Concerns over liability if information you share is later improperly shared <input checked="" type="checkbox"/> Lack of proper consent forms from the patient

CCO Provider Environment:

Hospital Engagement in HIT

Hospital Name	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Mid-Columbia Medical Center	Meditech, Iatric	Stage 1	Feed is live for ED and inpatient data—receiving notifications to fax.
Providence Hood River Memorial Hospital	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Hospitals in Washington State (of particular interest to PacificSource Columbia Gorge CCO)	Varies	Varies	Nearly all hospitals in Washington are live for ED data and are receiving notifications**

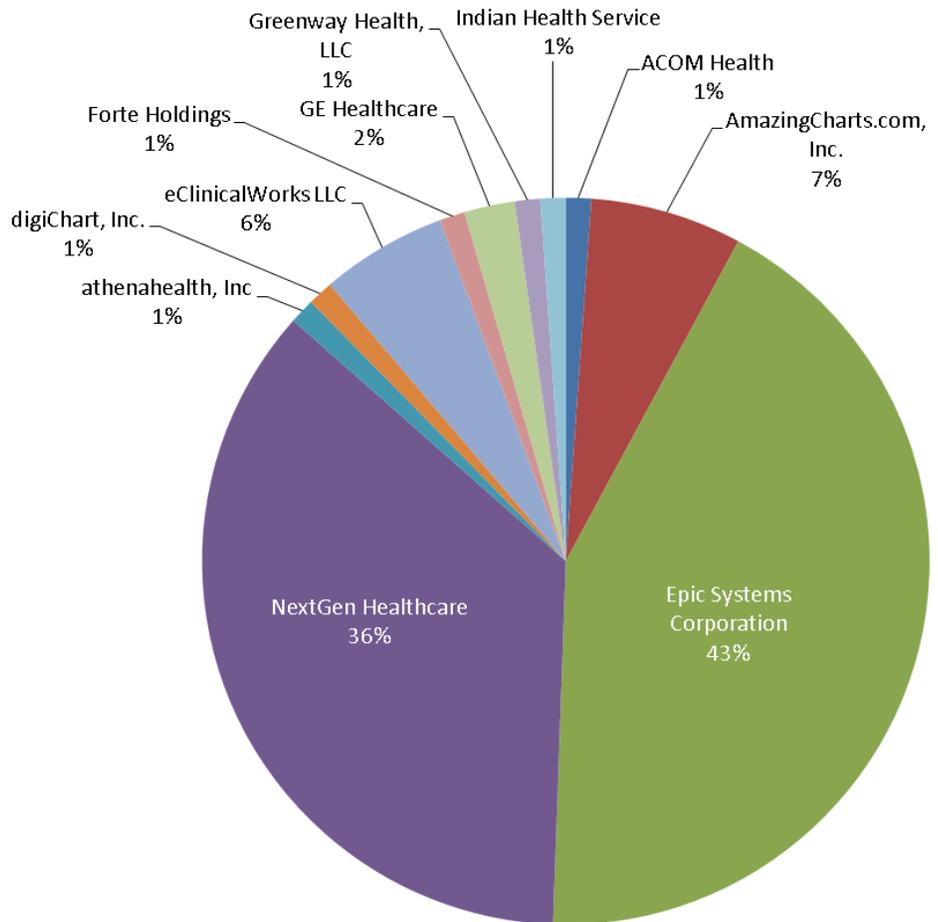
*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

**As of January 2015, CMT has agreements with all of the Washington Hospitals. However, Skyline and Tri-State are not yet implemented. Also, Garfield and Cascade Medical Center Hospital are manual entry and are not set up for Notifications.

Certified EHR Technology Products for PacificSource Columbia Gorge

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 89 unique providers affiliated with PacificSource Columbia Gorge CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 11 different EHRs in use within the CCO.



PrimaryHealth of Josephine Co. CCO HIT/HIE Profile

11,408 members¹

CCO Description:

- Services members in Josephine County and is made up of a multi-specialty group, two FQHCs and 6 one to two provider offices. Primary care provider locations include Grants Pass, Cave Junction and Medford.
- 90% of PrimaryHealth members are served in a Tier III PCPCH.
- PrimaryHealth is one of 4 Southern Oregon CCOs participating in the Jefferson Health Information Exchange (JHIE).

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination		Quality Improvement, Population Management, Data and Analytic Tools
Status	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input type="checkbox"/> Currently supporting <input checked="" type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing
Vendor Name	Medicity	TBD	Inteligenz
Product Name			CCO Metrics Manager
Version			2.1
Comment	Provided by Jefferson HIE	Currently exploring a more robust case management solution	CCO metrics-oriented analytics

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	<p>PrimaryHealth is participating in the Jefferson Health Information Exchange (JHIE) which aims to provide the care team with access to patient-centered health information at the time and place of care to improve timeliness, quality and coordination of care. JHIE covers a three county region in Southern Oregon inclusive of Jackson, Josephine, and Klamath Counties, and recently added partnerships with a 5th CCO and providers in the Columbia River Gorge area.</p> <p>Health Information Exchange:</p> <ul style="list-style-type: none"> • JHIE currently offers Direct secure messaging and a provider-to-provider closed-loop referral system through its technology vendor Medicity. These features support health information exchange and referrals among behavioral, physical, and dental health providers and with CCO Care Coordinators. • JHIE is in the process of implementing “phase 2” to include additional functions/services including clinical alerts, 30-day readmission alerts, patient search, and a consolidated clinical inbox to be accessible to any enrolled provider or CCO with a patient/member relationship. Patient matching and record location supports patient/provider attribution. EHR integration and connectivity will be supported as well, including single sign on for patient search of HIE, results delivery to the EHR and receipt of CCD/care summary to the EHR. • The Grants Pass Clinic is currently using JHIE and Siskiyou Community Health Center is planning
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¹As of 10/01/2014

<http://www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf>

	<p>to enroll.</p> <ul style="list-style-type: none"> Case managers will utilize JHIE as an information source and as a tool for information exchange. <p>Direct Secure Messaging²:</p> <ul style="list-style-type: none"> JHIE offers Direct secure messaging and a provider-to-provider closed-loop referral system through its technology vendor Medicity. The JHIE Medicity HISP is DirectTrust accredited, and thus interoperable with CareAccord and other Direct secure messaging users across the state. JHIE participates in the flat file directory sponsored by OHA, to share Direct secure messaging addresses across Oregon organizations using accredited HISPs to support cross-organizational exchange. <p>Hospital Notifications³:</p> <ul style="list-style-type: none"> JHIE will include hospital event notifications from its member hospitals (Asante, Providence, Sky Lakes, Mid-Columbia Medical Center) to JHIE members as part of “phase 2” and is contemplating connecting to PreManage to enable its members to send and receive hospital alerts from hospitals beyond the JHIE region across the state. CCO receives both a 30-day Admit/Discharge/Transfer (ADT) list and a separate last 24-hour file from one of their hospitals. The 24-hour file is of greater value and is more often and broadly utilized than the 30-day data. <p>Care Management and CCO-Provided Information to Provider/Care Teams:</p> <ul style="list-style-type: none"> The CCO is currently investigating a new case management tool/application. PrimaryHealth has a secure email system that it uses to support some care coordination functions. <ul style="list-style-type: none"> Using secure email to share information about high-risk patients. Though Direct secure messaging provides added value, getting the information-receiving entities enrolled with JHIE or CareAccord would require additional time and effort. Receiving information regarding long-term care patients via secure email. Integrating this information with other systems has not yet been defined and is still in process.
<p>Quality Improvement, Population Management, Data and Analytics Tools</p>	<p>As discussed in greater detail below, there is an evolving use of data by PrimaryHealth and their providers.</p> <p>Data Access/Availability and Analytic Tools</p> <ul style="list-style-type: none"> From their EZCap claims system, PrimaryHealth obtains a mapped data feed in addition to which encounter data files are obtained from MedImpact (pharmacy benefit manager) and PHTech (mental health claims manager). PrimaryHealth has contracted with Inteligenz for their CCO Metrics Manager tool. The CCO Metrics Manager provides a data warehouse with web-based presentation layer, which reports on the status of target metrics, including gap analysis and gap closure workflow. The flexibility of the system allows users to further define criteria to generate custom reports to facilitate population health management. For example, CCO Metrics Manager compiles a ‘high utilizer list’ which is used by PrimaryHealth to identify potential

² Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

³ Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

	<p>outreach/case management members.</p> <ul style="list-style-type: none"> • PrimaryHealth uses the CCO Metrics Manager for incentive metric progress monitoring, improvement planning, and bonus distribution. Their process has involved sending a list to each clinic with CCO metrics evaluation results informing them whether they have met relevant metrics. The distribution of incentive bonuses is tied to these results/reports. Clinics were rewarded for their performance on metrics. Incentive payment checks were hand-delivered with metrics evaluation results, including (but not limited to): <ul style="list-style-type: none"> ○ the quality metrics measures overall and per provider, with a comparison to other providers ○ advice on the coding for certain measures ○ gap list of patients needing screening ○ top 10 medical utilizers within the clinic’s patient registry ○ diabetes registry • The CCO’s primary key practice, Grants Pass Clinic, has requested to receive monthly dashboard reports on the incentive metrics in an electronic format. There seems to be an interest among the larger clinics to improve their metrics scores. <ul style="list-style-type: none"> ○ In general, medical clinics and providers are becoming accustomed to accessing, examining, and utilizing their data for the purpose of population management, decreasing their reliance on the CCO to fulfill this role. ○ Some examples of insights that have resulted from providers’ newly developed relationship with data include: <ul style="list-style-type: none"> ▪ Congestive heart failure – providers were surprised at the unexpectedly high mortality rate when looking at the data ▪ Screenings in general – providers believed they were conducting adequate screenings and were surprised to learn of existing gaps ○ CCO is working with Grants Pass Clinic to increase the credibility of the data and ensure the metrics they track are credible and something that the provider can affect. ○ Providers becoming increasingly involved with and invested in their data and outcomes has fostered some healthy competition among them. • PrimaryHealth used a learning collaborative for the medical homes for training on data, This evolved into a leadership group that gathers to discuss data-related topics, including how to effectively and meaningfully distribute data to providers. <p>Incorporating Clinical Data: Defining tools for data analytics and population health management are anticipated for 2015 with services available in 2016 through participation with JHIE.</p>
<p>Clinical Quality Metrics (CQM) Collection and Reporting</p>	<p>Current CQM Strategy</p> <ul style="list-style-type: none"> • PrimaryHealth utilizes CCO Metrics Manager for a number of purposes related to CQM reporting, including educating practices about specific incentive metrics, and determining and distributing incentive bonuses. See more complete description above. • Most CCO members are seen at one of two clinics, both of whom were included in the Year 1 sample; the Year 2 sample will remain the same. <p>Longer-term CQM Strategy: Utilizing JHIE is part of the CCO’s long-term strategy for CQM reporting. JHIE member CCOs will be able to collect CQMs from providers using JHIE and are exploring using JHIE to submit data to the CQMR.</p>
<p>Technical Assistance to</p>	<p>Transformation funds have supported PrimaryHealth in providing technical assistance to Grants Pass Clinic, which serves 60% of the CCO’s members. TA has included workflow modification</p>

Practices for EHRs and Meaningful Use	<p>guidance, as in developing a process for capturing the depression screening data that were being collected but not entered into the medical record. This involved a training program to assist nurses with keeping track of every depression screening. At the end of the day, the medical home assistant manually confirmed that the screenings were properly recorded. This approach leverages an assistant to take the burden off of the provider.</p> <p>Within the context of current clinic staffing levels, though there may be a need for TA, finding time to take advantage of it is challenging.</p>
Patient Engagement through HIT	<p>Grants Pass Clinic offers a secure patient portal on their website. This portal facilitates access to some medical records, scheduling and secure correspondence with primary care providers.</p>
<u>Telehealth</u>	<p>PrimaryHealth is currently working with OHSU and Asante Health Systems to facilitate Genetic Counseling via Telehealth in Josephine County.</p>
Other	<p>Local Provider Directory: The CCO maintains a provider directory within their administrative systems; JHIE includes a provider directory based on user enrollment and clinical results attribution expected to be compliant with anticipated HPD standards.</p> <p>Support for Behavioral Health EHR PrimaryHealth’s chemical dependency treatment center, Choices, is collaborating with OnTrack addictions recovery center and community corrections on the implementation of an EHR/billing software called Echo. They are collaborating on forms development and various other aspects to simplify implementation as well as provide a community standard.</p>
Barriers to Implementation of HIT Tools/ Services	<ul style="list-style-type: none"> • Prioritizing staff, coordinating system upgrades, and ensuring that data collection is consistent across providers is key. • Providers are currently involved in numerous healthcare transformation activities and therefore feeling overwhelmed and reluctant to engage in additional initiatives. • Bringing many people and systems together across a common platform to report clean, meaningful data takes time, work, and a lot of testing. • JHIE and its partners would like to include access to the Prescription Drug Monitoring Program data to support efforts to reduce inappropriate prescribing and abuse of prescription drugs.
Barriers to Behavioral Health Information Sharing	<p>JHIE and its partner CCOs would like mental health agencies in their network to be able to contribute data to JHIE’s community health record for patient search, but data management concerns resulting from the sensitivity of mental/behavioral health information (and the potential co-mingling of that information with physical health data) present challenges.</p> <p>Barriers/challenges experienced in sharing behavioral health data (including mental health, substance abuse, and addictions) include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Confusion over compliance with state or federal laws <input type="checkbox"/> State or federal laws prohibit the type of sharing I want/need to do <input type="checkbox"/> Our organization’s technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data). <input checked="" type="checkbox"/> Concerns over privacy and confidentiality protection for the patient <input type="checkbox"/> Concerns over liability if information you share is later improperly shared <input checked="" type="checkbox"/> Lack of proper consent forms from the patient

CCO Provider Environment:

Hospital Engagement in HIT

Hospital Name	EHR Vendor	Stage of Meaningful Use*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Asante Three Rivers Medical Center	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Asante Ashland Community Hospital	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Asante Rogue Regional Medical Center	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Lower Umpqua Hospital	Healthland	Stage 1	Feed is live for ED and inpatient data – receiving notifications by printer.
Providence Medford Medical Center	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Sky Lakes Medical Center	Meditech	Stage 1	Feed is live for ED and inpatient data—receiving notifications to printer.

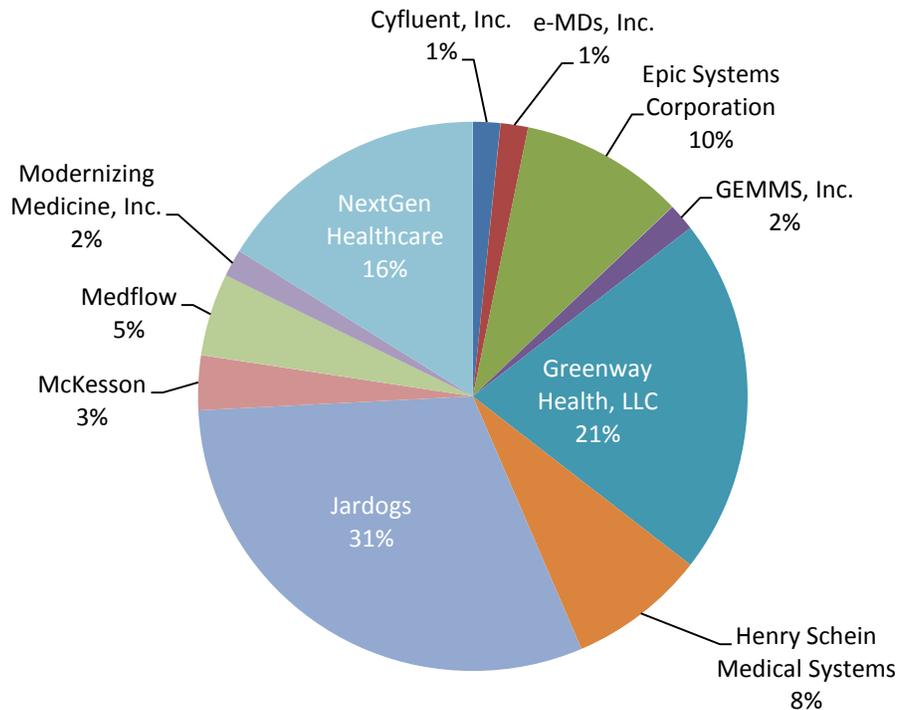
*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Certified EHR Technology Products for PrimaryHealth of Josephine County

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 62 unique providers affiliated with PrimaryHealth CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 11 different EHRs in use within the CCO.

PrimaryHealth CCO Certified EHR Technology (CEHRT) products



Trillium Community Health Plan CCO HIT/HIE Profile

92,020 members¹

CCO Description:

- About 80% of members are assigned to one of four main medical groups: Community Health Center of Lane County, Lane Independent Primary Physicians, Oregon Medical Group, and PeaceHealth Medical Group
- 83% of members are assigned to Tier 3 PCPCH clinics.
- In addition to its Medicaid plan, Trillium operates a Medicare advantage plan, and became a PEBB plan in 2015.
- Trillium took major action in 2014 to address capacity for the expansion population, including supporting the creation of a new clinic, supporting expansions at 4 clinics, technical assistance for practice efficiencies, and other efforts.

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination			Quality Improvement, Population Management, Data and Analytic Tools	
	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input type="checkbox"/> Currently supporting <input checked="" type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing
Status					
Vendor Name	The Advisory Board	Collective Medical Technologies	(Trillium developed in-house)	Optum	SAS, IBM
Product Name	Crimson Care Management (CCM)	PreManage	Care Timeline	Impact Intelligence, Impact Pro	SAS, SPSS
Comment	Care management tool	In conversations with CMT about ED/inpatient notifications	Graphical representation of a member's medical history, for care team	Cost, utilization, and quality analysis and risk stratification based on claims	Supports in-house analytics

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	<p>Health Information Exchange: See Care Coordination section below.</p> <p>Direct Secure Messaging²: Not currently interested in leveraging Direct secure messaging given other efforts to share information with providers.</p> <p>Hospital Notifications³:</p>
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¹As of 10/01/2014

www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

² Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

³ Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

Trillium is currently receiving ED utilization and ADT notifications from the local hospitals, however these data are currently being hand-entered into Crimson (see “care management” section below). The CCO is in conversations with CMT about PreManage as a way to automate information collection into Crimson.

Care Management and CCO-Provided Information to Provider/Care Teams:

Trillium is completing its launch of the Crimson Care Management tool to support several care management projects.

- The tool:
 - includes actionable clinical information to support care management
 - provides providers and the CCO care managers a full picture of their patients or members, defined sub-populations, and individual patients through integrated data.
 - includes psychosocial risk factors when calculating patient risk and prioritizing tasks, giving care managers the information needed to act effectively.
 - targets various factors, depending on the member’s specific situation.
- If there is a certain risk level associated with a member when they come in, they are further assessed and if warranted, are sent to Trillium’s complex case management team and entered into the program within Crimson.
- When running a given “program” in Crimson, a particular population is identified for the purpose of setting up a protocol in the Crimson system to trigger alerts in order for that identified population to receive a call. “Basically, Crimson is programmed to perform interventions.”
- Working with Crimson to customize the tools so they will set up programs/projects within the Crimson system and accurately identify members of the project.
- Projects/care management programs include:
 - The “Trillium Integration Incubator Project,” (TIIP) in which the Crimson platform will be used as a case management tool in four PCP clinics that have a behavioral health physician(s) embedded in the clinic (integration), and four behavioral health clinics with an embedded PCP(s) (reverse-integration).
 - Trillium continues to examine and suggest improvements to clinic workflows. They have attempted to identify effective handoff protocols.
 - The CCO is also making progress with assessing the TIIP associated results, trends and outcomes.
 - Crimson has been rolled out to two county perinatal programs that are actively using and having a good experience with the program. The CCO is planning to use the data to examine and monitor: members with care plans (monitoring progress towards goals), prenatal care coordination, demographic information, as well as other information not available through claims.
 - Trillium has launched an internal perinatal program within Crimson which includes programs for (a) conditions related to pregnancy, (b) pregnancy involving chronic conditions, (c) postpartum, (d) tobacco cessation, and (e) Interfacing with the county programs.

Care Timeline is a tool developed by Trillium in house that presents providers with a graphical representation of a member’s entire medical history.

- Trillium intends to roll this tool out first to ED providers and/or as a package with their Crimson Care Management tool (working with Crimson to develop use cases for integrating Care Timeline) for PCPs.
- The web-based application depicts every encounter the member as a dot on a graphical timeline. Users can select dots to have access to all the information for each claim including

	<p>diagnoses, labs, etc.</p> <p><u>Member lists</u> – Trillium also provides ‘hot spotter lists’ (which will eventually be part of Crimson solution), generated by Impact Intelligence (see description below), to each PCP and each BH practitioner.</p> <ul style="list-style-type: none"> • Includes members who have any of the ACA conditions or are 10% riskiest <ul style="list-style-type: none"> ○ Includes risk score, amount paid, ED visits, In-patient visits. ○ Care management program will work with these members. • The list is viewed as critical information by some providers, who use the information to follow up with patients.
<p>Quality Improvement, Population Management, Data and Analytics Tools</p>	<p>In addition to Crimson Care Management (described above), the CCO utilizes Optum’s Impact Intelligence and Impact Pro to analyze cost, utilization and quality of both members and practitioners using claims.</p> <ul style="list-style-type: none"> • Impact Intelligence and Impact Pro assign risk scores, quality indexes, episodes and confinements, allowing the CCO to assess the burden of disease, identify populations to target for complex case management and disease management. • Every single member gets risk assessed when loaded into the system. Risk scores are used for prioritizing care coordination. • Trillium uses Impact Intelligence to generate patient lists for providers (see description above), and Impact Pro to identify potential candidates for special case management programs. <p>Incorporating Clinical Data: In 2014, Trillium also piloted bringing clinical (EHR) data into the Crimson tool: Community Health Center (CHC): EHR can pull data at patient level, excluding information as needed. Trillium conducted validation with the CHC last year before submitting data including comparing EHR reported numbers against what Trillium showed for basic claims data. CHC conducted a demo of their EHR functionality, identifying potential issues.</p>
<p>Clinical Quality Metrics (CQM) Collection and Reporting</p>	<p>Current CQM Strategy: Trillium has utilized EHR data extracted by and provided to Trillium by CHC.</p> <p>Longer-term CQM Strategy: Trillium expects to extract individual-level clinical data (including lab values, blood pressure, etc.) out of EHRs and integrate within Crimson, which would be available for pushing out to the CQMR.</p>
<p>Technical Assistance to Practices for EHRs and Meaningful Use</p>	<p>Trillium has been actively providing technical assistance to their practices in several ways.</p> <ul style="list-style-type: none"> • The CCO has conducted training about meaningful use for their practitioners. • Trillium hired a community integrator to work with provider offices as well as provide a connection between the provider offices and Trillium. • Trillium encourages providers to use the data in their EHRs, rather than rely on the claims data the CCO has available. Trillium is a significant source of support for providers, offering IT and analytic resources to help them interface with their EHR vendor or work with their IT systems to set up reporting tools needed to pull relevant information out of their own system. • Trillium hired a Performance Metrics Coordinator whose job it is to make PCPs experts on the CCO metrics and to offer assistance to help meet them. This coordinator will assist with configuring EHRs, helping with workflow, etc. • Trillium implemented a Clinic Performance Assistance program, embedding Trillium employees at clinics to assist with data extraction from EHRs for the purposes in closing gaps in care. Currently there are eight Clinic Performance Assistants at 11 clinics. • Trillium convenes an HIT Group of providers, sharing information and providing support

<p>Telehealth</p>	<p>Trillium allocated transformation funds for telehealth/telemedicine. The CCO is supporting a pilot telehealth program involving community health workers being given tablets/laptops for performing needs and health risk assessments. Based on the collected data, PCP can make a referral request for care coordination services. The care coordination team then assesses each case and determines the appropriate plan of action.</p> <p>Trillium is also in the research phase of a pilot project they funded which provides tablets/laptops to patients upon hospital discharge. This is to help ensure that when patients are discharged, they have the means by which to contact a care support person electronically for questions or help on medications or post discharge issues. The expectation is that this will help reduce hospital re-admittance. This project involves a partnership between Trillium, the hospitals and the home health agency with telemonitoring capability.</p> <p>Trillium has allocated up to \$50,000 for Behavioral Health telemedicine implementation to support primary care medical home implementation and practice. We are particularly interested in behavioral health services integrated with primary care practices that are not able to imbed a clinical behavioral health provider as a part of team based care; in providing access to integrated behavioral health services provided by a clinician to members living in rural communities; in developing efficient consulting relationships with psychiatric prescribers and primary care providers; and in developing efficient use of psychiatric prescribers in outpatient behavioral health clinics.</p>
<p>Other</p>	<p>Local Provider Directory: Trillium has invested resources into developing and maintaining a provider directory within their administrative systems and their HIT tools including Crimson.</p>
<p>Barriers to Implementation of HIT Tools/ Services</p>	<ul style="list-style-type: none"> • Disparate EHRs of which many are in the middle of reinstalling, reconfiguring, and/or changing data hosts. • Trillium has found that EHR workflows needed to properly collect CQM data are not consistent across disparate PCP clinics, and in some cases not implemented correctly at all. This is particularly a problem with capturing data for the depression screening measure. With regards to clinics that are part of a large health system, getting the workflows altered presents a greater challenge as the EHR workflows are set at the corporate level. Additionally, some providers do not follow all prescribed corporate workflows exactly. • The CCO expressed challenges related to dealing with weekly data dumps that Crimson sends to the CCO for various uses, including data manipulation through SAS. They are finding it difficult to perform verification of such a large amount of data each week. • Trillium has experienced difficulty in getting practices in their provider network to participate in surveys regarding Meaningful Use, CQMs, etc. • Trillium is experiencing some challenges with obtaining clean and complete data from Crimson. More specifically, they are having difficulties reading the data files and validating that the expected data is being accurately brought into its assigned location. • Challenging to identify who needs complex case management simply using logic and examining existing data. Though reviewing diagnoses to assist with this process is helpful, it is often insufficient. • Though there are no concerns regarding Broadband connectivity, the CCO community health works do occasionally experience wireless network coverage issues in rural areas. They have been using iPads to conduct surveys and have not been able to access online survey tool when needed.

CCO Provider Environment

Hospital Engagement in HIT

Hospital Name	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Cottage Grove Community Hospital	Cloverleaf, Healthwise, MU Quality Manager, PeacehealthEHR	Stage 1	Feed is live for ED data—receiving notifications to printer.
Peace Harbor Hospital	Cloverleaf, Healthwise, MU Quality Manager, PeacehealthEHR	Stage 1	Feed is live for ED data—receiving notifications to printer.
Sacred Heart <ul style="list-style-type: none"> • River Bend • University District 	Cloverleaf, Healthwise, MU Quality Manager, PeacehealthEHR	Stage 1	Feed is live for ED data—receiving notifications to printer.
McKenzie-Willamette Medical Center	Medhost	Stage 1	Contract with vendor signed—IT interface work in progress.

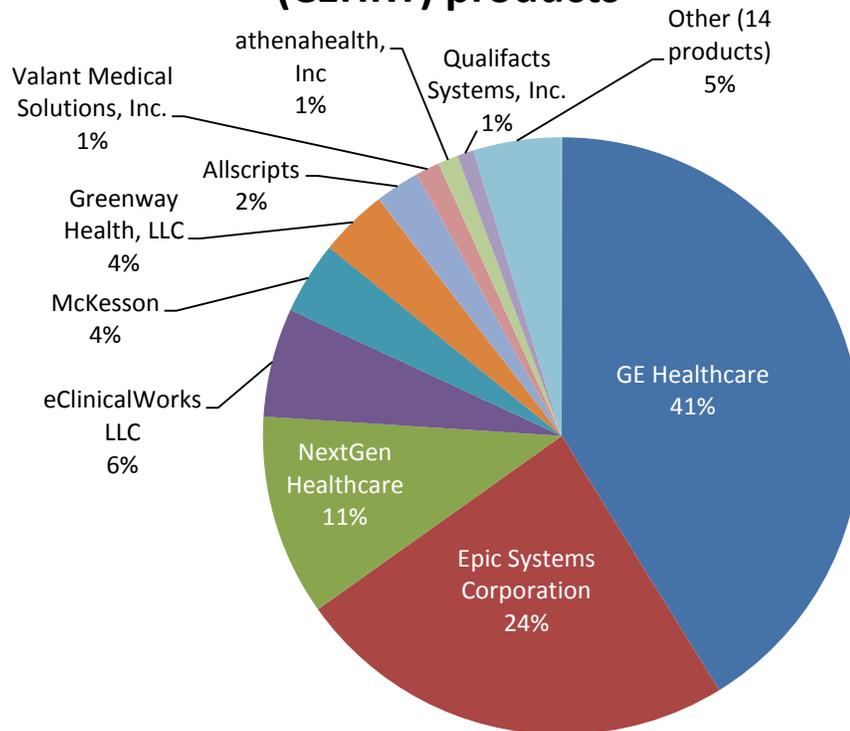
*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top 10 Certified EHR Technology Products for Trillium

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

Trillium Certified EHR Technology (CEHRT) products

There were 459 unique providers affiliated with Trillium CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 24 different EHRs in use within the CCO. The top 10 products are represented in the chart, which are in use by 437 unique providers.



Umpqua Health Alliance CCO HIT/HIE Profile

26,432 members¹

CCO Description:

- Geographically more than an hour from any larger city, resulting in a variety of primary care practices: sole practitioners, group practices, rural clinics, and FQHCs. There is one community hospital in the area.
- 65% of members are served in rural clinic and FQHC clinics settings; the rest are seen by small 1 - 2 doctor practices.
- Majority of members are assigned to practices that are either certified PCPCHs or in the process of becoming certified.
- 92% of providers are using a certified EHR.
- Umpqua Health Alliance CCO formed out of the Douglas County IPA (DCIPA) Medicaid managed care organization. In 2013, DCIPA partnered with the hospital system to form a new parent company, Architrave, which has several components, including owning several practices, providing support for the CCO, owning an IT subsidiary which owns/operates Umpqua One Chart (community-wide EHR), and contracting with Inteligenz for analytic tools.

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination	Quality Improvement, Population Management, Data and Analytic Tools	
Status	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing
Vendor Name	GE Centricity	Inteligenz	Inteligenz
Product Name	Umpqua One Chart	Architrave 2.1 (aka Inteligenz 2.1)	CCO Metrics Manager
Version	2014 certified		
Comment	Community-wide Electronic Health Record	Analytics and data mining	Population health management

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	<p>Health Information Exchange:</p> <ul style="list-style-type: none"> • Umpqua’s community-wide GE Centricity EHR tool, Umpqua One Chart, operates as a community health record for the Douglas county area. The EHR is utilized by the vast majority of providers in their community, and includes data on more than 85% of the CCO’s members. The EHR is available to both physical and mental/behavioral health providers. • Established connections to share information from four local labs (Quest, OML/Peace Health, Labcorp, and Mercy) and radiology providers at Mercy Medical Center, and have bidirectional exchange set up with Oregon’s immunization registry, ALERT. • Umpqua has had capability to export and import a care summary in CCD format since 2010. <p>Direct Secure Messaging²:</p>
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¹As of 10/01/2014

<http://www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf>

	<p>Direct secure messaging is available via Umpqua’s HISP, Surescripts. However, the CCO reports that there is infrequent occasion to use it, given the high percentage of providers using One Chart and the fact that the hospital’s EHR interfaces with Umpqua One Chart. Rather than use Direct, they ‘flag’ each other, which is also used for communication between providers and the hospital.</p> <p>Hospital Notifications³: In collaboration with local hospital Mercy Medical Center, Umpqua One Chart developed bridging of pertinent ER and admission documentation.</p> <p>Care Management and CCO-Provided Information to Provider/Care Teams: [See description below under population management]</p>
<p>Quality Improvement, Population Management, Data and Analytics Tools</p>	<p>Umpqua employs two Inteligenz products:</p> <ul style="list-style-type: none"> • <u>Architrave 2.1</u> is an analytics and data mining tool that extracts, analyzes, and reports on clinical and claims-based data in their data warehouse. <ul style="list-style-type: none"> ○ The tool calculates retrospective and prospective risk scores, diagnoses, prescription drugs use, costs, and premium received and spent. ○ Data can be grouped by age, disease, registry, provider, and eligibility ○ Umpqua uses the resulting reports to work with providers. In addition, they help Umpqua identify high-risk patients so they can dedicate case managers to the highest risk people. ○ Umpqua has used the tool for the last year, and staff are still learning how to use it for population management. • <u>CCO Metrics Manager</u> is a claims-based population health management product from Inteligenz focused specifically on the CCO incentive measures. The tool allows Umpqua to track CQM performance across patients, providers, clinics, etc., and identify areas that need improvement. <ul style="list-style-type: none"> ○ One example of Umpqua’s use of the tool for assisting them in meeting a CCO metric involves well-child visits, which are to occur once a year. The Metrics Manager allows Umpqua to identify who across their population is subject to that measure as well as who has met the measure (by patient, by doctor, by plan, by address). Umpqua has a team of navigators who then work with the providers to encourage and support their efforts for getting the visits done. For example this support team has relevant information about foster children’s need for completing a dental visit, mental health visit, and medical visit within 60 days of entering foster care. ○ Umpqua staff hand-delivered incentive payment checks to providers, during which visit she also asked them to help by doing well child visits. The payment was significant enough to warrant attention and ensuing cooperation. • The two tools have enabled Umpqua to maximize their performance on metrics. <ul style="list-style-type: none"> ○ They can use the Inteligenz tools within the EMR, with relevant information populating the chart. ○ The CCO has added additional internal metrics for next year, including specialty provider metrics.

² Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

³ Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

	<ul style="list-style-type: none"> ○ The analytic and predictive abilities of Architrave 2.1 will continue to be fine-tuned, based on population healthcare and individual case management needs. • Umpqua learned that no system off the shelf would do the things they needed to do as a CCO in Oregon, and so they worked to develop the solution they needed. Umpqua considers themselves an ‘information company’ as they “have Information coming in and better information going out.” <p>Incorporating Clinical Data:</p> <ul style="list-style-type: none"> • Architrave 2.1 is in the process of being programmed to mine clinical data in the required CCO metrics format. • Clinical data can be collected from any provider utilizing Umpqua One Chart, as long as the data is captured in the correct discreet format. This data can be fed into a data warehouse, and then extracted utilizing a proprietary database mining tool developed by Inteligenz.
<p>Clinical Quality Metrics (CQM) Collection and Reporting</p>	<ul style="list-style-type: none"> • The CCO is in good shape technologically to be able to report on the CQM measures in Year 2. Similar to Year 1, Umpqua will report on CQMs using clinical data that is fed into Umpqua’s database from Umpqua One Chart. • Umpqua credits their relative success of achieving CCO incentive metrics to having everybody in the community on the same EHR system. • The CCO was able to work in a new workflow for depression screening into the latest One Chart upgrade in 2014. They built in a PHQ-2, PHQ-9, AUDIT, DAST, and SBIRT screenings into the system.
<p>Technical Assistance to Practices for EHRs and Meaningful Use</p>	<p>Umpqua has dedicated resources to assisting providers with meeting Meaningful Use. They track each provider’s progress toward MU1 and MU2, including what their MU status is likely to be for this attestation year. The CCO is investing considerable effort into ensuring providers are well prepared for attestation. They have also invested resources into the IT aspect by confirming that their system is ready to help facilitate the process of providers receiving credit for their accomplishments, while not actually helping providers attest.</p> <ul style="list-style-type: none"> • Umpqua has inquired regarding the state’s role in and expertise with MU. They are interested in receiving any information the state has available on MU. • Umpqua has engaged Sage, a computer consultant group knowledgeable about MU. They plan to discuss next steps, including the most effective ways to support the providers.
<p>Patient Engagement through HIT</p>	<p>Umpqua One Chart currently includes a limited-feature patient portal. Though Umpqua considered working together with Mercy to create a community patient portal, after some review it was decided to improve and optimize their current Kryptiq patient portal.</p>
<p>Telehealth</p>	<ul style="list-style-type: none"> • Developing a CAHPS survey tablet application to allow patients to complete the survey in the waiting room. • Umpqua has provided mental health Skype sessions, but the patients seemed generally unsatisfied with the experience.
<p>Other</p>	<p>Local Provider Directory: Umpqua maintains a provider directory within their administrative systems including within the Inteligenz tools.</p>
<p>Barriers to Implementation of HIT Tools/ Services</p>	<ul style="list-style-type: none"> • A few providers are on alternate EMR systems and a smaller few not on any EMR, leaving approximately 13% of members for whom data is not being collected. • Increased demand on providers to collect and enter data has become a major barrier as there are ever growing and conflicting requirements. • Need for implementation of workflows to ensure entry of consistent and accurate data. • General challenges getting information from disparate systems, like OHSU, or the VA in Portland. The CCO is interested in any state-coordinated efforts that help Umpqua One Chart connect to external systems around the state.

	<ul style="list-style-type: none"> Umpqua pointed out the financial burden on smaller providers who may need to work with their EHR vendor or other folks to configure their systems to produce clinical quality metrics
Barriers to Behavioral Health Information Sharing	Umpqua would like clarification concerning 42 CFR Part 2, specifically regarding what is and is not allowable. For example, can they treat depression the same way they treat diabetes in their EHR? The CCO would like to know what information they can and cannot share.

CCO Provider Environment:

Hospital Engagement in HIT

Hospital Name	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Mercy Medical Center	Meditech	Stage 1	Feed is live for ED and inpatient data—receiving notifications to fax.

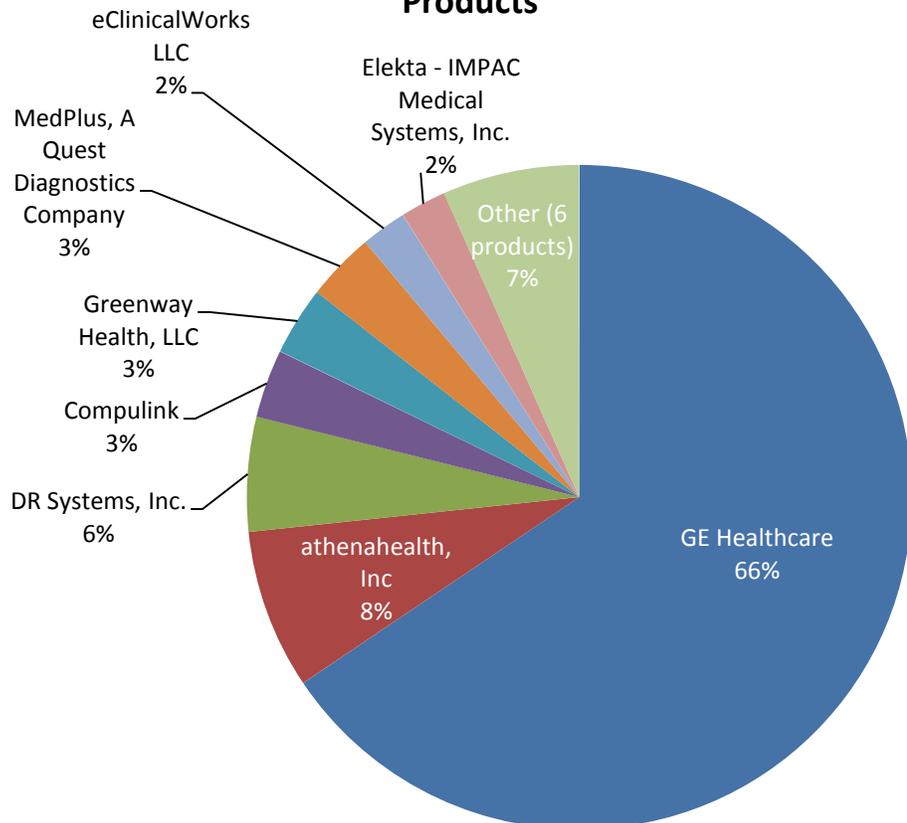
*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top Certified EHR Technology Products for Umpqua Health Alliance

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 90 unique providers affiliated with Umpqua Health Alliance CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 14 different EHRs in use within the CCO. The top 8 products are represented in the chart, which are in use by 84 unique providers.

Umpqua Certified EHR Technology (CEHRT) Products



Western Oregon Advanced Health (WOAH) CCO HIT/HIE Profile

21,341 members¹

CCO Description:

- Over 80% of members are managed by a few large group practices, serving members in North Bend, Coquille, Myrtle Point, Bandon, Gold Beach, and Coos Bay.
- The Waterfall Clinic, a small FQHC, serves approximately 5% of member population.
- The CCO evolved from a physician-owned IPA.
- The region experiences some challenges with broadband connectivity (i.e., geographical limitations). Reaching some rural communities is difficult.

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination		Quality Improvement, Population Management, Data and Analytic Tools
Status	<input type="checkbox"/> Currently supporting <input checked="" type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input type="checkbox"/> Currently supporting <input checked="" type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input checked="" type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing
Vendor Name	TBD	TBD	Milliman
Product Name			Patient Relationship Manager (PRM)
Version			Gen 1: launched Gen 2: in development
Comment	Solution in development to exchange clinical data in concert with the Milliman solution	Coordination with Bay Area Hospital HIE efforts through participation in governance: BACIA	Analytics, quality metrics, population/ care management solution

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	<p>Health Information Exchange: The Bay Area Community Informatics Agency (BACIA) is a governance and policy-making body, coordinating health information exchange efforts across Coos Bay and the Southern Oregon Coast. Participants in BACIA include: Bay Area Hospital, North Bend Medical Center, Bay Clinic, Southwest Oregon IPA, and WOAHH CCO. Soon to include South Coast Orthopedics and Waterfall Clinic. BACIA and WOAHH have brought together the relevant partners and established trust and a shared commitment, which they feel is essential to the success of a community-oriented venture around HIE.</p> <ul style="list-style-type: none"> • In 2007, BACIA started with an investment in the Medicity HIE solution, and decided in 2013, to replace this solution with a combination of solutions operated by the hospital and CCO, which are under development. • Bay Area Hospital is implementing Mobile MD, which will offer a number of enhancements to their provider workflow, as well as a patient portal for their EHR. The hospital may expand to the full HIE component offered by Mobile MD over time.
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¹As of 10/01/2014

www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

	<ul style="list-style-type: none"> • WOAH expects to add an HIE component to its Milliman Patient Relationship Manager (PRM) solution (see description below). The PRM tool is having a significant impact on how the community HIE evolves. BACIA/WOAH are considering the possibility of having WOAH as the focal point for the community HIE and case managers across the community becoming principal users. <p>Direct Secure Messaging²: The WOAH solution and BACIA efforts do not currently support Direct secure messaging, although the hospital and providers in their community that seek meaningful use incentives will need to employ it. Further exploration of the role that Direct secure messaging and CareAccord might play may be warranted.</p> <p>Hospital Notifications³: WOAH expects to be receiving clinical data into the PRM tool from the regional hospital in the next few months, and are interested in the potential to bring PreManage data into their tool. BACIA representatives expressed interest in exploring whether PreManage may relate to their HIE efforts in the future.</p> <p>Care Management and CCO-Provided Information to Provider/Care Teams:</p> <ul style="list-style-type: none"> • WOAH envisions using the Milliman PRM tool to support provider workflows, and ultimately the care management model using PRM could be used more broadly than Medicaid in the community. • Care Coordinator reports and PCP/Provider Management Reports offer EHR-like information about patients. Offers a new way to view patients and brings to the care provider’s attention patients they may not have been considering.
<p>Quality Improvement, Population Management, Data and Analytics Tools</p>	<p>The PRM Gen 1 tool includes predictive analytics/risk assessment, care coordinator and PCP/Provider management reports, quality metrics and care gaps information, and business intelligence tools.</p> <ul style="list-style-type: none"> • A principal goal of the PRM is to ensure that the CCO or provider is able to communicate with patients/customers, to be able to impact their decision making at the time that they are about to make a decision that may be adverse to their health. • Another goal is efficiency of care, ensuring the tool can quickly and easily inform the CCO or provider about where/how to prioritize efforts across a population or patient panel • Milliman Advanced Analytics are used to risk-stratify patients in order to target case management with a goal of reducing potential volatility of risk/cost across a population, not merely high cost patients. This process involves: <ul style="list-style-type: none"> (1) benchmarking against the average, (2) discovering where the highest risk is and identifying the portion that is controllable, (3) examining healthcare expense volatility and potentially avoidable healthcare expenses (rather than average cost), (4) patients with the greatest area of potentially avoidable costs are ranked as a priority for additional ambulatory care management (not based on ‘risk-factors’).

² Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

³ Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

	<ul style="list-style-type: none"> The PRM tool helps the CCO and providers target which patients they should actively manage, and then assists in identifying what issues should be actively targeted for each patient, including what has been avoidable historically. Data currently used in the PRM tool are claims/administrative data including prescriptions (mental health prescriptions and prescriptions for which the patient paid with cash are not included). PRM Gen 2 would include clinical data integration and aggregation. <p>Incorporating Clinical Data: WOAH is evaluating the PRM Gen 2 tool, which includes clinical data.</p>
Clinical Quality Metrics (CQM) Collection and Reporting	<p>Current CQM Strategy: WOAH is working directly with its provider network for CQM reporting, not through the PRM tool at this time.</p> <p>Longer-term CQM Strategy: Depends on their decision about whether to implement Milliman’s PRM Gen 2 product, which would incorporate clinical data and calculate CQMs.</p>
Technical Assistance to Practices for EHRs and MU	In an effort to strengthen provider relations, WOAHA plans to establish several best practices to help improve clinic workflow and outcomes.
Telehealth	WOAH is supporting the following telehealth initiatives: <ul style="list-style-type: none"> Providers who have left the community but are still interested in providing behavioral health through videochat A multi-discipline, non-profit entity overseeing a feasibility study cataloging the location of the telehealth medicine equipment and developing a plan for its use PeaceHealth’s telehealth project: consult care
Other	WOAH maintains a provider directory within their administrative systems including within their PRM tool.
Barriers to Implementation of HIT Tools/ Services	<ul style="list-style-type: none"> Experienced, trained IT staff and analysts are difficult to hire and retain. Some outsourcing efforts by community partners have resulted in frustration and lack of performance. A multitude of competing demands (e.g., every IT department in the region is extremely taxed by EHR adoption/upgrades, MU2 deadlines, and other state and federal requirements). One challenge of the CCO taking a more central role in managing the community HIE is that there are different needs for the hospital than for the CCO. For example, the hospital is working around provider workflow to ensure consistent metrics and data, and the CCO is focused on population management. <ul style="list-style-type: none"> Other areas that would need development were the PRM tool to become more central in the community include questions regarding the management of access to patient information; the means by which case managers would coordinate data; and clarification regarding data needs. WOAH indicated they faced challenges with CQM reporting in Year 1 on both the front-end (requisite physician workflows) and back-end (extracting the data). Lack of consistent workflows that allow for accurate reporting of data.
Barriers to Behavioral Health	Barriers/challenges experienced in sharing behavioral health data (including mental health, substance abuse, and addictions) include: <ul style="list-style-type: none"> _____ Confusion over compliance with state or federal laws _____ State or federal laws prohibit the type of sharing I want/need to do

Information Sharing	<input checked="" type="checkbox"/> Our organization’s technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data). <input type="checkbox"/> Concerns over privacy and confidentiality protection for the patient <input type="checkbox"/> Concerns over liability if information you share is later improperly shared <input checked="" type="checkbox"/> Lack of proper consent forms from the patient <input checked="" type="checkbox"/> Other: Mental Health providers use a record that is significantly different from the medical EHR.
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CCO Provider Environment:

Hospital Engagement in HIT

Hospital Name	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Bay Area Hospital	Siemens	Stage 1	Feed is live for ED and inpatient data—receiving notifications to printer.

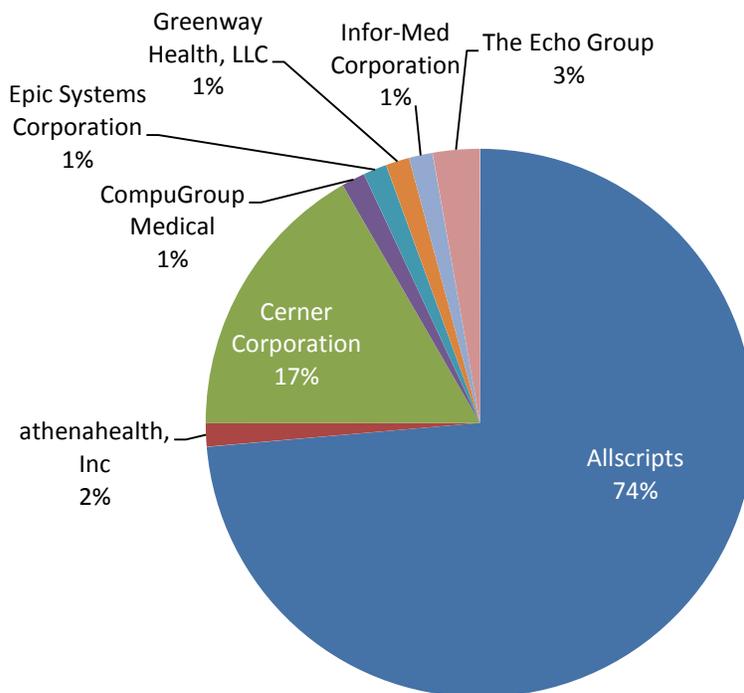
*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Certified EHR Technology Products for Western Oregon Advanced Health

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

WOAH Certified EHR Technology (CEHRT) Products

There were 72 unique providers affiliated with WOAHC CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 8 different EHRs in use within the CCO.



Willamette Valley Community Health CCO HIT/HIE Profile

100,574 members¹

CCO Description:

- Served by about 62 primary care practices, which includes two Federally Qualified Health Centers (FQHCs), and many practices are members of the Mid-Valley IPA (MVIPA).
- Of the primary care practices, 38 have achieved at least Tier 1 PCPCH status, with 22 practices at Tier 3.
- Over 80% of the practices are very small with 4 providers or less. There is one large practice of over 40 providers and a handful of medium-sized practices with 10-15 providers.
- MVIPA hosts NextGen EHR for many of its members.

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination	Quality Improvement, Population Management, Data and Analytic Tools
Status	<input type="checkbox"/> Currently supporting <input checked="" type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input type="checkbox"/> Currently supporting <input checked="" type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing
Vendor Name	Collective Medical Technologies	Arcadia Solutions
Product Name	PreManage	Community Data Warehouse
Comment	In conversations with CMT about bringing ED and inpatient notifications to their community.	Working in conjunction with community partners

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	<p>Health Information Exchange: Health care stakeholders in the community have considered a regional community solution to HIE in the past, and the CCO and its HIT committee continues to be interested in how best to support a community HIE solution, however, there are no concrete plans for a community-wide HIE currently .</p> <p>Direct Secure Messaging²: Although WVCH promoted Direct secure messaging and a significant number of organizations have registered with CareAccord, many of these folks are not using CareAccord at this time, in some cases because it is not embedded in their EHR/workflow. As providers need to meet Meaningful Use, many will use a HISP embedded in their EHR, including the MVIPA members using MVIPA’s NextGen (with Mirth as the HISP). The CCO commented that CareAccord is likely to be most useful for providers not seeking to meet Meaningful Use, and those that do not have an EHR.</p>
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¹As of 10/01/2014

www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

² Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

	<p>Hospital Notifications³: Though hospital data will be included in the Community Data Warehouse (see description below), WVCH is not otherwise engaged in providing hospital notifications to PCPs. WVCH is in the process of exploring options for bringing PreManage to its community.</p> <p>Care Management and CCO-Provided Information to Provider/Care Teams: WVCH expects that Case Managers will likely be primary users of the Community Data Warehouse tool (see description below) for reaching out to patients, creating reminders, and metrics, among other uses.</p>
<p>Quality Improvement, Population Management, Data and Analytics Tools</p>	<p><u>Community Data Warehouse:</u> An overarching goal for the CCO is to connect clinical data from disparate EHRs, hospital data, pharmacy data, and health plan claims data for use at the point of care for primary care providers, and case management staff to help with care coordination and the health care decision making process. To that end, WVCH is proceeding with the Community Data Warehouse, a pilot project involving the development and implementation of a population health management, data aggregation, and analytics tool. This effort will be a proof of concept for the CCO board to consider whether to implement more fully.</p> <ul style="list-style-type: none"> • The Warehouse is spearheaded by Silverton Health in collaboration with Yakima Valley Farm Workers, independent of WVCH. WVCH decided to adopt the Warehouse as its own in a pilot phase, as the Warehouse project met many of the CCO’s HIT objectives, with the exception of HIE capabilities. In addition, the Warehouse project was underway, with the vendor, Arcadia, selected and agreements/governance established. • The project currently comprises over 15% of WVCH’s member population – and is scalable should the CCO want to expand after the initial implementation. • Participants in the project include a hospital and approximately ten PCP clinics using at least two different types of EHR software/versions. • The tool is expected to integrate hospital, ambulatory EHR, pharmacy, and claims data. • One of the key objectives of the Community Data Warehouse project is to improve analytic capability at a community level. <ul style="list-style-type: none"> ○ Existing analytic capability is generally limited by the measurement and reporting capabilities provided by the EHR vendors. Some practices have developed additional reporting capabilities in-house or via MVIPA. <p>Incorporating Clinical Data: The expectation is that clinical EHR data will be integrated into the Community Data Warehouse for a variety of purposes.</p>
<p>Clinical Quality Metrics (CQM) Collection and Reporting</p>	<p>Current CQM Strategy:</p> <ul style="list-style-type: none"> • WVCH intends to leverage capabilities provided by the participating practices’ EHR systems (primarily MVIPA’s NextGen providers) for Year 2 CQM measurement and reporting. • WVCH indicated a concern that they won’t have a complete year of data for the depression screening measure for Year 2, as the NextGen EHR systems were not upgraded to include the ability to enter a depression screening until July 31st, 2014. <p>Longer-term CQM Strategy: WVCH does not yet know what level of clinical information will be supported by the Data Warehouse project, and how it might support the CCO incentive metrics moving forward.</p>

³ Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

Technical Assistance to Practices for EHRs and MU	<ul style="list-style-type: none"> • The CCO is exploring ways to increase the efficiency of EHRs including the use of Scribes for their veteran providers. • MVIPA provides technical assistance to providers using NextGen EHR. In fact, O-HITEC subcontracted with MVIPA to deliver TA services.
Other	Local Provider Directory: WVCH maintains a provider directory within their administrative systems. The collaborative will maintain provider information in the Community Data Warehouse.
Barriers to Implementation of HIT Tools/ Services	<ul style="list-style-type: none"> • WVCH is aware that providers do not experience EHRs as increasing their productivity, efficiency, or cost savings, bringing the value of EHRs into question. • WVCH is interested in supporting dental care use of EHRs and HIT. The CCO ascertained that dental care providers are lagging behind physical health in terms of EHR adoption, although dental providers are eligible for the EHR incentive program and certified dental EHRs exist. The CCO expects to closely monitor and support efforts in this area. • The majority of practices are primarily dependent on the measurement and reporting capabilities inherent to their EHR systems and do not have the resources to develop improved data analytic capabilities on their own. • Each new measurement and reporting requirement brings with it the necessity to evaluate and enact data entry workflows, which result in structured data being available for reporting purposes. EHR system usability is a constant barrier to reliable data entry and therefore accurate measurement. • While the Community Data Warehouse project will provide WVCH with population management, care coordination, quality, and analytics capabilities, it does not address the CCO’s HIE and/or query-response needs. • WVCH expressed concerns regarding making significant investment in HIE given challenges related to interoperability, including the limitations of CCDA integration, and challenges related to message delivery via Direct secure messaging.
Barriers to Behavioral Health Information Sharing	Barriers/challenges experienced in sharing behavioral health data (including mental health, substance abuse, and addictions) include: <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Confusion over compliance with state or federal laws <input type="checkbox"/> State or federal laws prohibit the type of sharing I want/need to do <input checked="" type="checkbox"/> Our organization’s technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data). <input checked="" type="checkbox"/> Concerns over privacy and confidentiality protection for the patient <input checked="" type="checkbox"/> Concerns over liability if information you share is later improperly shared <input type="checkbox"/> Lack of proper consent forms from the patient

CCO Provider Environment:

Hospital Engagement in HIT

Hospital Name	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Salem Hospital	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
West Valley Hospital	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Santiam Memorial Hospital	Healthland	Stage 1	Feed is live for ED and inpatient data—receiving notifications to fax.
Silverton Hospital	Meditech, Optuminsight	Stage 1	Feed is live for ED and inpatient data—receiving notifications to printer.

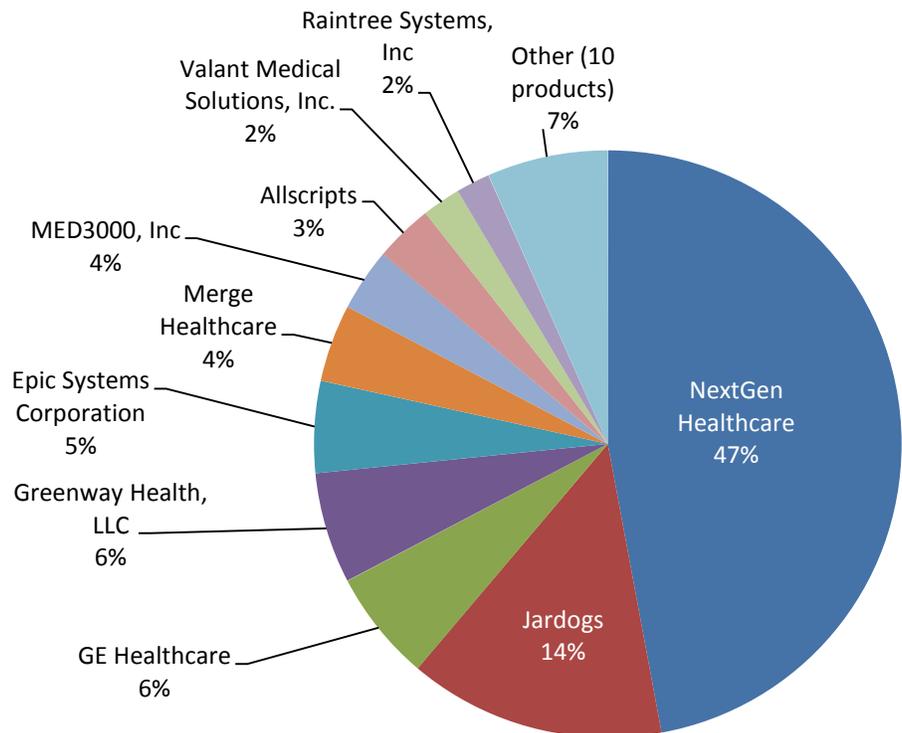
*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top 10 Certified EHR Technology Products for Willamette Valley Community Health

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

WVCH Certified EHR Technology (CEHRT) Products

There were 376 unique providers affiliated with WVCH CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 20 different EHRs in use within the CCO. The top 10 products, represented in the chart, are in use by 351 unique providers.



Yamhill CCO HIT/HIE Profile

24,661 members¹

CCO Description:

- Two major hospital systems: Providence Medical Group Newberg and Willamette Valley Medical Center (WVMC) McMinnville with closely affiliated primary care and specialty care clinics with largely employed providers;
- One large independent primary care clinic: Physicians Medical Center (McMinnville) seeing a majority of pediatric patients.
- One FQHC: Virginia Garcia serving a large portion of Spanish speakers and adults.
- Remainder of Yamhill CCO network: small independent primary care and specialty care clinics.
- Yamhill County DHHS supplies the majority of behavioral health services.
- Yamhill CCO formed out of community partners and is supported by a partnership with CareOregon who provides administrative foundation and support.
- Prior to the CCO forming, the majority of Medicaid members were fee for service.
- Yamhill CCO was awarded the Early Learning Hub for their region.

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination		Quality Improvement, Population Management, Data and Analytic Tools		
	<input type="checkbox"/> Currently supporting <input checked="" type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing	<input checked="" type="checkbox"/> Currently supporting <input type="checkbox"/> Planning/Developing <input type="checkbox"/> Not Pursuing
Status					
Vendor Name	The Advisory Board	Collective Medical Technologies	The Advisory Board	The Advisory Board, Milliman	SAS
Product Name	Crimson Care Management (CCM)	PreManage	Crimson Care Registry (CCR)	Crimson Population Risk Management (CPRM)	Business Intelligence Software
Comment	Care management tool	Hospital notifications	Identifies gaps in care	Population management, Risk stratification, with Milliman analytic support	Claims-based analytic reporting (provided by CareOregon)

¹As of 10/2014

www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

Description of HIT/HIE Initiatives

<p>Information Sharing and Care Coordination</p>	<p>Overall, the CCO is investing in a suite of tools within the Crimson Care Ambulatory tool, which was selected in part because one local hospital had invested in it, and two major clinics are already connected. The suite has three tools – 2 that Yamhill CCO is implementing (CPRM and CCR – see next section below), and 1 that the CCO is considering (CCM) for care management.</p> <p>Health Information Exchange: See “Care Management” section below</p> <p>Direct Secure Messaging²: The CCO has not engaged in many conversations around using Direct for their CCO needs, and is using a secure email service when necessary. However, Yamhill CCO has identified radiology (echocardiogram) image transfer type platform as a significant need, which could be supported by Direct secure messaging/CareAccord.</p> <p>Hospital Notifications³: One clinic already receives a daily feed of emergency department visits for their patients, but it is limited to their area (one hospital). YCCO is supportive of EDIE and is interested in exploring the integration of PreManage into the Crimson Care Management tool.</p> <p>Care Management and CCO-Provided Information to Provider/Care Teams: The CCO is exploring the possibility of implementing the Crimson Care Management (CCM) tool, which would include more real-time, actionable clinical information to support care management. With Crimson Care Management, providers and the CCO care managers get a full picture of their patients or members, defined sub-populations, and individual patients through integrated data. Crimson includes psychosocial risk factors when calculating patient risk and prioritizing tasks, giving care managers the information needed to act effectively.</p> <p>See below for a description of the Crimson Care Registry and Crimson Population Risk Management tools which also support providers in care delivery and managing their populations. For example, Yamhill CCO’s aim is that behavioral health services providers could utilize the CPRM tool for case management and to facilitate the coordination of services.</p>
<p>Quality Improvement, Population Management, Data and Analytics Tools</p>	<p>The CCO invested in the Crimson Care Registry (CCR) and Crimson Population Risk Management (CPRM) tools.</p> <ul style="list-style-type: none"> • The Crimson Care Registry component allows for gathering/aggregating/sharing of clinic level EHR data to identify gaps in care and specific health data points in the population (e.g., identifying members in need of colorectal cancer screening). The CCR can also produce the three CQM CCO metrics. • The Crimson Population Risk Management tool pools, processes (by Milliman), and analyzes medical claims data from CareOregon and OHA to risk stratify and score members to allow for the identification of members with high medical costs. • YCCO considers the Crimson PRM tool a critical component of developing alternative payment models. Their strategy has involved using the CPRM to risk score members

² Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

³ Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

	<p>assigned to various clinics, and then base the global budget those clinics receive for that population on the risk score of the members.</p> <ul style="list-style-type: none"> Yamhill CCO supports the Community Hub, which is a referral-based program to which any provider can refer members they feel are high utilizers in order to establish a relationship with a community health worker. The Crimson Population Risk Management tool is being considered for integration into the Community Hub program that works with high-utilizers of ED and may be used as a way to identify high-risk score members for inclusion in the Community Hub. <p>Care Oregon supports Yamhill CCO with claims-based analytic reporting is conducted via SAS Business Intelligence software, including metrics and dashboards for the CCO to use.</p> <ul style="list-style-type: none"> Current reporting capability includes aggregate reporting for CCO level data, provider level data, and member level data for demographics, utilization, and gaps in care <p>Incorporating Clinical Data:</p> <ul style="list-style-type: none"> The Crimson software includes the capacity to include EMR data within their analytics.
<p>Clinical Quality Metrics (CQM) Collection and Reporting</p>	<p>Current CQM Strategy: CCO relied on OCHIN for the Year 1 CQM submission. However, given the increases in the required population on which to report, this approach will likely not suffice for Year 2. CCO is exploring a multi-pronged approach, including the use of Crimson Care Registry as well as OCHIN and Providence, to meet the needed percentages.</p> <p>Longer-term CQM Strategy: The vision for longer term reporting is that data would be collected in, and reported from, the Crimson Care Registry to the CQMR.</p>
<p>Telehealth</p>	<ul style="list-style-type: none"> Yamhill CCO is pursuing a teledermatology pilot, as part of their participation in OHA/Transformation Center’s Council of Clinical Innovators. Due to the lack of access to dermatology care, they are bringing a teledermatology provider into the community which involves putting an iTouch in primary care exam rooms to support teledermatology consults during a primary care visit. The remaining challenge is to resolve billing for such a service. Partners within the Yamhill CCO community previously utilized tele-mental health. Yamhill CCO supports and encourages providers’ use of the <i>Oregon Psychiatric Access Line about Kids</i> (Opal-K), which provides free, same-day child psychiatric phone consultation to primary care clinicians in Oregon. Additional telehealth/telemedicine being considered include after hours crisis intervention and services within the CCO pain clinic.
<p>Other</p>	<p>Common Core Referral/Early Learning: YCCO sponsors the Yamhill County Early Learning Hub. They were the only CCO in the state that applied and was awarded the status and is therefore under some scrutiny regarding how CCO is approaching the integration of early childhood interventions. The CCO already had a Common Core Referral process in place for the Maternal Child Health (MCH) population. That is, any provider or (non-profit) entity in the community that sees a child, family, or pregnant woman of concern, they only need to fill out the basic common core referral form and fax it to the CCO. The CCO then conducts an assessment and determines the services available to meet the needs. The process is low-tech (handled via paper and fax) and includes basic information, but is very effective in getting individuals the assistance they need.</p> <p>Local Provider Directory: Yamhill CCO maintains a provider directory within their administrative systems and Crimson systems.</p>

Barriers to Implementation of HIT Tools/ Services

- Presence of multiple EHR systems across the provider network.
- Crimson integration administrative barriers include lack of clinic interest in participating and lack of staff to devote to the process.
- Clinic staff stretched thin dealing with technical and regulatory requirements.
- Current CCO staffing limitations, specifically the lack of technology and/or analytics-dedicated employees. YCCO is exploring the possibility of hiring a data/analytics staff person.
- YCCO has experienced challenges with getting some providers organizations involved with Crimson. This has been due in part to concerns regarding HIPAA including having correct business agreements that identify who would have access to the data and lack of clarity regarding acceptable 'pushing and pulling' of data between organizations (i.e., what information is acceptable to share).
- Once the data was pooled from CareOregon and OHA and processed by Milliman, they found a significant rate of duplicate records in Crimson. A data validation effort ensued, involving a joint effort between Crimson and Milliman.
- Starting ACO in McMinnville being run through Regence (Regence Active Care – devoted to fostering ACOs). They have 123 patients already enrolled. The challenge with this is that Regence has their own HIT/HIE platform (Lumeris). This adds to the complexity of establishing a community-wide HIT/HIE infrastructure.
- Uncertainty among CCO staff as to the status of dental practices with regards to Meaningful Use and other state HIT/HIE goals/metrics.

CCO Provider Environment:

Hospital Engagement in HIT

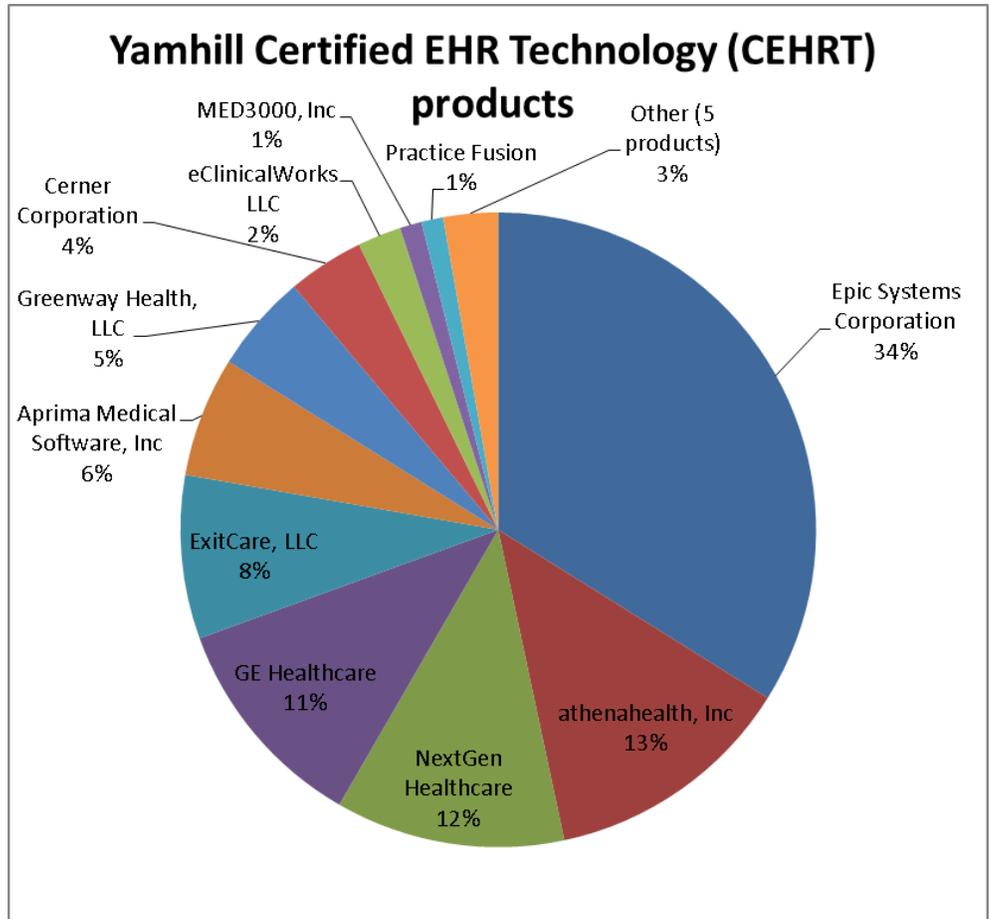
Hospital Name	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Willamette Valley Medical Center	Meditech	Stage 1	Feed is live for ED and inpatient data—receiving notifications to fax.
Providence Newberg Medical Center	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.

*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top Certified EHR Technology Products for Yamhill Service Area

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 180 unique providers in Yamhill CCO's servicing area that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 16 different EHRs in use within the CCO. The top 11 products are represented in the chart, which are in use by 175 unique providers.



Appendix 10

Oregon SIM Driver Diagram

Key actions supporting the drivers

- Patient-centered primary care home (PCPCH) technical assistance & standards for practice transformation
- Training and certification of health care interpreters
- Long-term care (LTC) Innovator agents for medical-long term care system coordination
- HIT/HIE supports for care coordination (e.g. real-time notification, tele-health tools)

- Work with experts on best approaches for alternative payment methods
- Multi-payer engagement around value-based payment, beginning with primary care
- Testing & adoption of alternative payment methods across markets, with T.A. via Transformation Center
- CCO and hospital quality pool in Medicaid

- CCO – local public health authority projects to address priorities
- CCO and early learning hub collaborative projects for kindergarten readiness
- Congregate care/housing with services demonstration
- Regional equity coalitions; equity leadership training for health care providers
- Integrate and improve oral health with physical, behavioral

- Alignment of quality measures across markets (Medicaid, PEBB, commercial plans offered on the Exchange)
- Increased production & dissemination of evidence-based clinical guidelines; patient decision aids
- Medical-long term care system coordination; administrative alignment for those dually eligible for Medicare/Medicaid

- Transformation Center as hub – provider and system engagement, technical assistance & dissemination
- Data and analytic tools to support innovation & identify community or population health needs
- Quarterly dashboards for timely feedback on 3-part aim goals

Primary Drivers

Driver 1: Improving care coordination at all points in the system, with an emphasis on patient-centered primary care homes (PCPCH)

Driver 2: Implementing alternative payment methodologies to focus on value and pay for improved outcomes

Driver 3: Integrating physical, behavioral, and oral health care with community health improvement

Driver 4: Standards and accountability for safe, accessible, and effective care

Driver 5: Testing, acceleration, and spread of effective delivery system & payment innovations

AIM 1 (SIM)

Spread key elements of the Coordinated Care Model to:

- State employees by Jan. 2015
- Dual eligibles and other Medicare beneficiaries by 2016-2017
- Marketplace participants and Oregon Educators by Jan. 2017

AIM 2

Reduce per member, per month (PMPM) cost trend while maintaining or improving quality:

- Reduce Medicaid PMPM trend 2 percentage points (p.p.) by FY 2015
- Reduce public employees PMPM trend 2 p.p. by FY 2016
- Reduce PMPM trend for most duals (in CCOs) by 2015, others over 2016-2017

Ultimate Aims

- Better health for Oregon-ians
- Better care
- Lower health care costs

Appendix 11

Housing with Services Evaluation



Housing with Services

YEAR 1 EVALUATION, OCTOBER 2014

Paula C. Carder, PhD, Institute on Aging

This report describes the initial findings of an evaluation of the Housing with Services project in Portland, OR. Support was provided by Oregon's State Innovation Model (SIM) grant from the Center for Medicare and Medicaid Innovation (CMMI).



Portland State
UNIVERSITY

Acknowledgements

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The Portland State University Bridges to Baccalaureate Program provided two student interns (Maximilian West and Ana Serrato) who assisted with data collection and entry. In addition, PSU's Institute on Aging supported a portion of Dr. Carder's time and the School of Community Health supported graduate student Jack Phillips, who assisted with data collection.

Thank you to Alyssa Adcock, MSW, Housing with Services Project Manager and Howard Klink, Project Director.

Housing with Services, LLC is a collaborative model of supportive services delivered or made available to low-income residents of affordable housing.

The Oregon Health Authority's State Innovation Model grant helped to establish the project and funded the evaluation of the program implementation and resident- and system-level outcomes.

The Housing with Services program goals include reducing hospital and long-term care service use, improving health outcomes among building residents, addressing social determinants of health, increasing member engagement in preventive health care, and saving health-related costs by coordinating services to low-income tenants of affordable housing.

EVALUATION PLAN

The evaluation includes several components:

- a process and implementation evaluation of the consortium model based on interviews with stakeholders and review of Housing with Services progress reports;
- a self-administered survey of residents in the 11 partner buildings that included questions about health status and health service use, satisfaction, social integration, and demographic information;
- tracking health service utilization, based on administrative data provided by the Housing with Services LLC and partner organizations; and
- a cost analysis of services delivered through the consortium.

YEAR 1 EVALUATION

During the first year of the Housing with Services project, the scope grew from four properties owned by one non-profit organization to 11 properties owned by three organizations. A Limited Liability Corporation was created, Housing with Services, LLC, representing 10 partner agencies that are in the process of creating a new model of housing with services delivered to low-income older adults and persons with disabilities.

CONSORTIUM MODEL

Cedar Sinai Park (CSP) is an Oregon non-profit agency that provides housing and community-based care to elders and adults with special needs. CSP chose to create a limited liability corporation (LLC) with a group of local health, housing, and social service providers in order to create a formal structure for making decisions and delivering services. Many of these providers had participated in nearly two years of program planning meetings. Some providers chose not to participate in the LLC but continue to serve residents in the 11 affordable housing properties and/or serve new referrals. For some stakeholders, such as trade organizations and government agencies, participation in an LLC was not an option, though these stakeholders remained interested in and supportive of the project. Other agencies determined that buying into an LLC did not match their financial needs. Once the LLC was formed and the demonstration project began, the program planning meetings were discontinued.

*Limited Liability
Corporation Members, 2014*
Cedar Sinai Park
CareOregon
Home Forward
REACH CDC
Asian Health & Service Center
Jewish Family & Child Service
Sinai Family Home Services
LifeWorks NW
Cascadia Behavioral Healthcare

LESSONS

- A consortium model needs to provide clear and on-going communication and opportunities for feedback to project partners.
- Recognizing and incorporating the expertise of local organizations is vital during program planning.
- The stakeholders who participated in program planning efforts appear to have established a strong sense of project ownership and motivation to make the demonstration project a success.

BUSINESS MODEL LESSONS

Cedar Sinai Park, as the originator of the Housing with Services project and owner of four affordable apartment buildings, is the largest financial partner in the LLC, at 51%. The LLC equity contributions totaled just over \$335,000. After Cedar Sinai Park contributed 51%, the remaining organizations each paid a relative share of these costs as their equity contribution. Each percentage of equity was worth \$3,000, allowing smaller non-profit agencies to afford participation.

LESSONS

- Because non-profit organizations must receive board approval in order to enter financial agreements, and board meeting schedules and agendas can take months to align and permit agreement or discussion.
- Questions and answers about the legal and financial expectations of an LLC must be prepared in advance of program implementation and presented in language that is accessible to community members who serve on boards.
- Because many non-profit social service organizations operate on a modest budget, they are cautious about committing limited resources to a project that might not allow them to recoup their costs.
- Setting a relatively low equity contribution rate allowed non-profit agencies with limited resources to participate in the LLC.
- Program success relies on fundraising for program implementation and evaluation.

SERVICE PLANNING

A services sub-committee, including Resident Advisory Council members, identified the types of services most needed and wanted by residents. After several workgroup meetings, the draft set of services was shared with service providers, the LLC members, and CareOregon staff. How services would be delivered and paid for remained a topic of discussion even as the service plan was being implemented. Providers agreed to be flexible and to

provide services as resident needs and preferences were better understood over time.

CAREOREGON

As the healthcare provider/payer with the largest number of clients in the 11 buildings, CareOregon (a coordinated care organization) was a key decision-maker in terms of services, staffing, and reimbursement of services available to the residents of the buildings. As part of their support of the program, CareOregon committed in-kind staff and began offering health-related services and education to all residents (rather than to CareOregon members only). As of October 2014, CareOregon provided:

- **Two part-time registered nurses** (1.5 FTE total), serving as a Health Navigator and a Care Coordinator, screen residents and provide advice and referrals
- A **medication therapy management** program called MedChart
- A Health Resilience Program for **identifying high-risk patients**
- **Benefits enrollment** - assistance Medicaid clients with a providers of choice

ON-SITE PRIMARY CARE PHYSICIAN

A primary care physician who accepts CareOregon and Family Care insurance is now available twice weekly in the clinic attached to one of the downtown buildings. This arrangement allows Medicaid clients to choose this provider rather than the one they were randomly assigned to visit through Medicaid enrollment that occurred as part of the State's response to the Affordable Care Act. However, residents may choose to retain their own provider.

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

Providence operates the only PACE program in Oregon, serving dual-eligible individuals who are age 55+ and who meet health-related eligibility criteria defined by Oregon Department of Human Services. Providence is in the process of implementing an on-site PACE program in one of the participating apartment buildings located in downtown Portland.

CONSUMER PARTICIPATION

Consumer choice was a key concern to stakeholders. Residents may choose whether or not to accept services without affecting their housing status or their relationship with current or future health and social service providers.

A consumer advisory group attended planning meetings and sub-committee meetings. Community organizations who represent diverse client groups, including immigrants from China, Korea, Vietnam, Russia, and Iran attended program planning meetings in order to provide feedback on culturally appropriate services.

- Although this program seeks to provide services to residents who need or want them, both housing and service agency staff must protect the privacy of their clients. This makes sharing information and tracking service use over time a challenge.
- Residents value their privacy and independence and may choose whether or not to enroll in offered health services.
- Resident services staff in some buildings have for many years organized the types of services, such as health fairs and clinics, the program is now offering. It is important to understand and clarify roles and to avoid duplication of services and best use program resources to support residents.

RESIDENT SURVEY

A survey of all residents was done in order to collect baseline information before the services were to start (summer 2014). The questionnaire included questions about social isolation, food access, medication adherence, and perceived need for supports, as well as information about health service use and diagnosis.

A total of **1401 questionnaires** were distributed to all units in the 11 apartment buildings. The final response rate, based on **546 respondents**, was 39%. In-person interviews were conducted in six languages other than English and with visually impaired tenants.

DEMOGRAPHIC PROFILE

The residents include slightly more women than men; just over half were over age 65; the majority were White (63%) and others identified as Asian (18%), other (11%), African American (6%), or Hispanic (3%).

The population is low income, with **17% reporting no income**, 59% reporting less than \$11,000 and 24% more than \$11,000 annual income.

Many residents reported significant chronic diseases, especially mental health conditions—**43% reported depression; 37% reported anxiety; and 21% post-traumatic stress disorder.**

The reported conditions include both those that are silent (**high blood pressure**) and those that might cause acute symptoms that could result in hospital emergency department use (**sleep apnea, acid reflux, asthma, heart problems**). Nearly one-fourth reported **diabetes** (Table 1).

A different set of questions considered how health affects daily activities. A very large percentage of residents reported **pain—75%** and over 50% reported limitations in daily activities, mobility problems, and anxiety and depression (Fig. 1). Differences by age and gender were minimal (Fig. 2).

Self-reported Health Conditions

Table 1. Tenant Health Characteristics

	N	%
High blood pressure, hypertension	272	49.8
Depression	236	43.2
Anxiety	202	37
Sleep disorder, sleep apnea	167	30.6
Acid reflux	157	28.8
Diabetes or sugar diabetes	129	23.6
Heart trouble or heart disease	117	21.4
Post-traumatic stress disorder	116	21.2
Asthma	109	20
Severe vision problems	94	17.2
COPD, emphysema, chronic bronchitis	88	16.1
Schizophrenia, bipolar disorder, other mental illness	85	15.6
Kidney problems	61	11.2
Liver disease	57	10.4
Addiction to alcohol or drugs	50	9.2
Developmental or intellectual disability	47	8.6
Severe hearing problems	44	8.1
Dementia (such as Alzheimer's Disease)	13	2.4

Fig 1. Percent Reporting a Health-Related Problem

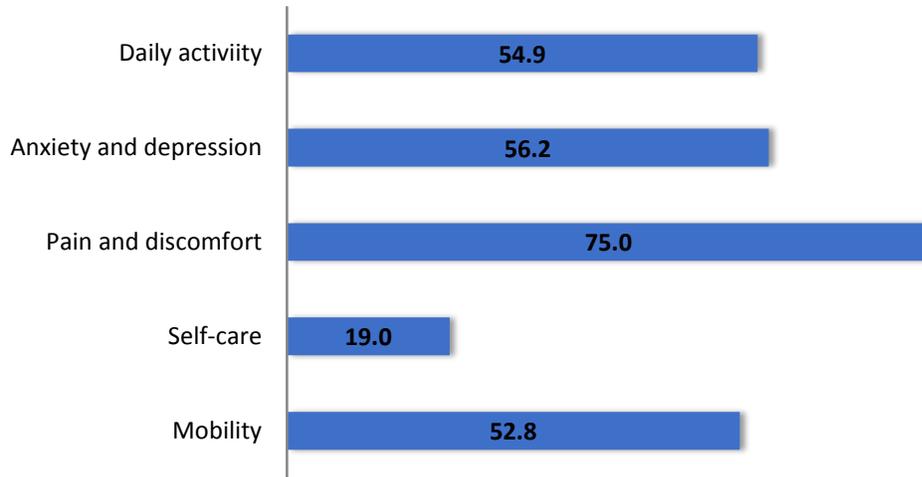
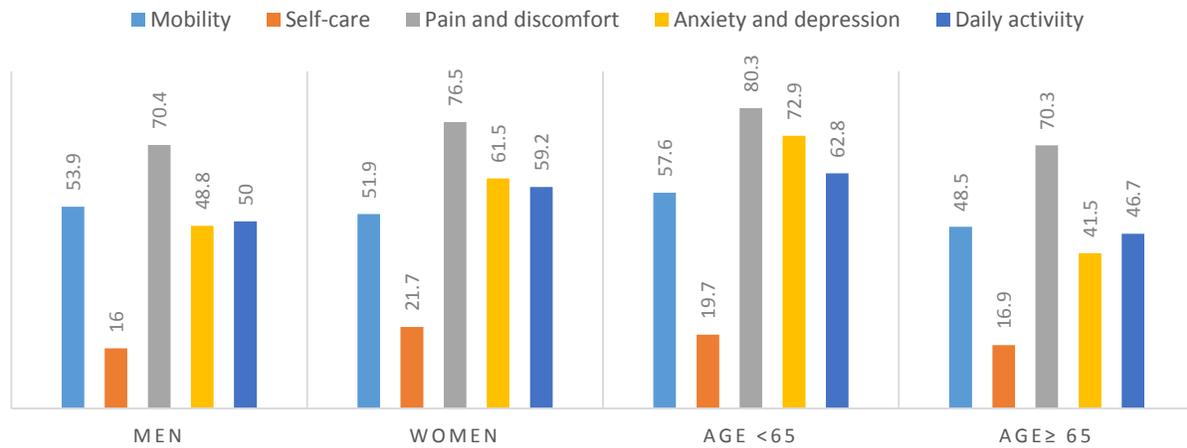


FIG. 2. PERCENT REPORTING A HEALTH-RELATED PROBLEM, BY AGE & GENDER



HEALTH-RELATED RISK FACTORS

Residents were asked about health-related risks, including those that could result in health service use, negative health outcomes, and disability.

- **63% reported problems remembering or concentrating;**
 - 24% reported that this occurs often/all the time;
- **46% had low adherence to taking medications as prescribed** (only 11% of residents reported not using prescription medicine);
 - **15% reported that they would like help taking medication;**
 - **17% reported receiving help taking medication;**
- **40% reported falling in the past year;**
 - **49% reported feeling unsteady** when walking
 - **47% worry about falling;** and
 - **32% reported a loss of some feeling in their feet.**
- **26% reported food access concerns;**
 - **19% reported hunger due to mobility issues.**

Community involvement supports health. Nearly **46%** of residents scored as having a **high level of social isolation**. More residents reported feeling a medium to high level of involvement with their building community (49.4%) compared to those who felt a medium to high level of involvement with their neighborhood community (38.7%).

Health Service Use

In the prior six months:

- **34.7% visited an emergency department (ED);**
- **50% saw a doctor at least 3 times;** and
- **17% were admitted to a hospital overnight.**

Residents who reported a mental health diagnosis were significantly more likely than those who did not to:

- have low medication adherence,
- be food insecure,
- visit a doctor in the prior six months,
- visit the emergency department in the prior 6 months, and
- have an overnight hospital stay in the prior 6 months

SUMMARY

Many residents of the 11 apartment buildings participating in the demonstration project have significant physical and mental health conditions and health-related risk factors. The project goals include increasing access to services, improving health outcomes, and reducing risk factors while decreasing health service costs, especially hospital and long-term care use.

The services package is being implemented during 2014-2015. During that time, the evaluation project includes tracking referrals and services delivered to residents and interviews with LLC partners and stakeholders. Residents will again be surveyed during the Fall of 2015 and their responses compared to the survey results described in this report.

Housing with Services, LLC, represents an experiment in coordinating and financing culturally relevant, high quality health and social services for older adults and persons with disabilities who live in subsidized housing. The project is an example of coordinated care in action, with health providers and payers working with housing- and community-based organization to coordinate care on behalf of low-income persons. The Housing with Services project is also exploring the sustainability and replicability of a model of a consortium of diverse providers with a limited liability corporation structure addressing social determinants of health.

Appendix 12

Patient-Centered Primary Care Home Program 2014 Annual Report

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The Oregon Health Authority
Patient-Centered Primary Care Home Program

2014 Annual Report

Report date: May 2015

For more information, contact:

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Patient-Centered Primary Care Home Program
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Executive Summary

Patient-Centered Primary Care Homes are health care clinics that have been recognized by the Oregon Health Authority (OHA) for their commitment to providing high quality, patient-centered care. At the heart, this model of care promotes collaborative, whole person relationships between the primary care home, community and the patients and families served. Primary care homes reduce costs and improve care by catching problems early, focusing on prevention, wellness, and managing chronic conditions.

Patient-Centered Primary Care Home Program Overview

The [Patient-Centered Primary Care Home](#) (PCPCH) Program was created by the Oregon Legislature through passage of House Bill 2009 as part of a comprehensive statewide strategy for health system transformation. The program is part of Oregon’s vision for better health, better care and lower costs for all Oregonians. The PCPCH is Oregon’s version of the “medical home” which is a model of primary care organization and delivery that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

The PCPCH Program identifies primary care homes, promotes their development, and encourages Oregonians to seek care through recognized primary care homes. In 2010, the [Oregon Health Policy Board](#), which serves as the policy-making and oversight body for the [Oregon Health Authority](#) (OHA), set three goals for the PCPCH program:

1. all OHA covered lives will receive care through a PCPCH;
2. 75% of all Oregonians have access to a PCPCH by 2015; and
3. align primary care transformation efforts by spreading the model to payers outside of the OHA.

This report is a comprehensive description of the PCPCH Program in Oregon chronicling the PCPCH model development, program operations, PCPCH characteristics, program evaluation and future direction of the program.

PCPCH Model of Care

Following the passage of HB 2009, the PCPCH Program convened a Standards Advisory Committee (committee) of Oregon stakeholders including patients, clinicians, health plans and payers to assist the OHA in developing the PCPCH model of care. The committee developed six core attributes and a number of standards that describe the care delivered by PCPCHs.

The six core attributes are as follows:

- **Accessible** – Care is available when patients need it.

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- **Accountable** - Practices take responsibility for the population and community they serve and provide quality, evidence-based care.
- **Comprehensive** - Patients get the care, information and services they need to stay healthy.
- **Continuous** - Providers know their patients and work with them to improve their health over time.
- **Coordinated** - Care is integrated and clinics help patients navigate the health care system to get the care they need in a safe and timely way.
- **Patient and Family Centered** - Individuals and families are the most important part of a patient's health care. Care should draw on a patient's strengths to set goals and communication should be culturally competent and understandable for all.

Using the framework of the core attributes and standards, the committee also developed a set of detailed PCPCH measures. All PCPCHS must meet 10 "Must Pass" measures that reflect the most essential elements of the PCPCH model.

There are three levels, or tiers, of PCPCH recognition a clinic can achieve depending on what measures of the model they have attested to implementing. With the exception of the 10 "Must Pass" measures, each measure is assigned a point value. The total points accumulated by a clinic on their application determine their overall tier level of PCPCH recognition.

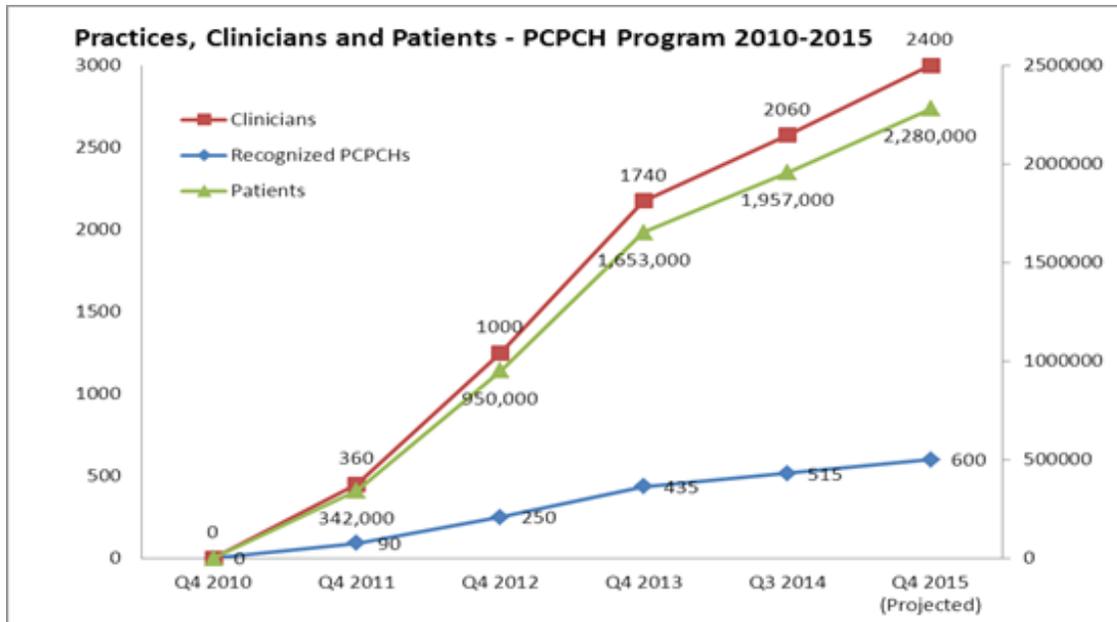
The committee reconvened in 2012 and 2013 to review PCPCH implementation progress and to refine the model to further guide primary care delivery transformation. In 2015 the committee will convene again to develop recommendations on standards for integration of primary physical health care in sites where the main focus is delivery of behavioral health care services.

PCPCH Program Achievements

Operations

- By the end of 2014, there were 538 recognized PCPCHs, representing over 50% of all eligible clinics in Oregon and serving approximately 2 million Oregonians, over half the state's population. More than 95% of clinics recognized as PCPCHs chose to reapply for recognition to maintain their PCPCH status. The following graph illustrates the current and projected growth of PCPCHs, providers, and patients in Oregon.

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(**Based on estimation of a median of 4 clinicians and a median of 3,800 patients per PCPCH.)

- The percentage of [Coordinated Care Organization](#) (CCO) members (Medicaid) receiving health care from a recognized PCPCH has increased from 51.8% in 2012 to 80.4% in 2014. The increase in enrollment of CCO members in a PCPCH has been especially dramatic in Eastern Oregon where enrollment has increased from just 3.7% to 68.6%, over the same time period.¹
- In 2012 PCPCH Program staff began conducting on-site visits to verify the clinic practice and patient experience in the practice accurately reflects the measures a clinic attested to on their PCPCH application. By the end of 2014, a total of 75 visits had been completed in 23 out of 36 counties in Oregon.
- In 2013 OHA and the [Oregon Health Leadership Council](#) (OHLC) convened a series of meetings that brought together payers and other key partners from around the state to develop consensus-based strategies to support primary care homes in Oregon. Representatives from participating organizations agreed to shared goals, objectives and key actions that support aligning payment with quality by signing a [Multi-payer Strategy to Support Primary Care Homes](#).

Program Evaluation

- Oregon implemented the PCPCH Program as part of the state's strategy to achieve the Triple Aim of improving the individual experience of care, improving population health

¹ Oregon Health Authority. (2015). Oregon's Health System Transformation: 2014 Mid-Year Report. Retrieved from <http://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx>

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management and decreasing the cost of care. A 2013 survey of PCPCH recognized clinics found that:

- 85% of practices feel that PCPCH model implementation is helping them improve the individual experience of care, and
 - 82% report progress towards improving population health management.²
- A recent study examined the change in health care service utilization and costs over time in PCPCHs compared to non-PCPCH clinics. The study found a significant increase in preventive procedures and a significant reduction in specialty office visit use and cost in the PCPCH group.³
 - PCPCH clinics demonstrated significantly higher mean scores than non-PCPCH clinics for diabetes eye exams, kidney disease monitoring in diabetics, appropriate use of antibiotics for children with pharyngitis, and well-child visits for children ages three to six years.⁴

Technical Assistance

- Practice Enhancement Specialists and Clinical Transformation Consultants (providers) working with the program are available to help PCPCH clinic staff identify needs, barriers, and areas of improvement, as well as connect them with resources to assist in their primary care transformation journey.
- Through our partnership with [Oregon Health Care Quality Corporation](#), the [Patient-Centered Primary Care Institute](#) (PCPCI) is advancing practice transformation state-wide through technical assistance opportunities and resources. In 2014 PCPCI hosted 15 webinars for over 600 participants, and worked with 24 clinics in a series of Learning Collaboratives focused on primary care home model implementation.

² Gelmon, S. B. & Trotta, R. (2013). Patient-Centered Primary Care Home (PCPCH): Report on the Results of the 2012 – 2013 Supplemental Surveys, August 2013. Portland State University. Submitted to the Oregon Health Authority.

³ Wallace, N. (2014). Patient Centered Primary Care Home (PCPCH) Evaluation: Cost and Efficiency. Portland State University. Submitted to the Oregon Health Authority.

⁴ Oregon Health Care Quality Corporation. 2013. Information for a Healthy Oregon: Statewide Report on Health Care Quality. Retrieved from http://qcorp.org/sites/qcorp/files/Information%20for%20a%20Healthy%20Oregon%20August%202013%20for%20web_1.pdf

Health Care System Transformation in Oregon

For more than two decades the State of Oregon has been on the forefront of health system transformation, and a national leader in promoting and fostering innovation rather than relying on traditional approaches to address healthcare delivery system challenges. Oregon’s broad transformation goals align with the Triple Aim of healthcare reform, as originally defined by the Institute for Healthcare Improvement (IHI)⁵: better health, better care and lower costs for all Oregonians.

The [Patient-Centered Primary Care Home \(PCPCH\) Program](#) was established by the Oregon Legislature through passage of [House Bill 2009](#) as part of a comprehensive statewide strategy for health system transformation. The program is part of Oregon’s vision for better health, better care and lower costs for all Oregonians. The PCPCH is Oregon’s version of the “medical home” which is a model of primary care organization and delivery that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

PCPCHs are an important part of healthcare transformation in Oregon, and are a foundational component of the Coordinated Care Model (CCM) Oregon has adopted as the basis for this transformation.

Key elements of the [Coordinated Care Model](#) include:

- [Best practices to manage and coordinate care](#)
- [Shared responsibility for health](#)
- [Performance is measured](#)
- [Paying for outcomes and health](#)
- [Transparency and clear information](#)
- [Maintain costs at a sustainable rate of growth](#)

The CCM has been implemented in Oregon through [Coordinated Care Organizations](#) (CCOs). CCOs are community-based organizations that include all types of health care providers who have agreed to work together in their local communities for people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs are responsible for the health outcomes of the population they serve, and emphasize primary care, disease prevention and helping people manage chronic conditions. This focus helps reduce unnecessary emergency room visits and gives Oregonians the support they need to be healthy. CCOs have the flexibility to institute their own payment and delivery reforms that achieve the best possible outcomes for their members.

As a component of this model, CCOs are required to use recognized PCPCHs for primary care delivery to the greatest extent possible in their networks. Approximately 80% of CCO members

⁵ Oregon Health Care Quality Corporation. 2013. Information for a Healthy Oregon: Statewide Report on Health Care Quality. Retrieved from http://qcorp.org/sites/qcorp/files/Information%20for%20a%20Healthy%20Oregon%20August%202013%20for%20web_1.pdf

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receive their primary care through a recognized PCPCH.⁶ The goal is that 100% of CCO members are enrolled in a Tier 3 PCPCH.⁷

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⁶ Oregon Health Authority. (2014). *Patient-centered primary care home enrollment*. Retrieved from <http://www.oregon.gov/oha/Metrics/Pages/measure-patient-centered.aspx>

⁷ Oregon Health Authority. (2014). *2015 CCO Incentive Measure Benchmarks*. Retrieved from <http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx>

PCPCH Model of Primary Care Delivery

PCPCH Model Development

Following the passage of HB 2009, the OHA convened the PCPCH Standards Advisory Committee (committee), a diverse group of Oregon stakeholders including patients, clinicians, and health plans, to advise OHA on the PCPCH model of care.

The committee was tasked with the following:

- Define of core attributes of the PCPCH to promote a reasonable level of consistency of services provided by patient-centered primary care homes
- Develop a process to identify PCPCH's that meet the core attributes defined by OHA
- Define uniform quality measures for PCPCH's that build from nationally accepted measures and allow for standard measurement of PCPCH performance
- Define uniform quality measures for acute care hospital and ambulatory services that align with the PCPCH quality measures.
- Create policies that encourage the retention of and the growth in the numbers of, primary care providers.

Over the course of seven meetings between October 2009 and January 2010 the committee developed six core attributes and a number of standards that describe the care delivered by PCPCHs. The six core attributes are Accessibility to Care, Accountability, Comprehensive Whole Person Care, Continuity, Coordination and Integration, and Person and Family Centered Care. Using the framework of the core attributes and standards, the committee also developed a set of detailed PCPCH measures. The committee reconvened in 2012 to discuss pediatric aspects of care, and in 2013 to refine the PCPCH model.

Recently behavioral and mental health care providers have expressed interest in adopting the PCPCH model of care delivery. In 2015 the committee will reconvene to discuss improving primary care and behavioral and mental health integration within the PCPCH model. Please refer to Appendix A for the PCPCH Program Timeline.

The PCPCH model framework is intended as a tool for the OHA, policymakers and other Oregon stakeholders to assess the degree to which primary care clinics are functioning as patient-centered primary care homes and promote widespread adoption of the model. A list of all PCPCH standards and measures is in Appendix B.

PCPCH Core Attributes

The PCPCH core attributes are articulated in patient-centered language to communicate the benefits of the model of care to the general public.

Core Attribute 1: Access to Care (Accessible)

Patient-Centered language: “Be there when we need you.”

Intent: Care is available when patients need it.

Core Attribute 2: Accountability (Accountable)

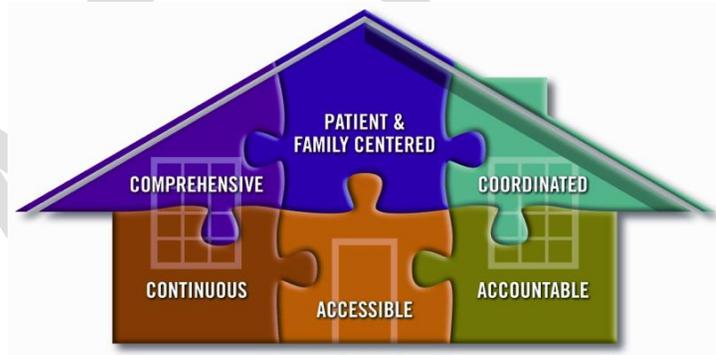
Patient-Centered language: “Take responsibility for making sure we receive the best possible health care.”

Intent: Practices take responsibility for the population and community they serve and provide quality, evidence-based care.

Core Attribute 3: Comprehensive Whole Person Care (Comprehensive)

Patient-Centered language: “Provide or help us get the health care, information, and services we need.”

Intent: Patients get the care, information and services they need to stay healthy.



Core Attribute 4: Continuous (Continuity)

Patient-Centered language: “Be our partner over time in caring for us.”

Intent: Providers know their patients and work with them to improve their health over time.

Core Attribute 5: Coordination and Integration (Coordinated)

Patient-Centered Language: “Help us navigate the health care system to get the care we need in a safe and timely way.”

Intent: Care is integrated and clinics help patients navigate the health care system to get the care they need in a safe and timely way.

Core Attribute #6: Person & Family Centered Care (Patient & Family Centered)

Patient-Centered Language: “Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness.”

Intent: Individuals and families are the most important part of a patient’s health care. Care should draw on a patient’s strengths to set goals and communication should be culturally competent and understandable for all.

PCPCH Eligibility

Any health care practice that provides comprehensive primary care and meets the core attributes can become a recognized as a PCPCH. Recognized PCPCH clinics include physical health providers, behavioral, addictions and mental health care providers, solo practitioners, group practices, community mental health centers, tribal clinics, rural health clinics, federally qualified health centers, and school-based health centers.

10 Must Pass Measures

All practices must meet 10 “Must Pass” measures to be recognized as a PCPCH. These 10 measures reflect the most essential elements of the patient-centered primary care home model.

Access to Care: Telephone and Electronic Access

Explanation: PCPCH provides continuous access to clinical advice by telephone

Intent: Access to clinical advice outside of in-person office visits is an important primary care home function associated with decreased emergency and urgent care utilization. The intent of this standard is to ensure that PCPCH patients, caregivers, and families can obtain clinical advice via telephone from a live person at all times.

Accountability: Performance and Clinical Quality

Explanation: PCPCH tracks one quality metric from the core or menu set of PCPCH Quality Measures.

Intent: Measuring and improving on clinical quality is a foundational element of primary care homes. The intent of this measure is to demonstrate that primary care homes have the capacity to monitor clinical quality data and improve their performance where appropriate.

Comprehensive Whole-Person Care: Medical Services

Explanation: PCPCH reports that it routinely offers all of the following categories of services: Acute care for minor illnesses and injuries; ongoing management of chronic diseases including coordination of care; Office-based procedures and diagnostic tests; Patient education and self-management support.

Intent: Acute and chronic medical care for common problems is a core component of primary health care. The intent of this standard is to ensure that primary care homes are routinely providing access to both acute and chronic medical care for all of their patients.

Comprehensive Whole-Person Care: Mental Health, Substance Abuse, & Developmental Services

Explanation: PCPCH has a screening strategy for mental health, substance use, or developmental conditions and documents on-site and local referral resources.

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Intent: Assessment and appropriate intervention for mental health, substance use and developmental, behavioral or social delays is a core component of primary health care. The evidence is clear that coordination and integration of care for individuals with mental health, substance use, or developmental conditions is strongly associated with improved health outcomes in these populations. The intent of this standard is to ensure that primary care homes are routinely assessing their patients for these issues, and providing appropriate treatment, referral and care coordination for these conditions.

Continuity: Personal Clinician Assigned

Explanation: PCPCH reports the percentage of active patients assigned to a personal clinician or team.

Intent: Interpersonal continuity of care is a core component of primary care, and is associated with improved health care outcomes and patient experience. The intent of this standard is to ensure that primary care homes are able to monitor and measure whether patients are assigned to a personal clinician or health care team. Primary care homes should seek to promote patients' relationships with their personal clinician and health care team.

Continuity: Personal Clinician Continuity

Explanation: PCPCH reports the percent of patient visits with assigned clinician or team.

Intent: Continuity of care is a core component of primary care, and is associated with improved health care outcomes and patient experience. The intent of this standard is to ensure that primary care homes can measure and improve patients' continuity with an assigned personal clinician or health care team.

Continuity: Organization of Clinical Information

Explanation: PCPCH maintains a health record for each patient that contains at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record; and updates this record as needed at each visit.

Intent: Primary care homes must maintain comprehensive and up-to-date patient records that are easily transmissible to other clinicians and facilities as patients move throughout the health care system. Maintaining a health record with up-to-date information is an essential pre-requisite to managing safe transitions of care between health care providers.

Continuity: Specialized Care Setting Transitions

Explanation: PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care.

Intent: Care coordination and communication during care transitions is an important aspect of patient safety, especially between inpatient and outpatient care settings. Primary care homes should take responsibility for facilitating appropriate transitions of care by developing working relationships with their usual providers of hospital care. PCPCHs that have clinicians providing their own hospital care do not need to have a written agreement in place.

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Coordination and Integration: End of Life Planning

Explanation: PCPCH demonstrates a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services.

Intent: Arranging for culturally appropriate end-of-life and palliative care is an important aspect of care coordination for patients, caregivers, and families. This standard is intended to ensure that primary care homes engage their patients, caregivers, and families in end of life discussions, routinely assess patients need and eligibility for hospice or palliative care when appropriate, and refer patients for these services or coordinate services within the clinic.

Person and Family Centered Care: Language/Cultural Interpretation

Explanation: PCPCH offers and/or uses either providers who speak a patient and family’s language at time of service in-person or telephonic trained interpreters to communicate with patients and families in their language of choice.

Intent: Cultural and linguistic proficiency is a core component of person and family-centered care. The intent of this measure is to ensure that primary care homes communicate with patients, caregivers, and families in their language of choice using trained medical interpreters.

Tier Structure

There are three levels, or tiers, of PCPCH recognition a clinic can achieve depending on what measures of the model they have attested to implementing. With the exception of the 10 “Must Pass” measures, each measure is assigned a point value. Must Pass and 5 point measures focus on foundational PCPCH elements that should be achievable by most clinics in Oregon with significant effort, but without significant financial outlay. Measures worth 10 or 15 points reflect intermediate and advanced functions. The total points accumulated by a clinic on their application determine their overall tier level of PCPCH recognition.

Tier 3

- 130+ points and all must pass standards
- 88% of PCPCHs are Tier 3

Tier 2

- 65-125 points and all must pass standards
- 11% of PCPCHs are Tier 2

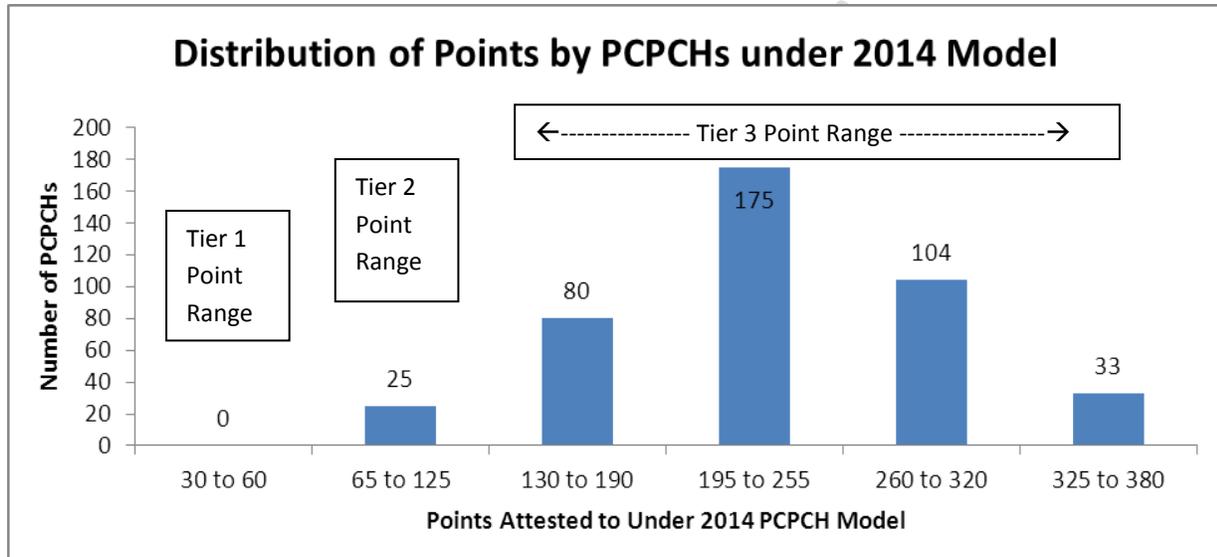
Tier 1

- 30-60 points and all must pass standards
- 1% of PCPCHs are Tier 1

Within the PCPCH model clinics can implement measures that are tailored to best serve the needs of their patient population and their practice transformation goals. The most and least common measures PCPCHs have attested to implementing are listed in Appendix D.

Point Values

There is variation in the total points a clinic can accumulate in the PCPCH model. Practices must attest to a minimum 30 points to become recognized as Tier 1 PCPCH. Under the 2014 PCPCH model the lowest number of points attested to by a practice is 65, with a maximum number of 380 points possible. The figure below illustrates the distribution of points earned by practices under the 2014 PCPCH model.



PCPCH Program Functions

In 2010, the [Oregon Health Policy Board](#), which serves as the policy-making and oversight body for the OHA, set three goals for the PCPCH program: 1) all OHA covered lives will receive care through a PCPCH, 2) by 2015 75% of all Oregonians have access to a PCPCH, 3) and align primary care transformation efforts by spreading the model to payers outside of the OHA. The PCPCH Program functions support the achievement of these goals.

Practice Recognition

PCPCH recognition is a voluntary attestation process, and practices are charged no fees to participate. Prior to applying for recognition practices are encouraged to review [The Patient-Centered Primary Care Home 2014 Recognition Criteria Technical Assistance and Reporting Guide](#) which contains details about the program and specifications for the PCPCH standards. It is also recommended practices complete the [Self-Assessment Tool](#) to determine which standards their clinic can attest to before completing the online application.

Recognized practices must submit a renewal application every two years if they want to maintain their PCPCH recognition status. In addition, practices are permitted to reapply once every six months if they have implemented additional PCPCH measures that result in an increased tier level or overall total points score.

The PCPCH Program began accepting applications from practices in September 2011, and by 2012 there were 90 recognized PCPCHs in Oregon. To date, there nearly 550 recognized PCPCHs in Oregon. Please refer to Appendix A for the PCPCH Program Timeline.

For more information about the PCPCH recognition process, visit www.PrimaryCareHome.oregon.gov.

PCPCH Standards Refinement

The PCPCH Standards Advisory Committee (committee) provides the OHA with policy and technical expertise for the PCPCH model of care. The committee convenes periodically to review PCPCH implementation progress and to advise on refining the model to further guide primary care delivery transformation. The intention of this work is incrementally adapt the PCPCH model to the changing health care needs of Oregonians, align the model with the best evidence where it was available, and to improve the effectiveness of the standards and measures overall. For more information about the committee, please see www.oregon.gov/oha/pcpch/Pages/committee.aspx. A list of past committee members can be found in Appendix C.

Technical Assistance and Resource Development

PCPCH Program Technical Assistance

The PCPCH Program provides technical assistance to providers and practice staff as they navigate primary care transformation around the primary care home model.

There are two Practice Enhancement Specialists (PES) on the PCPCH Program staff to provide guidance and general practice coaching to clinics implementing the PCPCH model. PCPCH Program staff are available to assist clinics with their attestation and provide guidance during the application process as well.

PCPCHs also receive support and assistance through the verification site visit process. The purpose of the site visit is to verify that the clinic practice and patient experience in the practice accurately reflects the standards and measures the clinic attested to on their PCPCH application. During and after a site visit, PCPCH Program PES help clinic staff identify needs, barriers, and areas of improvement, as well as connect them with resources to assist in their primary care transformation journey. Resources are tailored to a clinic's specific needs; some examples include practice management tools, printed materials, or connecting clinic staff with others who have successfully implemented the PCPCH model. For more information see the Verification of Standards and Measures section of this report.

Patient-Centered Primary Care Institute

In 2012 the Oregon Health Authority developed a public-private partnership with the [Oregon Health Care Quality Corporation](#) and the [Northwest Health Foundation](#) and founded the [Patient-Centered Primary Care Institute \(PCPCI\)](#). The Institute partners with technical assistance organizations and content experts to support PCPCHs in their transformation efforts.

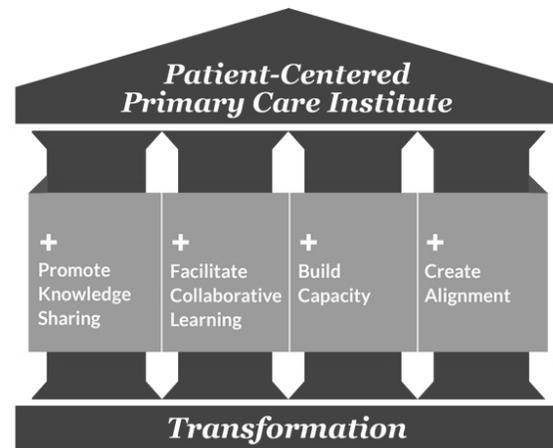


The mission of the PCPCI is built on four foundational pillars of practice change:

- 1. Promote Knowledge Sharing** through PCPCI's website that serves as a hub of information, announcements, news, and resources.
- 2. Facilitate Collaborative Learning** by partnering practices with technical assistance experts who lead face-to-face learning sessions, offer at-the-elbow coaching, and provide a space for practice participants to receive and offer peer-to-peer support. In the past two years, PCPCI has provided in-person training opportunities and practice coaching to more than 80 primary care practices in Oregon.

3. Build Capacity by offering avenues for transformation champions to collaborate, deploy resources collectively and improve the overall quality of the information and services available to primary care practices.

4. Create Alignment across efforts to improve primary care by identifying synergies, gaps, duplications and challenges, and connecting people to one another.



Patient-Centered Primary Care Institute Activities

Webinars

In 2014 the PCPCI hosted 15 webinars with nearly 600 attendees. Past webinar topics include:

- Engage, Collect, Partner: How to Use Patient Experience of Care Surveys in Your Practice
- Empanelment: What Do You Do After Every Patient Has an Assigned Care Team?
- Brief Intervention Skills for Primary Care Clinicians and Behavioral Health Consultants in the Primary Care Behavioral Health (PCBH) Model
- Coming Out of the Shadows: Addressing Substance Use in Primary Care
- National Health Service Corps and Other Programs - Tools to Support Providers and Expand Oregon's Health Care Workforce
- Patient-Centered Primary Care Home Program Overview
- PCPCH Site Visits: What to Expect
- Scrubbing and Huddling
- Strategies for Rural, Small Independent Practices
- Enhancing Adolescent Well-Visits
- Collaborating for Health: Motivational Interviewing in Primary Care
- Trauma-Informed Care in Primary Care Settings
- Clinician Wellness: Building Resiliency in the Primary Care Home Team

Learning Collaborative

Currently, 24 practices are participating in a series of Learning collaboratives, each one facilitated by technical assistance (TA) partners across the state. The practices are receiving in-person training, technical assistance and practice coaching to support adoption of the PCPCH model.

Each Collaborative TA partner works with six practices around foundational elements of practice transformation, such as quality improvement, and integrates these elements around a specific aspect of the primary care medical home:

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- **Improving Patient Experience of Care (2 learning sessions)** 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 PCPCH standards. This Collaborative includes fielding of the Clinician and Group CAHPS PCMH survey.
- **Improving Access through PCPCH** focuses on understanding a practice’s supply and demand and how to move to an “open access” scheduling model. This Collaborative is tailored to support the practices particular access needs around absorbing many new patients, creating more same-day capacity, reducing backlog, and utilizing all team members in non-face-to-face visits. This Collaborative also provides an opportunity for practices to designate a “practice coach in training,” which can be ideal for multi-site practices interested in sharing learnings across sites.
- **The Patient-Centered Communication Skills, Behaviors and Attitudes** collaborative has worked on embedding the spirit of patient-centered communication in a practice’s organizational culture, identifying ways to measure patient-centeredness, mastery of basic patient-centered office skills, cultural agility, health literacy and self-management support.
- Past Learning Collaborative goals include:
 - Increasing screenings and vaccination rates among targeted populations;
 - Enhancing care for patients with certain conditions, including building registries, proactively managing patients and activating reminders for patients who are due for check-ups;
 - Improving patient access to care by offering same day appointments, and decreasing deferred acute care and emergency visits;
 - Decreasing nurse triage time to increase nurse availability to provide proactive care management;
 - Ensuring that 75% of patients discharged from the hospital have a care coordination phone call, medication reconciliation, and allergy reconciliation; ensure those patients are offered an appointment with their physician in seven days; and
 - Receiving real-time reports and discharge summaries from local hospitals when clinic patients go to the emergency department or are admitted.

Practice Facilitation

Along with the current Learning Collaboratives, 15 practices that participated in the 2013 Learning Collaborative are continuing to collaborate with the PCPCI and utilize practice facilitation support from technical assistance (TA) partners across the state around planning and implementing PCPCH and quality improvement (QI) related efforts. The practices receive coaching and support through email, phone and in-person visits from an assigned practice coach. These practices have agreed to set at least two quality or process improvement goals and report progress towards these goals.

Communication and Provider Engagement

The PCPCH Program supports and engages health care providers and staff during their practice's primary care transformation through various communication methods. PCPCH Program staff answer questions, provide guidance, and communicate regularly with providers and other stakeholders through email at PCPCH@state.or.us and by telephone. In 2014 the program launched a monthly email newsletter featuring updates, links to relevant national and state research, technical assistance resources, and other useful information for health care providers and their staff. The newsletter is distributed to over 2,500 subscribers to the [PCPCH Program listserv](#). Any individual interested in primary care transformation in Oregon can subscribe to the newsletter.

The PCPCH Program website www.PrimaryCareHome.Oregon.gov was revised with expanded content on the site visit verification process, technical assistance, evaluation reports, and profiles of recognized PCPCHs. The website serves as a primary source of information for stakeholders and includes tailored content for patients, providers, policy makers, health plans, and the general public. In addition, a PCPCH Facebook page was created for those interested in engaging through social media.

In 2014 PCPCH Program staff began conducting outreach to the more than 400 practices in Oregon that are not currently recognized as a PCPCH. Seventy-six practices were recognized as PCPCH for the first time, and more than 30 practices whose PCPCH recognition had lapsed became re-recognized during the past year.

Aligning Payment with Quality

The OHA is working with public and commercial payers across Oregon to pursue innovative payment methods that move us toward a health care system that rewards quality, patient-centered care. This work supports the PCPCH Program goal of spreading the PCPCH model to payers outside of the OHA.

Multi-payer Strategy to Support Primary Care Homes

From July to September 2013 OHA and the [Oregon Health Leadership Council](#) (OHLC) convened a series of meetings that brought together payers and other key partners from around the state to develop consensus-based strategies to support primary care homes in Oregon.

Representatives from participating organizations agreed to shared goals, objectives and key actions that support aligning payment with quality by signing a [Multi-payer Strategy to Support Primary Care Homes](#). Key joint actions agreed to in this strategy include:

- All Oregon payers will use a common definition of primary care home based on OHA's PCPCH Program;
- Payers will provide variable payments, or other payment models, to those primary care practices in their network participating in OHA's PCPCH Program, based on each

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practice's PCPCH points total and their progress toward achieving outcomes which lead to the Triple Aim. The structure, qualifications, and amount of these payments will be the responsibility of each payer to determine or negotiate with practices in their network; and

- OHA's PCPCH Program will build in practice accountability for progress toward transformation. They will work with payers and practices to identify and agree on a common set of meaningful outcome metrics, consistent with those already in place for Oregon providers, as well as reporting formats and administrative processes that simplify the administrative burden on practices.

Public Employees' Benefit Board

The [Public Employee's Benefit Board](#) (PEBB) provides an age-adjusted, per-member-per-month incentive payments to Tier 2 or Tier 3 recognized primary care homes in the PEBB Statewide plan administered by [Providence Health & Services](#). In addition, PEBB members in the PEBB Statewide plan have lower cost share for primary care services when they access care through a recognized primary care home—from 10 to 15 percent.

Coordinated Care Organizations

Several CCOs offer incentive payments for recognized PCPCHs. Incentive payment amounts and structure vary by CCO.

Verification of Standards and Measures

On-Site Verification Visits

PCPCH recognition is based on a self-attestation model with a relatively low administrative burden for clinics. This approach has likely contributed to robust participation in the program; greater than 50% of primary care clinics in Oregon are recognized as a PCPCH.

The fidelity of a self-attestation model relies on a strong verification procedure. Therefore, PCPCH Program staff conduct on-site visits to recognized primary care homes across the state. The purpose of the on-site verification visit is threefold:

1. **Verification** that the clinic practice and patient experience accurately reflects the standards and measures attested to when the clinic was recognized as a PCPCH;
2. **Assessment** of the care delivery and team transformation process in the clinic to understand how the intent of the patient-centered model of care is integrated into the services the primary care home provides; and
3. **Collaboration** to identify clinic needs, barriers to implementation and areas of improvement needed to help practices successfully implement PCPCH standards. The site visit team helps practices establish improvement plans, and connects practices with technical assistance through resources including the Patient-Centered Primary Care Institute.

The PCPCH Program staff began conducting site visits in 2012. By the end of 2014, 75 on-site verification visits had been completed in 23 of out 36 counties in Oregon. Approximately 15% of recognized PCPCHs have had a site visit at their clinic.

PCPCH Site Visit Team

There are two PCPCH site visit teams conducting on-site verification visits at clinics across the state. Each team is comprised of a Compliance Specialist, a Practice Enhancement Specialist, and a Clinical Transformation Consultant. Team members have extensive experience in practice transformation and implementation of primary care home standards.

Compliance Specialist

The Compliance Specialist (CS) is the primary contact for the clinic before the site visit, and assists the clinics with scheduling and preparing for the site visit. The role of the CS is to review documentation to verify the clinic is meeting the standards attested to in its PCPCH application. During the site visit the CS interviews front office staff, quality improvement teams and clinic leadership. The CS also conducts a chart review with a clinician or other clinic staff member.

Practice Enhancement Specialist

The role of the Practice Enhancement Specialists (PES) is to observe and verify the functionality of attested to PCPCH standards during the site visit, and provide technical assistance to the clinic. The PES disseminates tools and strategies for clinical transformation to the PCPCH and serves as a practice coach for up to six months following the site visit.

Clinical Transformation Consultant

The Clinical Transformation Consultant (CTC) is a provider with extensive experience in practice transformation and the primary care home model. The CTC provides a clinical and quality improvement based perspective on PCPCH transformation. Having a CTC participate in the on-site verification visit provides clinicians the opportunity to learn from a peer how to overcome barriers and foster progress in transforming their practices. The CTC is available to assist the clinic for up to six months following the site visit.

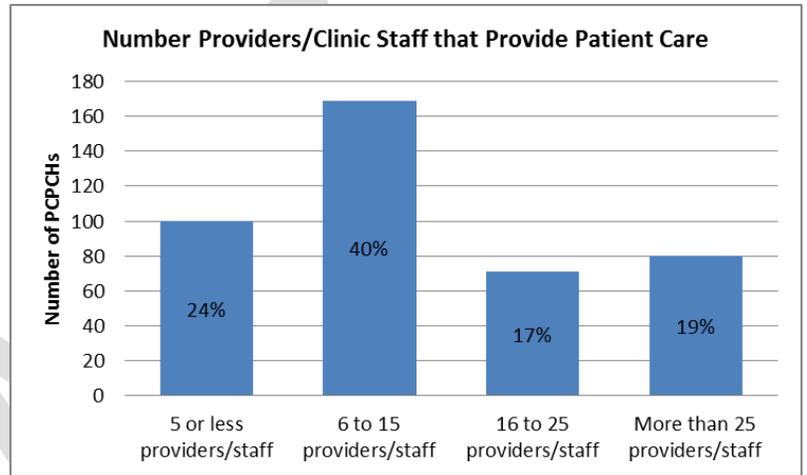
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Characteristics PCPCHs across Oregon

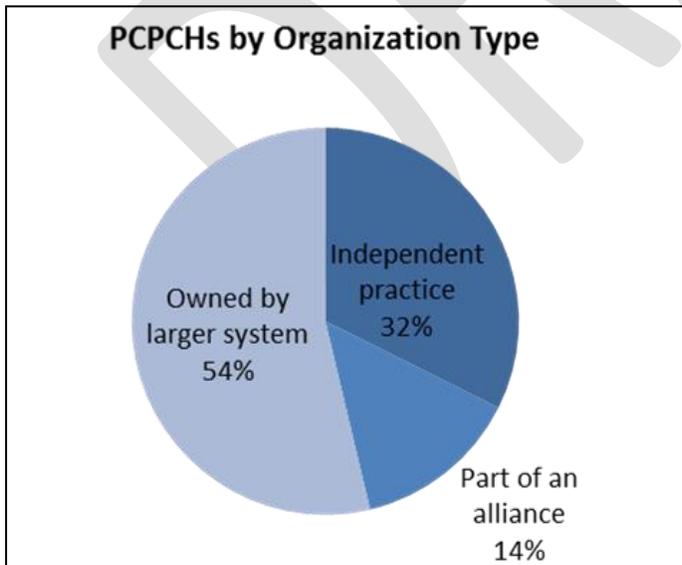
By the end of 2014, 538 practices were recognized PCPCHs across the state. Approximately 15% of PCPCHs became recognized by OHA for the first time in 2014. PCPCHs are diverse and vary by size, organizational structure, geography, and clinic type.

Size

Recognized PCPCHs range in size from practices with only one provider to practices with over 200 providers and clinical staff. The average number of providers and clinical staff in a PCPCH is 19, and 24% of PCPCHs have 5 or less providers or staff that provides direct patient care.⁸



Organizational Structure



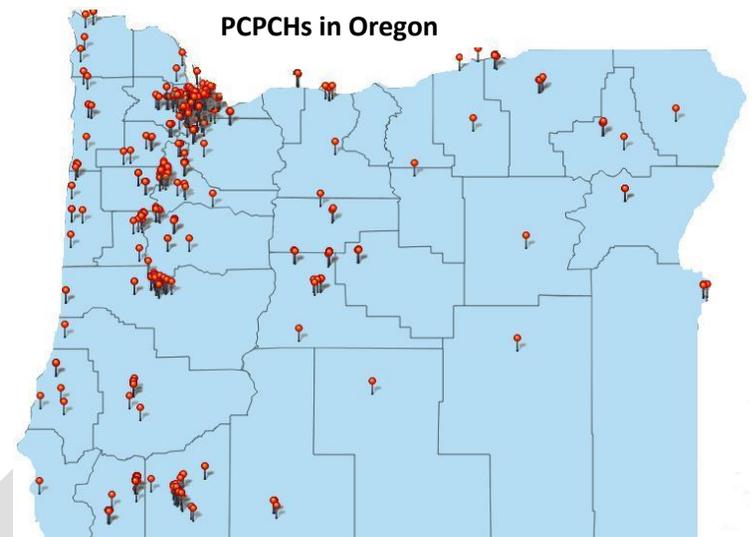
Approximately one-third of PCPCHs identify as being independent and unaffiliated with any other practice or larger organization and more than half identify as being owned by a larger system that governs the practice. 14% identify as having independent governance but are part of an alliance such as an Independent Practice Association (IPA) for shared group purchasing or other economies of scale.⁹

⁸ PCPCH application data self-reported by practices

⁹ PCPCH application data self-reported by practices

Geography

Currently PCPCHs are located in 34 of Oregon’s 36 counties; the goal is to have PCPCHs in all counties by the end of 2015. The spread of PCPCHs across the state has had significant impact on primary care delivery. The percentage of CCO members receiving health care from a recognized PCPCH has increased from 51.8% in 2012 to 80.4% in 2014. The increase in enrollment has been especially dramatic in Eastern Oregon where it increased from just 3.7% of CCO members enrolled in a PCPCH to 68.6% of CCO members enrolled in a PCPCH.¹⁰



The geographic distribution of PCPCHs is as follows:

- **35% Rural PCPCHs:** Communities 10 miles from a population center of a population of at least 40,000 people
- **26% Urban Small PCPCHs:** Urbanized areas with population between 40,000-100,000 people
- **18% Urban Medium PCPCHs:** Urbanized areas with population between 100,000-200,000 people
- **21% Urban Large PCPCHs:** Urbanized areas with population greater than 200,000 people¹¹

¹⁰ Oregon Health Authority. (2015). Oregon’s Health System Transformation: 2014 Mid-Year Report. Retrieved from <http://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx>

¹¹ Gelmon, S. B. & Trotta, R. (2013). Patient-Centered Primary Care Home (PCPCH): Report on the Results of the 2012 – 2013 Supplemental Surveys, August 2013. Portland State University. Submitted to the Oregon Health Authority.

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Clinic Type

The PCPCH Program recognizes a variety of clinic types including family medicine, pediatric-focused, internal medicine, Community Health Centers (CHC), Federally Qualified Health Centers (FQHC), School-Based Health Centers (SBHC) and clinics focused on naturopathic care. The table below lists PCPCHs by clinic type.¹²

PCPCHs by Clinic Type	# of PCPCHs	% of PCPCHs
Family Medicine	284	68%
Pediatric and/or Adolescent Clinic	108	26%
Internal Medicine	105	25%
Federally Qualified Health Center	67	16%
Women's Health Clinic	44	11%
Community Health Center	43	10%
Rural Health Center (designated)	28	7%
Behavioral/Mental Health Clinic with integrated primary care	30	7%
School Based Health Center	21	5%
Residency Training Clinic	21	5%
Solo Private Practice	17	4%
Other	12	3%
Native American or Indian Health Clinic	4	1%
Naturopathic Clinic	3	1%
Military or Veteran's Administration Clinic	0	0%
Note: Will not total 100% because clinics can select more than 1 clinic type		

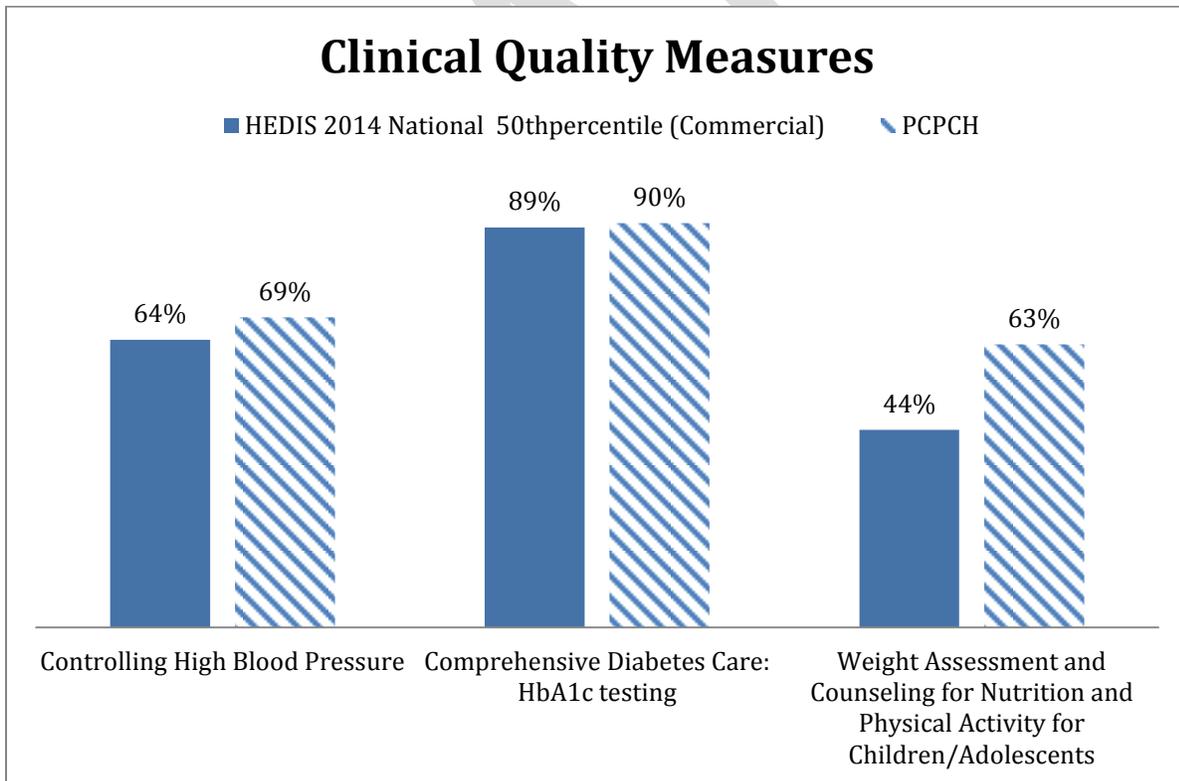
¹² PCPCH application data self-reported by practices

Program Evaluation

The PCPCH Program conducts evaluations to assess the effectiveness of the program. A variety of program components have been evaluated to provide a comprehensive analysis. Both PCPCH Program staff and contracted organizations have completed evaluations. Results are used to identify areas of development and improvement of the program’s implementation of the PCPCH model.

Clinical Quality Measures

A measure in the PCPCH model requires practices to track at least one quality metric from a menu of PCPCH quality metrics listed in the [2014 PCPCH Recognition Criteria Technical Specifications and Reporting Guide](#) (TA Guide). Practices implementing more advanced measures of the PCPCH model report their clinic’s performance on a tracked quality metric to the PCPCH Program and meet benchmarks set for that metric. The self-reported PCPCH performance on select tracked quality metrics is shown below. Compared to national [HEDIS](#) thresholds, PCPCHs performed better on average on several clinical quality measures.



The PCPCH data are self-reported on the PCPCH recognition application for Standard 2.A – Performance and Clinical Quality. Region 10 includes Alaska, Oregon, Idaho and Washington.

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In 2013 the Oregon Health Care Quality Corporation (Q-Corp) published the Statewide Report on Healthcare Quality.¹³ This report found recognized PCPCHs achieved significantly higher scores than non-recognized clinics on several measures of care. The measures are listed in the table below.

Measure	Mean PCPCH Clinic Score (n)	Mean Non-PCPCH Clinic Score (n)	Percent Difference	p-value
Chlamydia Screening	42.9% (175)	38.7% (130)	+10.9	0.011
Diabetes Eye Exam	62.4% (210)	59.9% (199)	+4.2	0.030
Diabetes Kidney Disease Monitoring	80.4% (210)	76.5 (199)	+5.1	<0.001
Appropriate Use of Antibiotics for Children with Sore Throats	83.4% (58)	75.0% (47)	+11.2	0.030
Well Child Visits in the 3rd, 4th, 5th and 6th Years of Life	63.3% (148)	55.3% (152)	+14.5%	<0.001

Oregon Health Care Quality Corporation. (2013). *Information for a Healthy Oregon: Statewide Report on Health Care Quality.*

Surveys of Recognized PCPCHs

The PCPCH Program contracted with [Portland State University](http://portlandstate.edu) to conduct a survey of staff and providers at PCPCHs.¹⁴ The online survey was distributed in August 2012 to the 205 PCPCHs and to an additional 368 PCPCHs in May 2013. The surveys collected information to supplement what clinics reported on their PCPCH application. Respondents were asked about practice size, geographic distribution, populations served, services provided, and organizational structure. The survey also asked questions based on the six core attributes of the PCPCH model as principles of the Triple Aim. Data collected from the survey were self-reported. In 2014 the

¹³ Oregon Health Care Quality Corporation. 2013. Information for a Healthy Oregon: Statewide Report on Health Care Quality. Retrieved from http://q-corp.org/sites/qcorp/files/Information%20for%20a%20Healthy%20Oregon%20August%202013%20for%20web_1.pdf

¹⁴ Gelmon, S. B. & Trotta, R. (2013). Patient-Centered Primary Care Home (PCPCH): Report on the Results of the 2012 – 2013 Supplemental Surveys, August 2013. Portland State University. Submitted to the Oregon Health Authority.

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PCPCH application system was revised to include questions about clinic characteristics for future data analysis.

Survey Findings by Core Attribute

- **Access to Care** – Nearly all practices administer a patient satisfaction survey (94%) but less than two-thirds share the results with their staff, patients or governing board. The majority of practices track access measures such as the third next available appointment and percent of no-show appointments. Almost all practices offer same-day appointments and allocate certain number of appointment slots per day for same-day appointments for patients.
- **Accountability** – 90% of practices have a quality improvement team. Of those practices, 96% use clinical quality data to systematically improve their practice and provide feedback to providers about clinical quality measures. Less than 15% of practices reported sharing their performance data with patients.
- **Comprehensive Whole Person Care** – Approximately two-thirds of practices report that primary care and behavioral health providers generally work together within their practice.
- **Continuity** – Over half of practices are notified when one of their patients is admitted or discharged from their usual hospital providers. Smaller practices reported they were less likely to be notified when their patients were admitted to or discharged from the hospital.
- **Coordination and Integration** – Nearly all practices use an Electronic Health Record (EHR) and have a system in place to track certain diagnoses, risk factors, and conditions that are clinically important to their patient population.
- **Person and Family Centered Care** – A majority of practices offer formal training programs to staff to improve their skills in cultural competence and patient communication.

Additional Findings

- **Achieving the Triple Aim**
 - 85% of practices report that PCPCH implementation is helping them to achieve the aim of improving the individual experience of care.
 - 82% report progress towards improving population health management.
 - Less than half reported that the implementation of the model helped them decrease the cost of care.
- **Additional Services**
 - Over 80% of practices reported adding at least one service during implementation of the PCPCH model. For example, services such as adding a care management team, sending reminders for preventive services, or implementing a process for tracking patients admitted or discharged from hospital.
- **Influencing the Decision to Become a PCPCH**

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- The two most important factors for practices in influencing their decision to become a PCPCH were the opportunity to improve patient care and eligibility for enhanced payment.
- Improved marketability and encouragement from Coordinated Care Organizations (CCOs) or other payers were not identified as key factors to this decision.
- **Barriers**
 - Cost and lack of resources were the most commonly identified barriers to PCPCH implementation. Other barriers reported by respondents included:
 - Staffing and training
 - Limited time
 - Administrative burden and reporting requirements
- **Technical Assistance**
 - 49% of respondents in the first survey and 32% of respondents in the second survey indicated that they currently participate in some formal education, training or technical assistance focused on building knowledge and skills related to implementing the PCPCH standards.
 - More than 50% of providers surveyed identified a need for additional training on the following topics:
 - Patient and family engagement and communication
 - Behavioral health integration
 - Complex care management
 - Comprehensive care planning
 - Care coordination

Cost and Efficiency

There is an increasing amount of evidence supporting the benefits of patient-centered medical homes including better patient experience,¹⁵ prevention and disease management,¹⁶ lower costs from reduced emergency department visits and hospital admissions and decreased provider burnout.¹⁷

Building on this evidence, [Portland State University](#) conducted research for the PCPCH Program that evaluated cost and efficiency.¹⁸ The evaluation assessed the effects of PCPCH designation on the service utilization patterns and expenditures among early adopters of the PCPCH model in Oregon.

¹⁵ Kern LM et al. (2013). Patient experience over time in patient-centered medical homes. *American Journal of Managed Care*, 19,5. P. 403-10.

¹⁶ Ferrante, JM, et al. (2010). Principles of the Patient-Centered Medical Home and Preventive Services Delivery. *Annals of Family Medicine*, 8,2. p.108–116.

¹⁷ Reid, RJ, et al. (2010). The Group Health Medical Home At Year Two: Cost Savings, Higher Patient Satisfaction, And Less Burnout For Providers. *Health Affairs*, 29. p. 5835-843

¹⁸ Wallace, N. (2014). Patient Centered Primary Care Home (PCPCH) Evaluation: Cost and Efficiency. Portland State University. Submitted to the Oregon Health Authority.

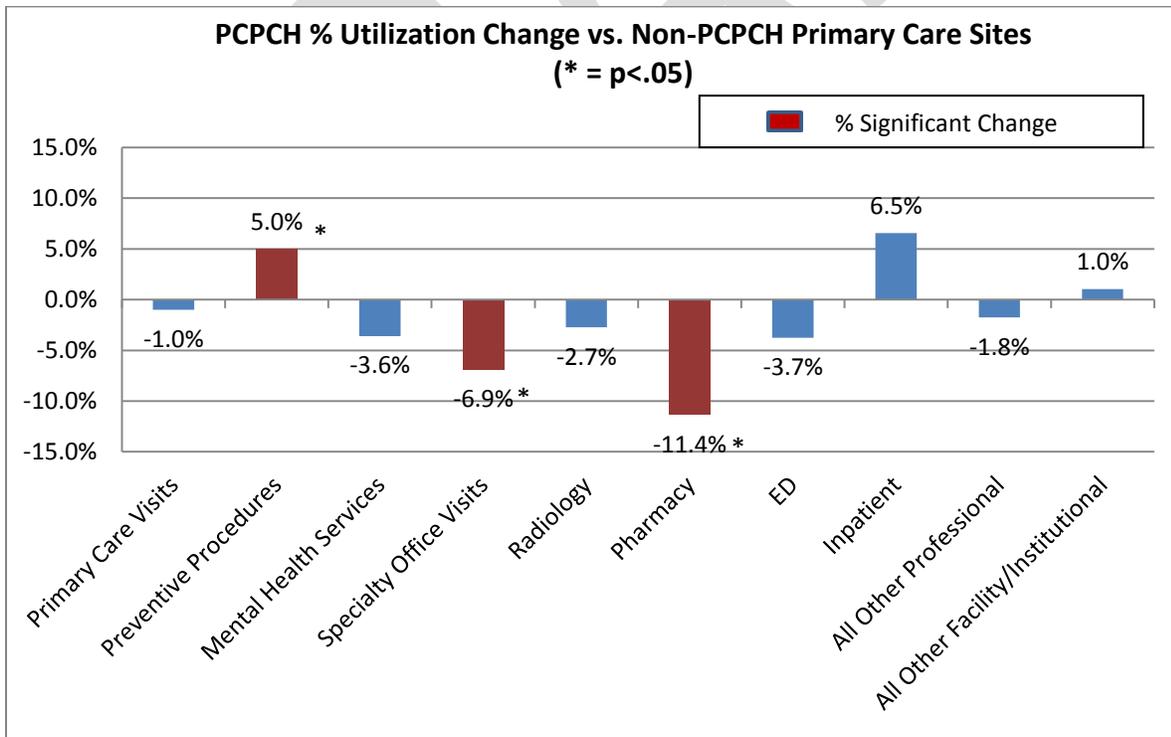
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The intent of this evaluation was to identify whether service use patterns and expenditures changed for patients served in PCPCHs compared to non-PCPCH practices. Using [Oregon's All-Payers-All Claims](#) (APAC) database, researchers calculated change in utilization and expenditures among patients receiving primary care at the clinic level during two time periods: October 2010 through September 2011 (pre-PCPCH recognition) and January 2012 through December 2012 (post-PCPCH recognition). These changes in PCPCHs were compared to changes in non-PCPCHs in the same time period. The difference in these pre-post changes is the estimated net effect of PCPCH designation on patient utilization and expenditure.

The findings indicate that preventive care procedures increased and specialty care visits decreased in PCPCH practices compared to non-PCPCH practices. These findings are consistent with the expectations of the PCPCH model that PCPCHs should emphasize primary care utilization over specialty care when appropriate.

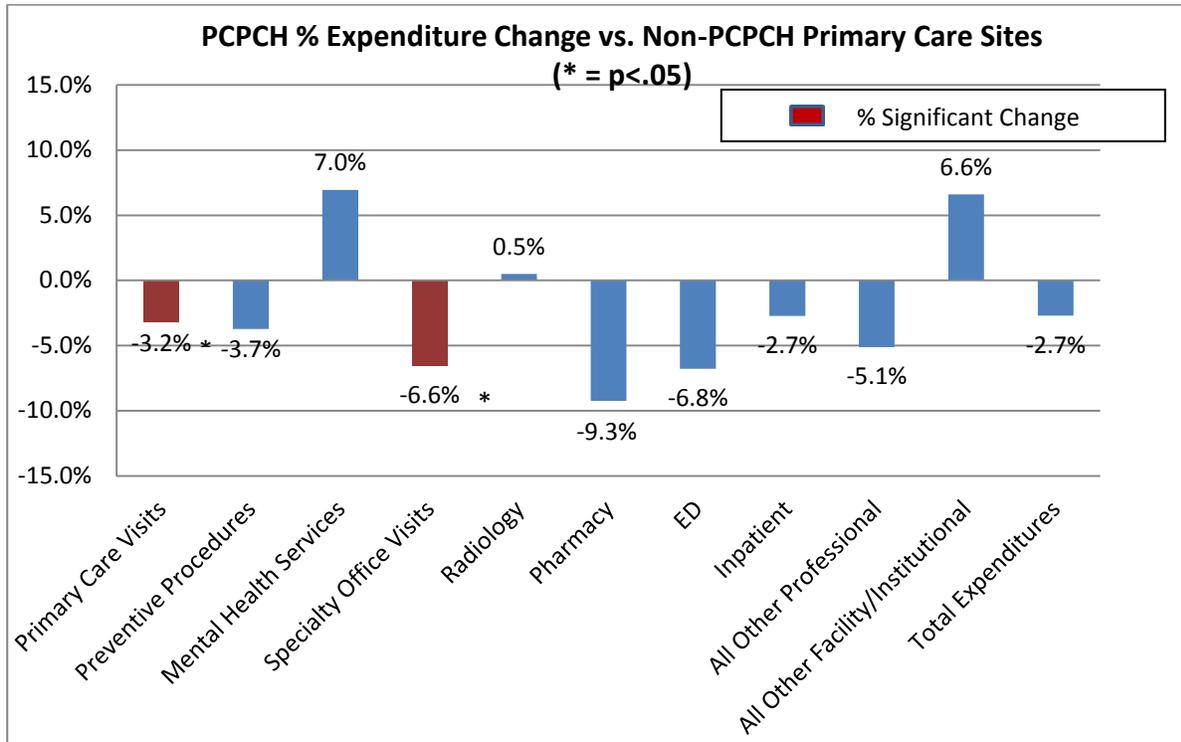
Utilization

In the first year following PCPCH recognition, PCPCHs had a statistically significant net increase in preventive procedures (5% increase) and statistically significant net reductions in specialty visits (6.9% decrease) compared to non-PCPCH practices. Pharmacy claims significantly decreased by 11.4% in PCPCH practices relative to non-PCPCH practices.



Expenditures

After the first year of being recognized as a PCPCH, primary care visit expenditures decreased significantly by 3.2% compared to non-PCPCH practices. Specialty office visit expenditures decreased significantly by 6.6% compared to non-PCPCH practices. Other important outcomes, such as reduced ED and inpatient use or reduced overall expenditures, while generally trending in the expected direction were not statistically significant. It is important to note that these are promising findings given the short time frame.



Implementation of the PCPCH Model

In May and June of 2013, researchers at Portland State University conducted 23 in-depth interviews with key stakeholders. The goal was to determine the factors that facilitated or impeded the development and implementation of the PCPCH model. After the interviews, members of the research team reviewed the responses to identify key themes among the participants interviewed.¹⁹

Summary of Key Findings: Implementation of PCPCH Model

1. Support for the program among policymakers and health system leaders was influenced by exposure to a successful Patient-Centered Medical Home (PCMH) program in a neighboring state, while health service providers' support was based largely on perception of the model as the "right thing to do." Both groups expressed belief in the benefits attributed primary care home model.
2. The PCPCH Program has received broad support, but its complexity and uncertainty regarding future modifications may present challenges to maintaining commitment to the shared vision of the PCPCH model and ongoing support for the Program.
3. Implementation of CCOs and other health system transformation efforts were seen as being integrally related to, and supportive of, the PCPCH model. However, in some respects they were also viewed as competition for resources and attention, suggesting the need for greater alignment of PCPCH with other transformation initiatives.
4. Strong leadership within OHA and the commitment of Program staff were complemented by external leadership among key community-based organizations.
5. Many individuals noted positive experiences serving on committees, task forces, and work groups, and several respondents indicated that including more participants would provide additional perspectives that could be useful for future Program improvements.
6. Communication with community stakeholders was critical to the successful development and implementation of the PCPCH Program, and will be equally important for its sustainability.
7. The range of concerns expressed by interviewees suggests the need for ongoing strategic planning to ensure the sustainability of the PCPCH Program and model of care.

¹⁹ Rissi, J.J. & Baker, R. (2014). Report on the Results of the 2012-2013 Qualitative Patient-Centered Primary Care Home Evaluation. Portland State University. Submitted to the Oregon Health Authority.

Findings from these interviews have influenced PCPCH Program operations. For example, staff are developing a strategic plan to improve communication of program goals to stakeholders. Aligning the PCPCH model with other areas of health transformation in the state such as the expansion of the Coordinated Care Model and Behavioral Health Integration is also a key area of focus for the program.

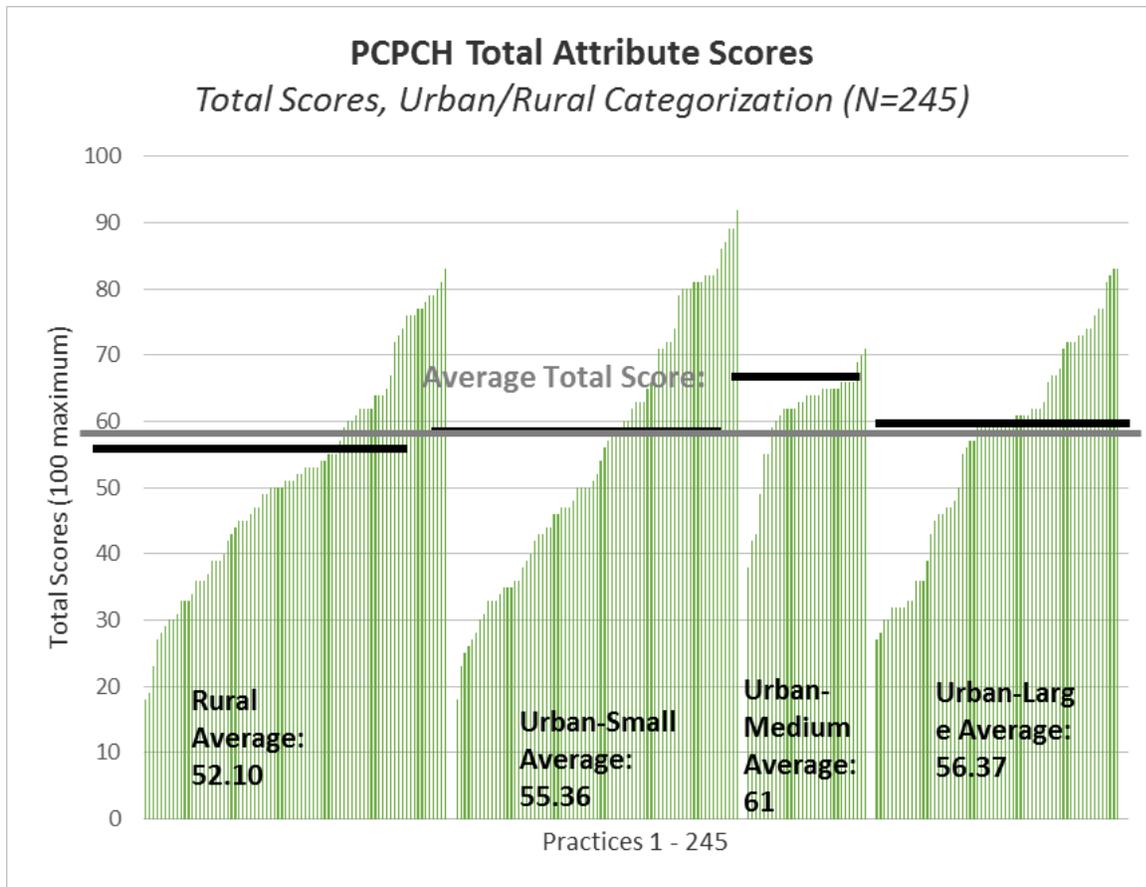
Attribute Scoring Methodology

In order to synthesize data collected from the PCPCH application and the supplemental survey sent to all recognized practices, researchers at Portland State University developed an attribute scoring methodology.²⁰ Using this method each practice was assigned a single score (1 to 100) comprised of their responses on the application and supplemental survey. This score allows the program to more easily compare recognized PCPCH practices using all available data.

Summary of Key Findings: Attribute Scoring Methodology

1. The average total attribute score across all recognized practices was 55.29 out of 100.
2. The data indicate that geographic location of the practice (rural, urban small, urban medium, urban large) was not a substantial factor in the average attribute score of a practice.
3. The data indicate that the organizational structure of the practice (whether the practice was independent, part of an alliance or owned by a larger system) was not a substantial factor in the average attribute score of a practice.
4. Performance on Attribute 2 (Accountability) of the PCPCH model was consistently low across all categories compared to the other 5 attributes of the model.

²⁰ Gelmon, S. B. Sandburg, B., & Bally, R. (2014). Implementation of Oregon's PCPCH Program: Results of Attribute Scoring. Portland State University. Submitted to the Oregon Health Authority.



Site Visit Report Evaluation

In the fall of 2014, the PCPCH Program contracted with the [Providence Health & Services Center for Outcomes Research and Education](#) (CORE) to analyze qualitative reports completed during the PCPCH site visit process.²¹ Below is a summary of their findings from the site visit reports:

Site Visit Findings by Core Attribute

- **Access to Care** – Practices struggled with the tracking of data and metrics such as patient satisfaction with access to care, after-hours access and tracking clinical advice received over the telephone.
- **Accountability** – Half of the practices were engaging in a quality improvement effort to directly help increase the clinic’s ability to be responsive to patient’s needs. However,

²¹ Center for Outcomes Research and Education, Providence Health & Services. (2014). Oregon’s Patient-Centered Primary Care Home Program Common Standards and Best Practices: Results from a 2013 Narrative Evaluation. Submitted to Oregon Health Authority.

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only one quarter of practices were using the Plan-Do-Study-Act model or similar Quality Improvement process.

- **Comprehensive Whole Person Care** - More than half of the practices reported using a pre-visit planning process that included “scrubbing and huddling” where providers and staff meet to discuss the needs of patients prior to scheduled appointment times. Over half of the practices had a co-located referral provider either located physically on-site or virtually available.
- **Continuity** – Findings indicated many practices are able to share information in real-time with external providers and nearly half of practices reported successful two-way communication with outside providers.
- **Coordination and Integration** – Many practices have room for improvement in care management, especially in proactive care, and care plans for patients with complex needs. There was also room for improvement in approximately half of practices to better track referrals, tests and results.
- **Person and Family Centered Care** – Patient engagement activities was one area identified in the findings for improvement. These activities include shared decision making, patient advisory councils, and encouraging patients to be more proactive in managing their health. All sites administered a patient care survey such as CAHPS although only 6% met the CAHPS benchmarks for experience of care domains. Only 20% of practices reported sharing these results with staff members.

Patient Reported Outcomes

The PCPCH Program contracted with the [Providence Health & Services Center for Outcomes Research and Education](#) (CORE) to conduct an evaluation of the PCPCH initiative on patient-reported outcomes. CORE used a set of existing survey data — the Oregon Health Study, a longitudinal study of low-income Oregonians — to assess access, quality, and health outcomes over time. The intent was to compare the change in key outcomes over time between groups to determine whether patients who had received care in a PCPCH did better over time than patients whose primary care occurred in a traditional setting. Below is a summary of their findings:

- **Access and Utilization** – In general, there was little evidence to suggest the PCPCH model affected access, utilization, or preventive screenings and behaviors. PCPCH and non-PCPCH patients saw very similar rates of improvement in most of these measures over time
- **Quality of Care** – In the quality measures, PCPCH patients were more likely to receive assistance for food, transportation, and housing when they needed it — a key indicator of whole person care that is a core part of the PCPCH model. However, they were also less likely to report that their care seemed well coordinated
- **Health** - There was some indication the PCPCH model is impacting patient health outcomes. All patients reported better overall health at follow-up than at baseline, but PCPCH patients saw more improvement than non-PCPCH patients. The result was only

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marginally significant ($p < .10$), but may be an early indication that the PCPCH model holds promise for helping improve patient health.

Ongoing Program Evaluation

As the PCPCH model of care delivery evolves there is a need for continued evaluation of the PCPCH Program. Upcoming evaluation efforts will focus on advanced primary care transformation and examining in greater detail a subset of high-performing PCPCH practices. Evaluation work will include:

- Examining patterns of utilization and expenditures amongst PCPCH practices with a focus on the high-performing sites;
- Assessing the usefulness of the attribution scoring methodology in evaluating PCPCH performance; and
- Identifying the organizational conditions and process improvement activities that are necessary to achieve performance improvement.

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Looking Ahead

PCPCH Program Goals 2015

The PCPCH Program has contributed greatly to furthering Oregon’s health care transformation initiative to provide better care, better health and lower costs to all Oregonians. Looking ahead the program has set ambitious goals for 2015, including:

- 600 practices recognized as PCPCHs at the end of the year
- Recognized PCPCHs in all 36 counties in Oregon
- Conduct at least 100 on-site verification site visits across the state
- Outreach to never before recognized practices
- Continued outreach to recognized PCPCHs to keep them engaged in transformation and the PCPCH model
- Convene the Standards Advisory Committee to refine PCPCH model
- Continue with program evaluation to assess if the PCPCH model is helping practices to reach the Triple Aim
- Develop a PCPCH Program strategic plan for 2015-2017

3 STAR Designation

In February 2015 the PCPCH Program launched the 3 STAR Designation. Currently almost 90% of practices are recognized at the highest level of the PCPCH model - Tier 3. Among the practices recognized as a Tier 3, there is tremendous variation in the measures practices attest to, the interpretation of the standards, and how the standards are implemented. The 3 STAR designation allows the PCPCH Program to distinguish practices that have implemented truly transformative processes into their workflow using the PCPCH model framework and recommended best practices. The 3 STAR designation acknowledges clinics that are trailblazers in practice transformation. Practices must meet the criteria below to be considered for 3 STAR designation.

3 STAR Designation Criteria

- Recognized as Tier 3 PCPCH under the 2014 PCPCH Standards
- Attest to a total of 255 points or higher on the PCPCH application
- Receive a site visit to verify the practice is meeting all PCPCH standards attested to.
- Meet 11 or more of the 13 specified measures below:
 - 1.B.1: After Hours Access
 - 2.D.3: Quality Improvement
 - 3.C.2: Referral Process with Mental Health, Substance Abuse or Developmental Providers
 - 3.C.3: Co-Location with Specialty Mental Health, Substance Abuse or Developmental Providers

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- 4.B.3: Personal Clinician Continuity
- 5.C.1: Responsibility for Care Coordination
- 5.C.2: Coordination of Care
- 5.C.3: Individualized Care Plan
- 5.E.1: Referral Tracking For Specialty Care
- 5.E.2: Coordination with Specialty Care
- 5.E.3: Cooperation with Community Service Providers
- 6.A.1: Language/Cultural Interpretation
- 6.C.2 or 6.C.3: Experience of Care

A complete list of PCPCH standards and measures is in Appendix B.

Program Implementation Challenges

The PCPCH Program is an integral component of broader health care transformation efforts in Oregon. As with any complex initiative, implementation has not been without challenges. Limited patient perspective, staffing capacity, and payment support to PCPCHs are three current challenges for PCPCH Program implementation.

Limited Patient Perspective

The PCPCH Program recognizes health care clinics for their commitment to patient-centered primary care; however program staff has limited direct interaction with patients. Currently program staff only solicits patient feedback during on-site verification visits and relies primarily on PCPCH providers and staff to relay their patients' perspective about the effectiveness of the PCPCH model to OHA. The limited engagement with patients makes incorporating their perspective in the PCPCH model challenging. In the future, the PCPCH Program plans to create more opportunities to engage with patients about the PCPCH model.

Staffing Capacity

The PCPCH Program does not currently have the staffing capacity to conduct on-site verification visits to the nearly 550 recognized PCPCHs. The goal of the program is that each recognized PCPCH will have a site visit once every three years. However, with the pace of primary care transformation this may not be sufficient to truly capture and verify how recognized PCPCHs have implemented the model.

Payment Support to PCPCHs

Through its health system transformation efforts, Oregon is counting on primary care providers to change care delivery but payment incentives are not changing at the same pace to adequately support the adoption of new care models. There are numerous pilot projects occurring across the state, but pilot project parameters and payer participation vary widely. This leaves some providers under-supported and others trying to juggle different initiatives and incentives across payers.

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A bill that aims to ensure that sufficient resources are allocated to Oregon’s primary care system is under consideration in the 2015 legislature. [Senate Bill 231](#) would require commercial insurers and coordinated care organizations to report the percentage of their total medical expenditures that are directed to primary care. The OHA would be responsible for reporting results to the legislature during the February 2016 legislative session. In addition, the OHA would be required to convene a learning collaborative with the purpose of sharing best practices on primary care alternative payment methodologies and initiative alignment.

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Stories from the Field: PCPCH Profiles from across Oregon

Oregon Health & Sciences University Family Medicine at Richmond Portland, Oregon

Recognized PCPCHs are committed to delivering primary care that is centered on the patient and their family. In practice, this means acknowledging patients as an important member of the care team, delivering care that is respectful of cultural backgrounds, and empowering patients to be responsible for their overall health and wellness. This core attribute of the PCPCH model is best demonstrated by [Oregon Health & Sciences University \(OHSU\) Family Medicine at Richmond](#), a Tier 3 PCPCH located in Portland, Oregon.

At OHSU Family Medicine at Richmond a Patient Advisory Council advises the clinic on new processes and systems. The council was created several years ago and is



comprised of patients who have been nominated for membership by their care team or express interest in joining the council. Patient Advisory Council members meet every other month to provide feedback to the clinic about topics such as workflow processes, new service lines and improvements to patient experience of care. **Incorporating the Patient Advisory Committee's recommendations into clinic operations improves how care is delivered to patients from the patient's perspective.**

Some members of the Patient Advisory Committee also serve on OHSU Family Medicine at Richmond Health Literacy Committee. This committee is comprised of clinic staff who review all new and revised materials developed for patients, such as brochures, forms, and standard letters. Materials that are easy for patients to understand improve health literacy and have been shown to reduce health disparities. **"Patients are a great voice and work right alongside us as if they were staff,"** states Erin Kirk, Clinic Quality Manager.

Winding Waters Clinic Enterprise, Oregon

[Winding Waters Clinic](#) has provided care to Wallowa County residents for 55 years. Winding Waters was incorporated by two physicians at a time when the local hospital emergency department, hospital in-patients and clinic patients were all taken care of by the same physicians. The patient was the focus for those pioneer physicians over 50 years ago and remains the primary purpose of Winding Waters Clinic today.

Winding Waters Clinic has been a Tier 3 PCPCH since 2011. **The PCPCH model has provided the framework for Winding Waters to achieve transformation to a medical home**, including providing 24 hour access to a physician via phone, implementing expanded hours, installation of an HER, establishing a Patient Advisory Council, moving into new office space physically designed around team-based care, creating a Care Coordination Team, implementing a Chronic Pain Management program, hiring of an RN Care Manager, and integrating Behavioral Health services into their clinic



Care Coordination Team at WWC

Winding Waters Clinic seeks out community partnership opportunities to continue its transformation work, allowing the clinic to positively impact the health of their community. Dr. Elizabeth Powers explains, “The impact of our clinic is no longer defined by or limited by the walls of our office building.” Community partners are co-located within their clinic space, and staff actively go out into the community to create opportunities for learning and health improvement. For example Winding Waters Clinic has partnered with a local social services agency (Building Healthy Families) to improve early literacy levels by participating in the national Reach Out and Read program. **The clinic also created a lending library in their waiting room for both children and adults.** Providers assess the literacy level of their patients using the “Newest Vital Sign” and check literacy of patient handouts using the [Patient Education Materials Assessment Tool](#) form.

*“The PCPCH model has become a part of the culture of Winding Waters Clinic.”
-Elizabeth Powers, MD*

Every day, Winding Waters Clinic staff see their efforts improving the lives of patients. “The care coordination team keeps a cookie jar full of stories, each of which illustrates how they have really made a difference in the life of one of our patients. This motivates us to continue to

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think creatively about how we can fill the ongoing gaps in resources for our patients and our community,” Dr. Powers states.

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Randall Children’s Clinic–Emanuel Portland, Oregon

The [Randall Children’s Clinic – Emanuel](#) is a pediatric primary care practice located in Portland and is affiliated with Legacy Health Systems. The practice is one of the first clinics in Oregon to be recognized as Patient-Centered Primary Care Home, and has maintained a Tier 3 status since 2011.



As the Randall Children’s Clinic - Emanuel embarked on its journey to become a PCPCH one goal was to improve access to care for their patients. Jeanene James, Medical Home Project Manager explains, **“We knew that patients were not satisfied with the way their health care was being managed.** Our access to available

appointments was often weeks, if not months, out and patients were not receiving continuity care from the same provider. Families were enduring long wait times when calling the clinic and delays in receiving return calls from their care team.” To improve access for their patients the clinic expanded its hours and designated 3 days a week just for walk-in appointments for sick visits. Walk-in appointments are available Wednesday and Monday evenings, and Saturday mornings.

“With the changes we have made we are proud to say that when a patient calls to schedule a routine care exam we are usually only a few days to one week out. We are now able to tell patients of our walk in hours for those same-day sick calls and also have been able to build our schedules to hold 9 same-day appointments per provider each day. These additions have been greatly appreciated by our families and staff,” James states enthusiastically.

Legacy Health Systems conducts patient satisfaction surveys, and the results for Randall Children’s Clinic – Emanuel are at an all-time high. Clinic staff attributes these high marks to the changes that have been implemented to improve access and families feeling better about the proactive care their child is receiving.

Randall Children’s Clinic – Emanuel has come a long way since beginning its primary care transformation journey 2011, and it hasn’t always been easy. James explains, **“During this time we have had several setbacks which include staff and physician turnover, but we have always continued to keep our patients and their families a priority.”**

Harney District Hospital Family Care Burns, Oregon

[Harney District Hospital Family Care](#) began their transformation journey in 2013 after participating in a Patient-Centered Primary Care Home (PCPCH) Learning Collaborative hosted by the [Patient-Centered Primary Care Institute](#) (PCPCI). During the collaborative clinic staff realized they were doing many of the core attributes of the PCPCH model already, and used the tools they learned to improve their processes to deliver better care and coordination of services to their patients. The clinic has been a Tier 3 PCPCH since fall 2013.

Harney District Hospital Family Care is located in rural Burns, Oregon which has a population of approximately 3,000 residents. This can make coordinating care a challenge that requires creative solutions. Clinic Manager Stacie Rothwell explains, “We strive to help try to keep our patients local so they do not have to travel the 280 round trip to the next town for care. We are on target to provide over 1,500 specialty visits this year through our local clinic in collaboration with many specialists from Bend. **If we are able to identify a healthcare need that is going unmet, we strive to explore the options and feasibility of bringing it local.**” The practice is currently in the midst of enhancing their Mental Health Integration by adding Tele Psychiatry this spring, and recruiting of a full time social worker and therapist to enhance their integrated care model.

The addition of a Care Manager to the team has made a notable improvement to the quality of care provided to patients. Rothwell says, “Our Care Manager assists patients in many ways from helping them with managing chronic conditions, coordinating care, assisting with transitions in care, and providing patient and family education.”

A Patient’s Story

One clinic success story revolves around a 79 year old male patient. He is a single Basque gentleman who knows very limited English and is unable to read or write. He lives alone and enjoys taking care of his home and yard. In January 2014 his health began to rapidly decline and he experienced four major hospitalizations within a five month period.

In May 2014 our Care Manager met with this patient and his caregiver, a family friend. Medications were reviewed and barriers to care addressed. Education was provided on congestive heart failure and how to monitor his weight daily and increase the amount of medication if needed. Weekly home visits to check his weight, monitor medications and general well-being took place.

Six months later, his weight is stable, he feels well, his strength is back and he is once again back out visiting friends and taking care of his yard and home. If he has a problem with anything, he knows to seek out our Care Manager so she can help find solutions before his health begins to decline.

Springfield Family Physicians Springfield, Oregon

[Springfield Family Physicians](#) is a private practice serving individuals and families in the communities of Springfield, Eugene, and the surrounding areas. The practice was one of the first clinics in Oregon to be recognized as a Patient-Centered Primary Care Home (PCPCH), and they have maintained their Tier 3 recognition since 2011.

Continuity of care is one of the six key attributes of the PCPCH model. **From a patient’s perspective Continuity is best described in this way: “Be our partner over time in caring for us.”** Similar to most recognized PCPCHs, patients at Springfield Family Physicians are assigned a primary care provider (PCP) and the practice has clear communication strategies in place when a patient is unable to see his or her PCP. **What distinguishes Springfield Family Physicians is that their vision for continuity revolves around integrating mental and behavioral health services into the practice.**

A Patient’s Story

We have a longstanding patient who lives with diabetes and schizophrenia, and has little support from family. **She has never been able to be convinced to regularly check her blood sugar levels at home or engage in self-care for her diabetes.** Her A1C was 12.8. Our RN care manager, BH Care manager and Community Support Specialist accepted the challenge of working intensely with her to gain her trust, help her understand her illness and begin to make positive changes.

At first, this involved daily home visits from the RN or BH therapist. After a few weeks, the patient allowed the Community Support Specialist to take her shopping for groceries, and together they prepared a week’s worth of healthy meals. This was repeated several times until the patient could do it herself. Overtime, the daily home visits turned into daily telephone calls and occasional home visits. **The patient now checks her CBG each day, faithfully records the numbers, self-injects insulin, logs everything she eats and drinks, walks daily, calls the support team to report her numbers or ask questions, and actively engages with the healthcare team.** Her most recent A1c had fallen to about 9.0. She spent the holidays with her grown children, and we are hopeful that family support will improve as her confidence in caring for herself improves.

Before Springfield Family Physicians began their transformation journey the practice was struggling to meet the behavioral health needs of their patients. In 2012 they partnered with a local behavioral health organization to embed a part-time behavioral health therapist within their practice, and began experimenting with “warm hand offs” and “treatment to target” therapies. “The value of this onsite resource and the benefit to our patients was quickly realized,” stated Jane Conley from Springfield Family Physicians, “and it wasn’t long before the need required two fulltime therapists.”

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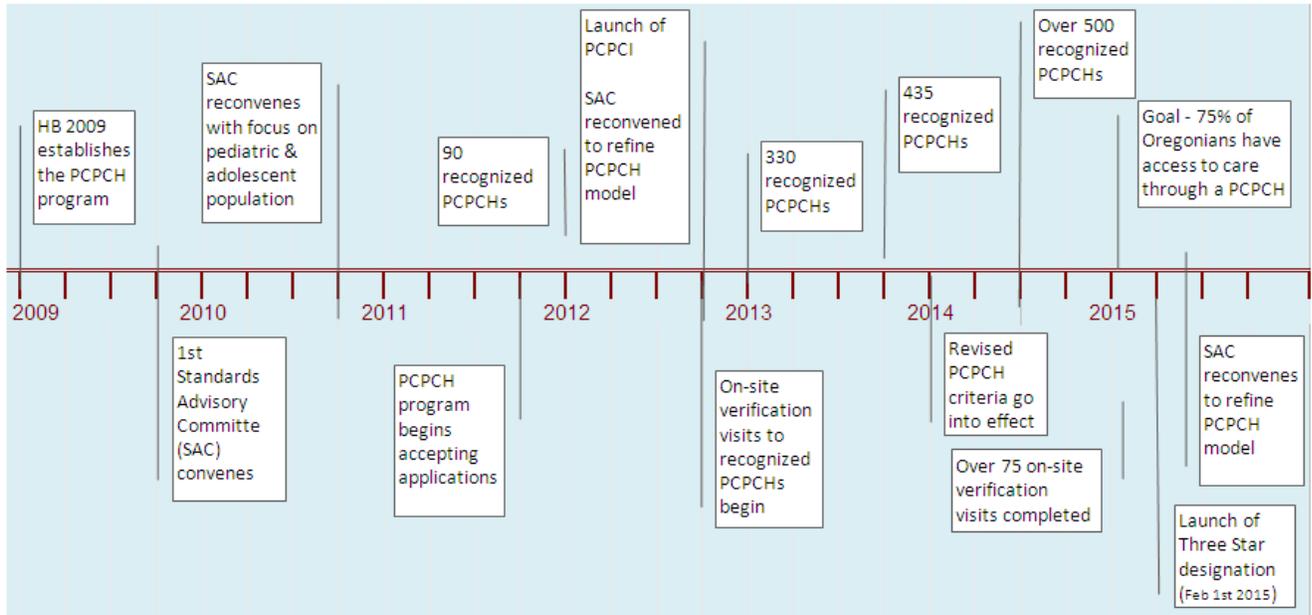
Patients noted the improved to care at Springfield Family Physicians too. A recent patient told Conley, **“Of course I like coming to this office for my behavioral therapy, because this is where I already feel safe.”** The rate of patients attending their behavioral health appointments has markedly improved since they began integrating behavioral health services into their practice, and Conley said the providers greatly appreciate having this resource readily available when a patient is in their office.

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Appendices

Appendix A: PCPCH Program Timeline

PCPCH Program Timeline (2009-2015)



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Appendix B: List of PCPCH Standards and Measures

2014 PCPCH Standards		
PCPCH CORE ATTRIBUTE	Must Pass?	Points Available
PCPCH Standard		
PCPCH Measures		
CORE ATTRIBUTE 1: ACCESS TO CARE - <i>“Health care team, be there when we need you.”</i>		
Standard 1.A) In-Person Access		
1.A.1 PCPCH surveys a sample of its population on satisfaction with in-person access to care.	No	5
1.A.2 PCPCH surveys a sample of its population using one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools on patient satisfaction with access to care.	No	10
1.A.3 PCPCH surveys a sample of its population using one of the CAHPS survey tools, and meets a benchmark on patient satisfaction with access to care.	No	15
Standard 1.B) After Hours Access		
1.B.1 PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours.	No	5
Standard 1.C) Telephone and Electronic Access		
1.C.0 PCPCH provides continuous access to clinical advice by telephone.	Yes	0
1.C.1 When patients receive clinical advice via telephone, these telephone encounters (including after-hours encounters) are documented in the patient’s medical record.	No	5
Standard 1.D) Same-Day Access		
1.D.1 PCPCH provides same-day appointments.	No	5
Standard 1.E) Electronic Access		
1.E.3 Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH provides patients with an electronic copy of their health information upon request.	No	15
Standard 1.F) Prescription Refills		
1.F.1 PCPCH tracks the time to completion for prescription refills.	No	5
CORE ATTRIBUTE 2: ACCOUNTABILITY - <i>“Take responsibility for making sure we receive the best possible health care.”</i>		
Standard 2.A) Performance & Clinical Quality		

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2.A.0 PCPCH tracks one quality metric from the core or menu set of PCPCH Quality Measures.	Yes	0
2.A.2 PCPCH tracks and reports to the OHA two measures from the core set and one measure from the menu set of PCPCH Quality Measures. (D)	No	10
2.A.3 PCPCH tracks, reports to the OHA and meets benchmarks on two measures from the core set and one measure from the menu set of PCPCH Quality Measures. (D)	No	15
Standard 2.B) Public Reporting		
2.B.1 PCPCH participates in a public reporting program for performance indicators.	No	5
2.B.2 Data collected for public reporting programs is shared within the PCPCH (with providers and staff) for improvement purposes.	No	10
Standard 2.C) Patient and Family Involvement in Quality Improvement		
2.C.1 PCPCH involves patients, caregivers, and patient-defined families as advisors on at least one quality or safety initiative per year.	No	5
2.C.2 PCPCH has established a formal mechanism to integrate patient, caregiver, and patient-defined family advisors as key members of quality, safety, program development and/or educational improvement activities.	No	10
2.C.3 Patient, caregiver, and patient-defined family advisors are integrated into the PCPCH and function in peer support or in training roles.	No	15
Standard 2.D) Quality Improvement		
2.D.1 PCPCH uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.	No	5
2.D.2 PCPCH utilizes improvement teams that are multi-disciplinary and meet regularly to review timely, actionable, team-level data related to their chosen improvement project and documents their progress.	No	10
2.D.3 PCPCH has a documented clinic-wide improvement strategy with performance goals derived from community, patient, family, caregiver, and other team feedback, publicly reported measures, and areas for clinical and operational improvement identified by the practice. The strategy includes a quality improvement methodology, multiple improvement related projects, and feedback loops for spread of best practice.	No	15
Standard 2.E) Ambulatory Sensitive Utilization		
2.E.1- PCPCH tracks selected utilization measures most relevant to their overall or an at-risk patient population.	No	5
2.E.2 - PCPCH tracks selected utilization measures, and sets goals and works to optimize utilization through: monitoring selected measures on a regular basis, and enacting evidence-based strategies to promote appropriate utilization.	No	10

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2.E.3 - PCPCH tracks selected utilization measures, and shows improvement or meets a benchmark on selected utilization measures.	No	15
CORE ATTRIBUTE 3: COMPREHENSIVE WHOLE-PERSON CARE - “Provide or help us get the health care, information, and services we need.”		
Standard 3.A) Preventive Services		
3.A.1 PCPCH routinely offers or coordinates recommended age and gender appropriate preventive services based on best available evidence.	No	5
3.A.2 PCPCH routinely offers or coordinates recommended age and gender appropriate preventive services, and has an improvement strategy in effect to address gaps in preventive services offerings as appropriate for the PCPCH patient population.	No	10
3.A.3 PCPCH routinely offers or coordinates 90% of all recommended age and gender appropriate preventive services.	No	15
Standard 3.B) Medical Services		
3.B.0 PCPCH reports that it routinely offers all of the following categories of services: Acute care for minor illnesses and injuries; Ongoing management of chronic diseases including coordination of care; Office-based procedures and diagnostic tests; Patient education and self-management support.	Yes	0
Standard 3.C) Mental Health, Substance Abuse, & Developmental Services (check all that apply)		
3.C.0 PCPCH has a screening strategy for mental health, substance use, or developmental conditions and documents on-site and local referral resources.	Yes	0
3.C.2 PCPCH has a cooperative referral process with specialty mental health, substance abuse, or developmental providers including a mechanism for co-management as needed.	No	10
3.C.3 PCPCH is co-located either actually or virtually with specialty mental health, substance abuse, or developmental providers.	No	15
Standard 3.D) Comprehensive Health Assessment & Intervention		
3.D.1 PCPCH provides comprehensive health assessment and interventions, when appropriate, for at least three health risk or developmental promotion behaviors.	No	5
Standard 3.E) Preventive Services Reminders		
3.E.1 PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders and to proactively advise patients/families/caregivers and clinicians of needed services.	No	5
3.E.2 PCPCH tracks the number of unique patients who were sent appropriate reminders.	No	10
3.E.3 Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH sends reminders to patients for preventative/follow-up care.	No	15

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CORE ATTRIBUTE 4: CONTINUITY - “Be our partner over time in caring for us.”		
Standard 4.A) Personal Clinician Assigned		
4.A.0 PCPCH reports the percentage of active patients assigned to a personal clinician or team. (D)	Yes	0
4.A.3 PCPCH meets a benchmark in the percentage of active patients assigned to a personal clinician or team. (D)	No	15
Standard 4.B) Personal Clinician Continuity		
4.B.0 PCPCH reports the percent of patient visits with assigned clinician or team. (D)	Yes	0
4.B.2 PCPCH tracks and improves the percent of patient visits with assigned clinician or team. (D)	No	10
4.B.3 PCPCH meets a benchmark in the percent of patient visits with assigned clinician or team. (D)	No	15
Standard 4.C) Organization of Clinical Information		
4.C.0 PCPCH maintains a health record for each patient that contains at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record; and updates this record as needed at each visit.	Yes	0
Standard 4.D) Clinical Information Exchange		
4.D.3 PCPCH shares clinical information electronically in real time with other providers and care entities (electronic health information exchange).	No	15
Standard 4.E) Specialized Care Setting Transitions		
4.E.0 PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care.	Yes	0
Standard 4.F) Planning for Continuity		
4.F.1 PCPCH demonstrates a mechanism to reassign administrative requests, prescription refills, and clinical questions when a provider is not available.	No	5
Standard 4.G) Medication Reconciliation		
4.G.1 Upon receipt of a patient from another setting of care or provider of care (transitions of care) the PCPCH performs medication reconciliation.	No	5
4.G.2 PCPCH tracks the percentage of patients whose medication regimen is reconciled.	No	10
4.G.3 Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH performs medication reconciliation for patients in transition of care.	No	15
CORE ATTRIBUTE 5: COORDINATION AND INTEGRATION - “Help us navigate the health care system to get the care we need in a safe and timely way.”		

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Standard 5.A) Population Data Management (check all that apply)		
5.A.1a PCPCH demonstrates the ability to identify, aggregate, and display up-to-date data regarding its patient population.	No	5
5.A.1b PCPCH demonstrates the ability to identify, track and proactively manage the care needs of a sub-population of its patients using up-to-date information.	No	5
Standard 5.B) Electronic Health Record		
5.B.3 PCPCH has a certified electronic health record and the PCPCH practitioners must meet the standards to be “meaningful users” of certified electronic health record technology established by the Centers for Medicare and Medicaid Services.	No	15
Standard 5.C) Complex Care Coordination (check all that apply)		
5.C.1 PCPCH assigns individual responsibility for care coordination and tells each patient or family the name of the team member responsible for coordinating his or her care.	No	5
5.C.2 PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs.	No	10
5.C.3 PCPCH develops an individualized written care plan for patients and families with complex medical or social concerns. This care plan should include at least the following: self management goals; goals of preventive and chronic illness care; and action plan for exacerbations of chronic illness.	No	15
Standard 5.D) Test & Result Tracking		
5.D.1 PCPCH tracks tests ordered by its clinicians and ensures timely and confidential notification or availability of results to patients and families with interpretation, as well as to ordering clinicians.	No	5
Standard 5.E) Referral & Specialty Care Coordination (check all that apply)		
5.E.1 PCPCH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians.	No	5
5.E.2 PCPCH demonstrates active involvement and coordination of care when its patients receive care in specialized settings (hospital, SNF, long term care facility).	No	10
5.E.3 PCPCH tracks referrals and cooperates with community service providers outside the PCPCH, such as dental, educational, social service, foster care, public health, non-traditional health workers and pharmacy services.	No	15
Standard 5.F) End of Life Planning		
5.F.O PCPCH has a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services.	Yes	0

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5.F.1 PCPCH has a process to engage patients in end-of-life planning conversations and completes advance directive and other forms such as POLST that reflect patients’ wishes for end-of-life care; forms are submitted to available registries (unless patients’ opt out).	No	5
CORE ATTRIBUTE 6: PERSON AND FAMILY CENTERED CARE - “Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness.”		
Standard 6.A) Language / Cultural Interpretation		
6.A.0 PCPCH offers and/or uses either providers who speak a patient and family’s language at time of service in-person or telephonic trained interpreters to communicate with patients and families in their language of choice.	Yes	0
6.A.1 PCPCH translates written patient materials into all languages spoken by more than 30 households or 5% of the practice’s patient population.	No	5
Standard 6.B) Education & Self-Management Support		
6.B.1 PCPCH has a process for identifying patient-specific educational resources and providing those resources to patients when appropriate.	No	5
6.B.2 More than 10% of unique patients are provided patient-specific education resources.	No	10
6.B.3 More than 10% of unique patients are provided patient-specific education resources and self-management services.	No	15
Standard 6.C) Experience of Care		
6.C.1 PCPCH surveys a sample of its patients and families at least annually on their experience of care. The patient survey must include questions on access to care, provider or health team communication, coordination of care, and staff helpfulness. The recommended patient experience of care survey is one of the CAHPS survey tools.	No	5
6.C.2 PCPCH surveys a sample of its population at least annually on their experience of care using one of the CAHPS survey tools. The patient survey must at least include questions on provider communication, coordination of care, and practice staff helpfulness.	No	10
6.C.3 PCPCH surveys a sample of its population at least annually on their experience of care using one of the CAHPS survey tools and meets benchmarks on the majority of the domains regarding provider communication, coordination of care, and practice staff helpfulness.	No	15
Standard 6.D) Communication of Rights, Roles, and Responsibilities		
6.D.1 PCPCH has a written document or other educational materials that outlines PCPCH and patient/family rights, roles, and responsibilities and has a system to ensure that each patient or family receives this information at the onset of the care relationship.	No	5

Appendix C: PCPCH Standards Advisory Committee Members

2012 Standards Advisory Committee Members

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Susan Kirchoff, RN Multnomah County Health Department

Co-Chair

Glenn Rodriguez, MD Oregon Academy of Family Physicians Director, Providence Milwaukie Hospital Family Practice Residency Program

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Patty Black, Peace Health Medical Group Patient Advisory Council

Kat Chinn NP, Nurse Practitioners of Oregon

Tatiana Dierwechter MSW, Benton County Health Department

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Sherrie Ford, Columbia County Health Department

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R J Gillespie MD, Oregon Pediatric Improvement Partnership

Arthur Jaffe MD, President, Oregon Pediatric Society

Chuck Kilo MD, Chief Medical Officer OHSU Founder Greenfield Health

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Carla McKelvey MD, IPP of OMA, Pediatrician

Janet Meyer MBA CEO- Tri-County Medicaid Collaborative Tuality Healthcare

Meg Portwood NP, Nurse Practitioners of Oregon

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John Saultz, MD, Oregon Health and Sciences University
Barney Speight, Oregon Health Authority
Jane-Ellen Weidanz, Oregon Health Authority

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Appendix D: Most Common and Least Common Attested To Measures

Standards attested to by 90% or more of PCPHs include:

- 1.C.1 – When patients receive clinical advice via telephone, these telephone encounters (including after-hours encounters) are documented in the patient’s medical record
- 1.D.1 – PCPCH provides same day appointments
- 3.D.1 – PCPCH provides comprehensive health assessment and interventions, when appropriate, for at least three health risks or developmental promotion behaviors
- 5.1.a – PCPCH demonstrates the ability to identify, aggregate, and display up-to-date data regarding its patient populations

Standards attested to by 10% or less of PCPCHS include:

- 2.C.1 – PCPCH involves patients, caregivers, and patient-defined families as advisors on at least one quality or safety initiative per year
- 2.C.3 – Patient, caregiver and family-defined family advisors are integrated into the PCPCH and function in peer support or in training roles
- 4.G.2 – PCPCH tracks the percentage of patients whose medication regimen is reconciled
- 6.C.3 – PCPCH surveys a sample of its population at least annually on their experience of care using one of the CAHPS survey tools and meets benchmarks on the majority of the domains regarding provider communications, coordination of care and practice staff helpfulness

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Appendix 13

Behavioral Health Integration Environmental Scan Report

Behavioral Health Integration Environmental Scan Report

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Executive Summary

Behavioral health integration is emerging across the five Coordinated Care Organizations (CCOs) surveyed in this state-wide scan. Integration efforts vary from the contemplation and planning stages (two of five CCOs studied), scattered implementation (two other CCOs), and more deliberate, CCO-led, on-the-ground implementation (one CCO). “Legacy” relationships and organizational structures influence the speed of integration efforts, as do other contextual factors such as geography, population density, workforce experience with integration, and CCO leadership.

Provider organizations within CCOs are achieving integration primarily through two strategies: collaborations between two or more organizations (typically a primary care practice and a behavioral-health focused clinic or center) and internal integration by a single organization (e.g., a primary care practice hiring its own behavioral health provider). At the practice level, clinicians in both models are still working out details of how day-to-day processes work, including space issues, clinical workflow, roles, electronic health records, and data collection for metrics.

Respondents repeatedly cited financing as a critical challenge to sustainability of integration efforts, even for those CCOs and clinicians who are actively engaged. Most behavioral health integration models involve delivering new kinds of services not built into traditional physical or mental health billing models. Thus, most of CCOs’ new attempts at integration are funded through “soft” temporary sources such as Transformation Fund grants and other short-term funds.

Opportunities abound for the Transformation Center to build on the strengths of integration efforts across the CCOs (clinician/leadership engagement, cost drivers, availability of new models of care, eagerness of many to share solutions) and to guide CCOs and providers toward solutions to shared barriers.

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Acronym List

ACA	Affordable Care Act
ACE	Adverse Childhood Experience
AMH	Addictions and Mental Health Division
APM	Alternative Payment Methodology
BH	Behavioral Health
BHC	Behavioral Health Clinician
CAC	Community Advisory Council
CADC	Certified Alcohol and Drug Counselor
CAP	Clinical Advisory Panel
CCO	Coordinated Care Organization
CHIP	Community Health Improvement Plan
CMS	Centers for Medicare and Medicaid Services
CMHC	Community Mental Health Center
COA	Certificate of Approval
ED	Emergency Department
FCHP	Fully Capitated Health Plan
FQHC	Federally Qualified Health Center
FUH	Follow-Up After Hospitalization for Mental Illness
HBAI	Health and Behavior Assessment and Intervention
IBHAO	Integrated Behavioral Health Alliance of Oregon
IHI	Institute for Health Care Improvement
LCSW	Licensed Clinical Social Worker
LPC	Licensed Professional Counselor
MAP	Medical Assistance Programs
MH	Mental Health
MMIS	Medicaid Management Information System
OHA	Oregon Health Authority
PCP	Primary Care Provider
PMPM	Per-Member-Per-Month
QMHP	Qualified Mental Health Professional
RFP	Request for Proposals
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, Referral to Treatment
SPMI	Severe and Persistent Mental Illness
SUD	Substance Use Disorders

Background

Compelling research evidence, health care reform initiatives, and clinician and patient needs are driving the integration of primary care and behavioral health services in Oregon and across the nation. Emotional, behavioral and physical co-morbidities are common and compound the risk for undesirable patient health outcomes.¹⁻¹¹ Patients suffer and health care costs increase when professionals from different backgrounds are unable to work together to meet patients' physical, emotional and behavioral health needs.¹²⁻¹⁴

Regardless of implementation site, integration requires extensive practice redesign, including changes to physical layout, professional roles, clinician and administrative workflow, and financing, and has implications for how professionals work together and how they develop caring relationships with patients.

Integration is a cornerstone of the state's vision for CCOs. This is because evidence shows patient experiences and outcomes improve and costs are contained^{6,7} (the Triple Aim) when behavioral and medical problems are addressed together. Efforts are currently underway at the state level to promote behavioral health and primary care integration via regulatory and legislative mechanisms. However, integration has not been widely adopted in health care systems across the country.⁸ One of the most important remaining problems is **how** to integrate primary care and behavioral health within the current fragmented health system.^{1,4,5}

Our team, led by Deborah Cohen, PhD from Oregon Health & Science University (OHSU), was contracted by the Oregon Health Authority (OHA) Transformation Center to begin addressing this question, by understanding the state of integration efforts in Oregon and by identifying ways that the Transformation Center can support, promote and encourage integration. The research questions that framed this scan are:

- What is currently being done to integrate behavioral and primary care within CCOs?
- What are the CCO visions for behavioral health integration?
- What are the current strengths and weaknesses of integration in the CCOs?
- What are the current opportunities for enhancing integration in the CCOs?
- What are the current barriers to integration in the CCOs?

Terminology

Primary care includes outpatient services typically within the scope of general practice for internal medicine, family medicine, and pediatrics.

Behavioral health refers to care that addresses emotional, behavioral and substance use problems.

Behavioral health clinicians (BHCs) include psychologists, psychiatrists, licensed clinical social workers, master's trained therapists, licensed professional counselors, etc.

Integration refers to efforts to bring together physical and behavioral healthcare for patients.

- What technical assistance do those delivering the care need, or what support would they find beneficial toward furthering their efforts?

While dental integration is another critical component to health care transformation and is a focus area for the CCOs, efforts to examine integration of dental care were outside the scope of this study.

The “Findings” section begins with a description of the contextual factors that emerged as important determinants of CCOs’ progress in integrating care. These include both geographical factors such as population density and number of local government entities covered by a CCO and structural factors such as within-CCO relationships and the presence or absence of pre-CCO relationships between entities now working on integration (what we call “legacy” structures). Also important were CCOs’ baseline levels of human resources for integration, the presence or lack of change champions, personnel trained in integration models, and leaders who could articulate and spread a vision of integration throughout the CCO.

The second section reports on CCOs’ quest to find ways to fund integration efforts and ensure their sustainability. Next, we describe current integration activities, which include documentation, staffing, and workflow changes, as well as consulting psychiatry, pain management, and substance use services as detailed by members of the five CCOs interviewed for this scan. We describe clinical models provider organizations are attempting and a number of practice-level factors such as electronic record-keeping, physical space, staffing, and workflow with which clinics are grappling. Patient stratification and sorting out the relationship between “behavioral health” and “specialty mental health” is part of this. Following that, we cover CCOs’ efforts in training and engaging providers. Finally, the last section outlines findings related to data, including CCOs’ experiences reporting OHA incentive metric data and related privacy and workflow issues.

The report ends by highlighting opportunities for the Transformation Center to assist and forward behavioral health integration within Oregon’s health care system transformation. Some of these suggestions come straight from CCO stakeholders, whereas others voice themes that echoed through multiple CCOs. Altogether, the findings suggest an important role for the Transformation Center to play in amplifying and coordinating the efforts toward integration that are emerging, whether incipient or in place, throughout the CCO structure.

Finally, an appendix with more information about each of the CCOs we studied is included at the end of this document. Each case summary includes information specific to each CCO: contextual information, financing approaches, specific integration efforts, training and engagement initiatives, and experiences with the incentive metrics and data reporting.

Methods

Sample

The sample included five of the 16 CCOs in Oregon. The five CCOs were selected in collaboration with the OHA based on variation in size, organizational structure, geographic location, and experience delivering integrated care. The people we interviewed within each CCO were purposively selected to represent a range of viewpoints on CCO activities and included CCO leaders as well as practice members in practices we knew were taking steps to integrate care.

Data Collection

The OHSU research team (Deborah Cohen, PhD, Jennifer Hall, MPH, Jason Kroening-Roche, MD, Ruth Rowland, MA, and David Cameron) collected and analyzed data from the CCOs. Semi-structured interviews with 4-10 key stakeholders were conducted with each CCO. Key stakeholders included both CCO leadership (n=19) and behavioral health and primary care clinicians (n=14) who deliver care in practices that are part of a CCO. Interviews were approximately one hour, and the majority were held in person; however, some were conducted using video software or over the phone. During these interviews, participants shared their experiences with behavioral health integration in their CCO.

We consulted a representative from the Oregon Health Authority's Medical Assistance Program (MAP) who provided information on Medicaid billing, coding and financing arrangements for integrated care.

Data Management

Interviews were professionally transcribed, and interview transcripts were de-identified and entered into Atlas.ti (Version 7.5, Atlas.ti Scientific Software Development GmbH, Berlin, Germany) for data management and analysis.

Data Analysis

Following each CCO visit, the research team debriefed with the OHA. Debriefing sessions were used to share and formulate preliminary thinking, and to refine the interview guide and sampling strategy. Following this, data were analyzed using an immersion-crystallization approach. The team reviewed the data together and built a code list. Team members independently read and coded the data, meeting weekly as a group to discuss emerging findings. During the second round of analysis we identified patterns around behavioral health integration activities, financing, facilitators, and opportunities for improvement that were seen across the CCOs as well as findings that were unique to each of them.

A draft report was prepared and shared with the Integrated Behavioral Health Alliance of Oregon (IBHAO), a group of state-based experts who have hands-on experience integrating care across Oregon. CCO-Oregon helps organize meetings for this group. CCO Oregon is a non-profit state member association that aims to be shaped by and to serve all stakeholders

that touch coordinated care in Oregon. Their purpose is to support the delivery of exceptional care at reduced costs while promoting the health and well-being of Oregonians.

IBHAO read this report to assess the validity of what we found. Many of the members of this group were working in CCOs that we did not study for this scan. Their review of our results was an important step in determining if our findings were transferrable to other CCOs. IBHAO members reported similar experiences and provided supplemental information and feedback that we used to refine and expand this report.

Findings from the Environmental Scan

1. Contextual and Organizational Characteristics

While CCOs only date back to 2012, their characteristics are heavily influenced by regional delivery-system history and the history of collaboration between local partners and leadership that came before. These legacy factors, along with geography and population density, are powerful contextual factors for understanding progress in CCOs' behavioral health integration efforts.

Geography and Population Density

CCO regions vary on the actual area the CCO covers, the population density of the region and the number of counties in the CCO. Each of these contextual factors is important to understanding integration efforts in a CCO. For example, CCOs responsible for large geographic regions covering multiple counties may have to manage variation, by county, in per capita population (density) and richness of resources that promote and support health and wellbeing. That is, some counties have resources and others do not. Additionally, behavioral health funding was, and arguably still is, distributed and managed along county lines. Thus, this county distinction remains important, particularly in CCOs that cover multiple counties. For instance, in one multi-county CCO, each county has its own Community Advisory Council (CAC) and developed its own Community Health Improvement Plan (CHIP). CCOs that have to work across multiple counties and large geographic expanses to foster integration face challenges in the effort it takes to coalesce and align the goals of multiple key stakeholders and organizations across communities. Oftentimes, relationships did not exist among these organizations prior to the CCOs and effort is required to build the relationships needed among county leaders to create and work toward integration goals.

Main Takeaway

Geography and political landscape of the region, which may be importantly influenced by county lines as well as the history of the region, and particularly the history of collaboration (or individualism) in a region, may be important as work is done to stimulate integration.

Further evidence of the importance of geography and population density is shown in the opposite case of CCOs that cover a single county and have tight relationships with their one county mental health organization. In CCOs such as this, the people in the county know each other and report a history of working together which has been one factor that has streamlined integration efforts in CCOs like this. We did observe one CCO that covered multiple counties over a smaller geographic region, and key informants in this CCO reported being able to make connections and establish relationships that were critical to carrying out CCO efforts. Importantly, the participants we interviewed in this CCO and the other single-county CCOs we studied reported that their CCOs and regions embodied a culture of collaboration that was based in a history and way of working together that preceded CCO efforts. This history and culture enabled the CCOs to make progress on integration, despite managing services across multiple county lines.

CCO Organizational Structure, Governance and Leadership

State regulations shape the governance structure of CCOs, as most CCOs have a CAC and a Clinical Advisory Panel (CAP). Other factors also shape regional leadership. One very important factor is the legacy system in the region, or the primary risk-accepting organizations prior to the emergence of CCOs. Given the rapid implementation of CCOs, many of the regional leaders, prior to CCO implementation, emerged as the leaders of the CCO efforts. Legacy systems for Mental Health Organizations (MHOs) also shaped CCO organizational structures. For example, some CCOs, specifically those led by health plans that didn't have experience managing mental health services, initially partnered with the MHO in the region because of their experience managing mental health services for Oregon Health Plan (OHP) members. In an effort to reduce administrative complexity, some of the CCOs have either stopped working with an MHO or reduced the MHO's roles and responsibilities by managing those services themselves and/or by contracting directly with mental health service providers. One CCO uses a slightly different structure where the MHO has a delegated agreement with the CCO to manage services, which allows them to function and operate as CCO employees.

Participants consistently reported that broad representation on key CCO advisory and decision-making bodies, such as the CAP and CCO governing boards, was important to integration efforts. Additionally, it was important whether these representatives and decision makers had behavioral health expertise and a vision for integration. At the CCO we visited that was most active in implementing integration projects, leaders with integration experience were active in the CCO decision-making body and were able to articulate a clear vision for integration. Additionally, CCOs varied in the extent to which they engaged the stakeholders on the CAP and CAC, with some key informants observing low engagement and top-down decision-making while others highlighted the important and influential role of the advisory panels, in particular the CAP. Influence of the CAC was less clear, as some CCOs have multiple CACs and therefore multiple CHIPs. While integration was consistently identified in the top needs in community health assessments across CCOs, respondents pointed out that their CHIP plans were not guaranteed funding, and thus would not drive integration efforts.

CAPs and other committees within the CCO were also described as an important means for disseminating and sharing integration strategies, both within leadership and between leadership and practice sites. Leadership also took on a more informal role in many CCOs with "lunch room" and other informal conversations referenced as an effective communication strategy to promote change. These personal relationships also fostered a better understanding of roles within an integrated team, helped repair misunderstandings, and provided a bridge between historically siloed individuals and groups.

CCO Vision for Integration

When asked about a CCO's vision for integration, few people we interviewed below the CCO leadership level could articulate one, and most could not or did not want to speculate. Instead, they reported their own immediate organization's vision for integration. We cannot know from

the interviews if the CCOs we studied did not have a vision for integration, did not communicate this vision to key stakeholders in the CCO, or both. We also cannot assess the value of having a clear vision at the CCO level. We know from prior work, however, that at the practice level it is important to have practice leadership and all practice members aligned with a clear vision and shared mental model for integration, as this influences action.

Past Experience with Integration

We spoke with practicing primary care and behavioral health clinicians as well as clinic leaders across the CCOs surveyed. Each of the CCOs had practices within it that had experience with integration. A majority of the practices had some experience with integration **prior** to the emergence of CCOs, and these experiences were universally positive. That is, most clinicians had had experience working on an integrated team of some configuration and had a positive memory of that experience that included real-time support, better patient outcomes, and better follow-up with patients. Clinicians who did not have experience with integration did not have these positive first-hand experiences and were less likely to appreciate the mechanics and potential of integration.

Main Takeaway

On-the-ground integration leaders are critical to integration spread both within and across CCOs. These leaders should be identified and tapped for participation on CCO boards and asked to help identify barriers and opportunities to integration within their CCOs, as well as in other CCOs. There is evidence that leaders in this area are, in some instances, banding together (i.e., IBHAO) to create a clearer vision of integration, change the policy landscape to make it more hospitable for integration. This work should be expanded and supported.

Clinicians working in practices currently integrating care pointed to the importance of clinical leadership and clinician champions in bringing integration to fruition. Clinics that were already integrating care identified clinician champions (behavioral health or primary care) who cared about integration as key to stimulating change at the practice level and CCO levels. In some CCOs, these on-the-ground leaders have sought out additional educational opportunities to support their success.

2. Integration Contracting and Financing

Financing issues (hand-in-hand with credentialing and licensing issues) were consistently identified by CCOs as the premier area where changes to policy structures were necessary if behavioral health integration was to succeed. This is because a major concern when building an integrated behavioral health program is financing, and billing and credentialing issues, as described below, emerged as barriers to financing these programs. Practices implementing behavioral health integration face significant start-up and ongoing expenses. While some benefits of BH integration are immediate, financial savings from integration may take months or years to fully manifest, and savings tend to manifest in parts of the health care system away from the sites doing the integration. For example, a primary care practice may invest in an integrated care program, and the savings accrues to the CCO, for example, in lower hospitalization or

emergency visit rates... Practices reported struggling to find ways to pay for integrated services, and most integration efforts were funded through short-term sources including Transformation Funds and outside-agency grants.

Financing issues were one of the more complex and confusing areas encountered during these interviews. Participants shared differing and sometimes conflicting information about licensing, billing requirements, and potential workarounds. Individual CCO leaders and providers could explain aspects of financing structures and policies their organizations encountered directly, but had difficulty providing “big picture” understanding of integration financing.

Legacy Service-delivery Structures

Before CCO implementation, participants explained that Oregon’s Medicaid services for physical health, mental health, and chemical-dependency treatment were provided through distinct systems. While the provider networks were often the same, these systems often had their own federal funding streams, state agencies, billing systems, and provider licensing and credentialing methods. Thus, CCOs inherited a bifurcated behavioral-health structure with parallel but separate provider systems. In most instances, participants reported that these legacy systems have not changed with the new CCO approach.

Billing, Codes, and Licensing

A key informant from MAP explained that licensed behavioral health providers could bill CPT codes, which include the health and behavior assessment and intervention codes or “HBAI” codes, as long as those codes were included in their contract with the CCO and they’ve enrolled with MAP. Medicaid’s mental health systems have used Healthcare Common Procedure Coding System (HCPCS) and CPT codes with modifiers, billable only by licensed behavioral health providers or organizations with a Certificate of Approval (COA) such as Community Mental Health Centers (CMHCs). Organizations that have obtained a COA can allow non-licensed providers (Qualified Mental Health Associates, Certified Alcohol and Drug Counselors, Peer Support Specialists, and Qualified Mental Health Professionals) to bill for services. CCO leaders reported that this separate billing system created challenges for removing silos between physical and behavioral health care.

Practices reported difficulty determining how to bill for behavioral health services; therefore, integration efforts were primarily funded through short-term Transformation Fund pilot awards or outside temporary grant sources, putting their sustainability at risk. Confusion around billing led to varied understanding among the CCOs about the best way to integrate behavioral health services into their practices, the required contracting relationships, and requisite processes to finance integration.

CCO leaders reported that for primary care practices that contracted with an agency with a COA, BHCs were not able to bill for services without completing Centers for Medicare and Medicaid Services (CMS) required mental health documentation, including a patient assessment, mental health diagnosis, and formal treatment plan. These documentation

requirements did not fit well with behavioral health integration models that relied on brief therapy sessions and quick and concise EHR documentation/ communication with primary care providers. Practices that chose not to work with an agency with a COA had to apply for a MAP number to bill HBAI codes; however, not all CCOs were aware of this option. For more information on these two approaches to integration, see the section “Integration Approaches and On-the-ground Activities” (page 17).

While licensed psychologists and Licensed Clinical Social Workers (LCSWs) could apply for a MAP number, participants shared experiences about state policies that prevented psychology residents and others in training from becoming credentialed to bill for services as they worked and acquired their requisite hours for licensure. Participants reported that credentialing for residents and others in training was possible in others states but not in Oregon. This barrier to credentialing may deter practices from pursuing a workforce that’s engaged and excited to pursue a career in behavioral health integration.

Even when BHCs could bill HBAI codes, participants perceived the reimbursement they received as low. One participant suggested that CCOs could prioritize these codes and raise the reimbursement amount to ensure appropriate payment for work, but it was not clear that all CCOs were aware of this option. Additionally, some clinicians had ideas for novel and potentially cost-saving delivery models such as group visits, telehealth, health coaching, and peer wellness support. There are a few group CPT codes, but, again, participants perceived the reimbursement rate as typically low for these as well, and CCOs may prohibit them from being billed.

Other Financial Concerns

In smaller communities with fewer financial resources for specialty mental health care, participants reported that mental health providers who were accustomed to focusing on Severe and Persistent Mental Illness (SPMI) populations were concerned that increasing funding for low-severity behavioral-health interventions in integrated or primary care settings would divert funds from their programs. In addition, some mental health providers viewed CCOs as one more level of administration siphoning off scarce program dollars. This perspective led to resistance to change and created barriers to initiating behavioral health integration programs in some CCO service areas.

The challenges described above specifically refer to Medicaid financing, but practices with varied payer mixes also reported having to navigate commercial billing structures when they chose to provide

integrated care to all of their patients regardless of insurance status. Compared to some commercial payers, Medicaid billing was perceived to be more supportive of integration, but the alternative of offering different services for different patient groups was also complex and

Main Takeaway

There is some slow movement and innovative thinking happening at the state and CCO level that may make conditions more supportive for integration. This information needs to be shared with CCO leaders and providers, many of whom are not aware of alternative billing and financing opportunities.

burdensome. Study participants that worked in practices with commercial and Medicaid patients have requested OHA assistance with aligning a payment model for all payers.

Progress toward Addressing Financial Barriers to Integration

In our interview with an informant from MAP, we heard of two recent changes that will improve the financial sustainability of integration efforts. **First, MAP has activated additional medical billing codes, which will allow credentialed behavioral health professionals to be reimbursed for services provided in medical clinics. These will apply, however, only for licensed clinicians.** **Second, OHA has created an integrated provider contract within the Medicaid Management Information System (MMIS) whereby a clinic or provider can bill for medical, mental health and substance abuse treatment services.** This type of contract would allow for the integration of primary care into behavioral health organizations models as well as for embedding of BHCs in primary care; many chemical dependency providers have already sought it to integrate mental health and chemical dependency services. **These new changes are not widely known or understood by CCO leaders and providers,** and the Transformation Center could help clarify and spread this information to the CCOs.

Some of the CCOs reported contemplating additional financial changes to promote behavioral health integration. One was planning to encourage integration by reevaluating its fee schedule to include new codes or pay more for current codes. Others had started or were contemplating capitated payments that would facilitate team-based, integrated care and support unbillable integration and case-management services.

3. Integration Approaches and On-the-ground Activities

Practices within interviewed CCOs primarily used two approaches for integrating care. These approaches and their variations are described here. Practice and operational issues relevant to both of these approaches included documentation and information sharing, staffing, scheduling, clinical space, screening, and access to specialty mental health services.

Single Organization

The simplest approach to integration involves a single primary care practice integrating behavioral health by hiring a behavioral health clinician (BHC). We saw several instances across CCOs where primary care practices hired their own BHCs as employees of the primary care team. One variation on the single-organization approach was through the use of a local university connection. The BHCs at these practices were employed by the primary care practice, but recent psychology graduates were connected to the primary care practices by a university coordinator.

Separate Organizations

A more common arrangement was the separate-organization approach, whereby specialty mental health clinicians who worked for the county or for a private mental health organization provided services in a primary care practice. CCOs also had arrangements where a primary

care provider (PCP) or practice was contracted by a CMHC to provide medical services to patients in a mental health clinic setting (sometimes called a “behavioral health home”). In both of these arrangements, primary care and behavioral health services were offered in the same space; however, the organizations that managed these two services remained separate. The degree to which these organizations collaborated varied widely across the practices. In some practices, the BHCs operated as though they were part of the primary care team, sharing space and participating in patient-management “huddles.” In others, the co-located mental health provider was isolated from the rest of the practice and did not regularly communicate with the primary care team, and often did not really understand the integrated approach.

Integration of Primary Care in Behavioral Health Organizations

As described above, one variation on the separate-organization model placed a primary care clinician in the mental health clinic setting. This arrangement was viewed as friendlier to members of the severe and persistent mental illness (SPMI) population who were more comfortable receiving both physical and mental health care in the CMHC setting. Two CCOs described high-functioning arrangements where primary care providers were embedded in CMHCs. One utilized nurse practitioners on a part-time basis, providing nearly full-time medical services to the SPMI population. Challenges existed in finding the right balance of access and provider utilization that made this service valuable for members and financially viable for the organization.

Electronic Health Records and Documentation

In single-organization implementations, BHCs and PCPs used the same EHR and shared patient information with each other in real time. BHCs employed by primary care practices used the practice EHR to optimize information-sharing among behavioral health and medical providers.

Separate EHRs were more common among practices using the separate-organization approach than when a single organization hired its own BHC. When CMHCs contracted with a primary care practice to provide behavioral health services, the BHC was still an employee of the CMHC or other behavioral health care organization. These organizations typically used a separate electronic health record system tailored toward AMH reporting requirements. Use of separate EHRs in separate-organization collaborations hindered the sharing of patient care notes and other information between the primary care and behavioral health teams, and PCPs in practices with separate EHRs found this barrier to information-sharing frustrating.

Staffing

The number of BHC on-site hours and weekday coverage varied across the practices. Some primary care practices had a BHC present for one or two days a week. The same was true for PCP coverage in bilateral integration sites. Practices with more experience integrating care tended to have someone present full-time regardless of the integration organizational approach they used. Many practices started out with a small amount of FTE for BHCs and added more coverage as the practice acquired more funding or demonstrated patient need. The ratio of

BHCs to PCPs also varied across the practices, with a single BHC working with between 2 and 22 primary care providers. In single-organization approaches, psychologists and LCSWs were the most common credentialed groups among BHCs. In separate-organization approaches, BHCs could have other credentials, such as Qualified Mental Health Professionals, etc. Informants reported that this is because individuals with those credentials could bill for services under the mental health organization's certificate of approval. For more on these issues see the section, "Integration Contracting and Financing" (page 13).

Scheduling and Workflow

Methods for managing BHC schedules varied across the practices and CCOs. Some practices continued to use 50-minute traditional therapy appointments. This kind of scheduling was more common within the separate-organization approach to integration. BHCs in these practices saw fewer patients per day and were not available for interruptions or warm hand-offs (when a PCP introduces the patient to the BHC at the time of the patient's medical visit). Other practices kept appointments with BHCs to less than 30 minutes. They kept their schedules open between appointments to allow time for warm hand-offs and absorbing additional patients throughout the day. Some practices allocated time in their schedules for PCPs and BHCs to huddle together and review the daily schedule. They used this time to discuss patients who might benefit from visiting the BHC. PCPs reported liking face-to-face communication and collaboration opportunities with BHCs. Practices that used brief therapy in place of traditional therapy also tended to see patients for fewer visits. If long-term therapy was needed, BHCs transitioned patients to the county or private mental health organization for services.

Space

Regardless of organizational approach, practices reported the layout of their current clinical space as a barrier for integration. Some practices reported wanting to keep the BHCs and PCPs close together, but current configurations did not always allow for close clinician proximity and collaboration. Several practices chose to use Transformation Funds to renovate or make changes to their space to foster opportunities for collaboration between BHCs and PCPs.

CCOs saw integrating space as key to reducing the perceived stigma of seeking help for behavioral and mental health concerns. Providers suggested that some patients who might feel uncomfortable making an appointment at a CMHC would have no problem accepting a warm handoff to a BHC "down the hall." Participants cited lower rates of follow-up when patients were sent to behavioral health providers off site.

Screening

The CCO practices we studied, adopted Screening Brief Intervention and Referral for Treatment (SBIRT) and PHQ-2/9 screening tools and were in the process of integrating them into their clinic workflow. However, at the time of this study, practices were not consistently using screening tools to refer patients to BHCs. We observed variation across clinics with regard to the clinician or staff member that administered these screening tools. For more information on screenings see the section, "Metrics and Data Reporting" (page 22).

“Specialty” Mental Health

Practices using a separate-organization approach reported having a strong connection with the CMHC and could easily transition patients into specialty mental health services for long term therapy or psychiatry services. PCPs appreciated having a BHC in the practice who could assist with this transition. All CCOs identified lack of access to psychiatry as an issue for their members. This was most often due to a shortage of clinicians, made more acute with the increased patient enrollment seen with the Affordable Care Act (ACA). A distinction between access to psychiatric services for Medicaid and privately insured patients was also noted. Poorer access for Medicaid patients was not the universal experience. Rather, members covered by either public or commercial insurers might experience poorer access, depending on location and the relative number of privately vs CMHC-employed psychiatrists available. Recruiting psychiatrists was challenging, especially for rural CCOs.

Additionally, participants reported that even with ACA, providers with large undocumented populations have nowhere to refer SPMI patients or patients with long-term mental health concerns such as post-traumatic stress disorder (PTSD). Whether or not there are resources in each county, clinicians' in these counties reported an inability to access these resources for undocumented patients (e.g., long wait times). Because of the perceived lack of access to specialty mental health resources for undocumented patients, in cases where FQHCs would typically refer out for services, practices reported managing these patients in the primary care setting. Practices felt this approach was not a sustainable option, especially those that see a high number of undocumented patients, as it does not allow for BHCs to keep an open schedule to accommodate warm handoffs, brief therapy and short-term interventions.

Consulting Psychiatry

Some CCOs have attempted to ameliorate psychiatry shortages through new consultation arrangements, most often by phone or via the EHR. One CCO provided BHCs in a specific clinic with dedicated weekly consultation time with a psychiatrist. A psychiatrist in another CCO reported consulting with PCPs through the EHR by looking at records, making medication recommendations, and giving advice about possible diagnoses. PCPs valued working with psychiatrists. When PCPs were supported by BHCs and psychiatrists, they felt more comfortable managing patients with psychiatric issues, which previously may have felt outside of their comfort zone or training. Financing consulting psychiatry services has been challenging for practices, as consultation time is not a billable service.

Main Takeaway

Practices may benefit from different kinds of assistance depending on the integration approach they've adopted. Practices vary within and across CCOs regarding how they document and share information, staff and schedule BHCs, and incorporate specialty mental health, pain management, and addiction treatment services.

Opioid Prescribing and Pain Management

CCOs across Oregon have recognized the impact of opioid misuse on population health and the need to work with prescribers to understand and adopt best practices for the treatment of complex chronic pain. Some CCOs have adopted new opioid prescribing policies and alternative pain therapies such as behavioral health counseling or physical therapy. Three CCOs explicitly discussed pain management as an area of focus, each with varying degrees of implementation. In one CCO, a CMHC sent BHCs to primary care offices to lead pain-management groups. This additional support was well received by PCPs within the region. Another CCO started to create a multi-disciplinary clinic that will be available to PCPs by referral. This practice was developed following a summit in which PCPs identified improved pain management as an area of need. A third CCO was in the early discussion stages of developing a pain clinic.

Substance Use Services

The degree to which substance use and mental health services were integrated differed greatly between CCOs. In multi-county CCOs, there was variation within CCOs as well. Some CCOs described successful historical integration that predated CCO development and has continued, while others have been unable to solve funding barriers to make integration a reality. Finally, Alcohol & Drug treatment residential facilities do not exist in every community, so some CCOs did not have local access to such resources for its members. According to informants, the result is access problems, including long wait-times and coverage gaps that require sending CCO members outside their borders and creates reimbursement and logistical issues, especially when contracts between CCOs are not in place. In addition to integrating mental and physical health, a few CCO practices integrated substance use services with primary care. One CCO developed a pilot to embed Certified Alcohol and Drug Counselors (CADCs) in a primary care clinic, however, this practice was not frequently reported among CCOs we studied.

4. Training and Engagement

As the previous section suggests, moving to an integrated model was no trivial switch but forced practices to change workflows, clinical routines, and even how providers viewed their roles and worked together. CCOs used different training and engagement strategies to support clinicians as they navigated the new territory.

For behavioral health providers trained in a traditional, “specialty” mental health model, the workflows involved in integrated care presented a “culture change” that not all enjoyed. Instead of pre-scheduled 50-minute blocks with clients, BHCs were often expected to have an open door or to have scheduled appointments interrupted by primary care providers needing to make an unscheduled warm hand-off. Some BHCs were accustomed to more in-depth, long-term interactions with clients and voiced complaints that the new delivery model did not allow time to address some clients’ more complex issues, especially when referrals to specialty mental health care were complicated or inaccessible. On the other hand, we also heard from newer BHCs trained specifically in integrated care who were eager to engage with patients in this model.

Culture change was an issue for some medical providers as well. Several BHCs observed differences in integration uptake or support among primary care providers. While one physician might immediately warm to the model and request frequent handoffs, others did not use services as frequent due to habit or lack of knowing how to use the BHC's services. These shifts in roles and practices presented challenges to the advance of integration even within clinics who were adopting it. To overcome them, the CCOs we spoke with provided opportunities to **engage, train, and disseminate information about integration to CCO clinicians and stakeholders through the use of conferences, learning collaboratives, presentations, and training sessions.**

The frequency and reach of engagement and training activities varied across CCOs. CCOs that hosted larger conferences targeting all clinicians held these events one to two times a year. Behavioral health integration topics at these events included introducing behavioral health and primary care integration, implementing the SBIRT screening in practices, and holding educational sessions on tobacco and addiction behaviors, Mental Health First Aid, and adverse childhood experiences (ACEs). CCO leaders also independently sought integration training and learning opportunities for themselves by traveling to practices within and outside of Oregon to learn about integration models and how practices with more integration experience deliver care.

Some CCOs provided specific training for BHCs who worked in integrated practices. One CCO developed its own week-long training for BHCs before embedding them in primary care. This intensive training focused on introducing integration models, brief interventions and therapeutic practices, medical vocabulary, and information on common diagnoses the BHCs were likely to encounter in primary care settings. Other CCOs hired integration experts to train new BHCs or sent BHCs to trainings that were hosted by a consultant or external organization. Training in integration for primary care providers was not as common. Most CCO-led engagement efforts for primary care providers focused on presenting the benefits and evidence behind integration to clinicians who worked in practices that had not started integrating care. **These efforts were to create buy-in and support for integration among primary care providers, and less to prepare and train providers to collaborate and work with BHCs.**

Some CCOs recognized the **importance of ongoing training and technical assistance.** While training at the start of integration implementation was important, some CCOs saw the need for providing **continuous assistance after BHCs were embedded** into primary care practices. Consultants periodically visited with providers to discuss integration challenges in their practice. **For practices just starting integration, there was often only one BHC in each clinic. Some CCOs also recognized the need for peer support and provided ongoing learning opportunities for BHCs across practices to meet regularly to support** each other, discuss complex cases, and share information about integration in their practices.

5. Metrics and Data Reporting

We asked participants about their experiences with the CCO incentive measures that specifically related to behavioral health: alcohol or other substance misuse (SBIRT), Follow-Up

After Hospitalization for Mental Illness (FUH), screening for clinical depression and follow-up plan, follow-up care for children prescribed ADHD medication, developmental screening in the first 36 months of life, and mental and physical health assessment within 60 days for children in DHS custody. Participants reported different barriers and challenges to tracking and reporting data to the state. These included issues related to the electronic health record (EHR), privacy concerns and HIPAA regulations, and workflow changes to their practice.

Electronic Health Records and Data Reporting

Practices did not have systems in place to track and record both the physical and the behavioral health data they needed to report to the state. Most EHR systems within physical health practices lacked the ability to effectively track and manage the complexities of behavioral health data. Having two EHRs posed a barrier to communication between clinicians and required more work to manage both record systems. Practices that hired their own BHCs through the single organization approach, rather than contracting through CMHCs, were able to integrate their BHCs into the existing EHR more easily. However, we have found from a separate study in Oregon that these EHRs often lack the templates and tools that BHCs need for patient care. Some study participants requested assistance with implementing an integrated EHR.

Patient Privacy

Patient privacy was a major concern in the CCOs we studied. Some participants expressed concerns about sharing mental health records because they were afraid of breaking HIPAA regulations. **This appeared to be related to substance use and drug and alcohol screening.** One CCO reported that the more they screened with SBIRT the more drug and alcohol referrals they generated, but with those types of referrals there were specific HIPAA guidelines to which they must adhere. Under 42 CFR (Code of Federal Regulations) Part 2, patients have the right to conceal information from their clinician about drug and alcohol treatment, and part of their chart note may have restricted privileges. Study participants tended to err on the side of caution when releasing patient information because of their uncertainty around 42 CFR Part 2 and HIPAA regulations. In general, there appear to be differing interpretations of these regulations that may impact integrated practices' ability to share patient information.

Main Takeaway

Practices with integrated BHCs are limited by the ability of their existing EHR systems. If the EHR cannot handle physical and behavioral health data it may pose a barrier to integrated care, both in terms of documenting and sharing information, and in terms of tracking and monitoring effectiveness.

Practices providing integrated care are unsure about the different privacy regulations for mental health, substance abuse, and physical health diagnoses, and their fear and uncertainty lead to erring on the side of caution. This hinders communication and coordination among clinicians.

Practices are working to adopt the CCO incentive measures, but they need time to implement new workflows for these measures. There is concern that specific measures do not reflect improved patient care and there is a desire to see new measures implemented that better track outcomes among patients.

Impact on Workflow

CCOs reported that some metric benchmarks were more difficult to achieve than others. **SBIRT was often cited as a difficult metric to meet**, since practices had to modify their workflows to accommodate the new screening tool, and practices had difficulty documenting and getting credit for the screening unless patients screened positive. Because the benchmark covered only screening and referral, and **practices might not have staff qualified to perform the brief intervention, many practices chose to conduct only the screening component**. Practices also created new workflows to accommodate PHQ-2/9 screening, but did not report as many issues implementing this tool.

Practices reported difficulty meeting the FUH measure, citing elements beyond their control. For example, PCPs said they were **not always notified when their patients were admitted** to the hospital and did not know follow-up was needed. Additionally, tracking down patients was time-consuming and not billable for practices.

To track data needed to meet the developmental screening incentive metric, some practices used the Ages and Stages Questionnaire (ASQ). While developmental screening was incentivized at the CCO level, some communities **lacked resources to meet the needs of children who screened positive**. These communities had to refer patients to programs in other regions, but these resources reportedly often had long waits and access barriers for families needing additional support. **The Early Learning Hubs may have the potential to work with practices to enhance the relationship and referral process, and the Transformation Center could assist by facilitating connections between these organizations.**

Alternative Measures

Currently all 17 CCO metrics are process measures, and leaders and providers supported a shift toward incentives based on patient outcomes to more accurately reward quality care. Some argued that increased screening or follow up activities did not necessarily result in improved patient outcomes.

Proposed alternative measures included reducing a patient's depression or anxiety or extending the length between such episodes. **Respondents suggested the need for an OHA metric measuring practice integration, possibly with financial rewards attached, both to recognize and remunerate those providing integrated services and to assess quality of providers.**

Limitations

CCOs are fast-changing and evolving organizations and these interviews were conducted at a single point in time. It is possible that new efforts have begun since data collection. We spoke with four primary care providers as part of this study. The clinicians we interviewed were involved in leadership, on committees and boards, and worked in practices where integration was already happening. Therefore, their views may not reflect those of the general PCP population in the state. **To mitigate this limitation, the state could share and seek feedback on this report from other PCPs.** We did not speak to substance use disorder (SUD) leaders or providers for this study. While we consider substance use and chemical dependency treatment as under the umbrella of behavioral health services, **detailed information about these services did not emerge in the interviews and may suggest that these resources are siloed from primary care.** There's a need to learn more about these services and their accessibility across the state.

Opportunities for Transformation Assistance

In 2006, the Institute of Medicine and National Academy of Sciences issued a report in the Quality Chasm series on Mental Health and Substance Use Disorders. The recommendation was clear. To achieve quality healthcare, mental health and substance use disorders needed to be integrated in healthcare. In 2008, Congress passed parity legislation ensuring that mental health and substance use disorders were covered similar to other medical conditions. With the passage of the ACA, additional systems were in place to help achieve this goal.

Oregon can lead the nation in breaking down the silos that, for many patients, separate treatment of physical, emotional, and behavioral health. While the items listed here suggest some specific areas where assistance from the OHA Transformation Center might be helpful, **we believe that shifting the cultural, political, professional, and payment environment toward supporting a more integrated health care system can make the biggest gains.**

Assistance with Financing

The Transformation Center should provide guidance on strategies for financing new integration models, paying specific attention to strategies that address challenges at the state, CCO, and practice levels. When experimenting with integration, **practices need the flexibility to try new things and see what works.** The Transformation Center could assist CCOs with their integration efforts by finding opportunities to provide financial rewards to CCOs achieving a high degree of behavioral health integration. **One possibility could be incorporating a metric assessing CCOs' degree of integration into the current set of incentive metrics.**

The Transformation Center should further assist by encouraging CCOs to utilize **MAP's newer billing codes for integration—the 96150 series.** This could include spreading awareness to CCO leadership about these new billing codes and encouraging CCOs to pay clinicians for using them. These codes can be used for group health, telehealth, health coaching, and peer support.

The Transformation Center should also spread and share knowledge about the application process and requirements for requesting MAP numbers that allow licensed BHCs to bill for Medicaid services in a medical setting. Additionally, the Transformation Center can work with state agencies to simplify these billing requirements.

The Transformation Center should help CCOs develop new integration models by encouraging the use of alternative payment methodologies. This assistance could free practices and clinicians from the constraints of fee-for-service billing and allow them to experiment with non-billable, but potentially effective, models of integrated service delivery.

The Transformation Center should work with state policy makers to create a “residency” program for psychology graduates and licensed clinical social workers modeled on what physicians do once they have completed medical school and passed their board examinations. This would entail allowing psychologists and clinical social workers to become credentialed so

they can bill for services while working toward licensure. Washington and other states already offer this option. This policy change would benefit the future BHC workforce hoping to gain experience working in integrated settings as well as practices wanting to support BH residency programs.

The Transformation Center should also help by encouraging alignment among billing systems in Medicaid and commercial insurance programs. This would allow practices to integrate services for all patients, not just a subset of patients with a certain type of insurance. This is especially important in rural practices where payer mix can vary dramatically from county to county.

Assistance with Training

Practices new to integration often do not have someone in the practice familiar with this care approach and are unable to hire BHCs or other staff with that expertise. The Transformation Center in collaboration with other departments within the OHA should host integration trainings for clinicians and staff from both behavioral health and physical health. Preferably, these trainings would not be held in Portland, but in practices around the state. These would include training for clinicians, nurses, and staff members. Training would be used to increase the level of awareness about services available in an integrated care model. Trainings could increase efficiency and maximize the value of integration by teaching clinicians about the role of the BHC, how to optimize the warm hand-off, and how to coordinate the different services that each clinician is able to provide. Trainings could also teach clinicians motivational interviewing skills and appropriate timing for when to provide brief interventions. These trainings could help break down the silos that exist between behavioral health and primary care. Trainings were also suggested as a way to break down the hierarchies and cultural distance that may persist between PCPs and BHCs and help practices develop efficient care processes.

Assistance with the Electronic Health Record

The Transformation Center should help support the development of screening, documentation and tracking tools for integration in existing EHR systems. For example, one CCO specifically requested that SBIRT be built into their EHR because screening tools don't come prepackaged in the EHR. This assistance could facilitate the use and documentation of SBIRT. We also heard that CCOs would like a way to communicate across organizations about individual patients—CCOs referenced the emergency department information exchange, EDIE, as an example that already exists. CCOs would like to be able to coordinate care more effectively so that they don't transfer a patient that needs residential treatment to a facility only to have their patient turned away. This would provide better care and reduce unnecessary expenses.

The Transformation Center and AMH should advocate to CMS for reducing documentation requirements and communicate and share their efforts to reduce or remove this barrier with CCO leaders and practices.

Privacy Regulations

The Transformation Center could assist by clarifying privacy regulations for behavioral health information, particularly substance use data, and address some of the cultural misunderstandings that would make it easier for practices and clinicians to share pertinent patient information. Providers and staff reported that they are unclear about HIPAA and 42 CFR regulations, creating a chilling effect on sharing important patient information.

Assistance Implementing an Integration Model

The Transformation Center should provide assistance by sharing successful integration approaches with all of the CCOs. One way to do this would be to encourage the formation of leadership groups, such as IBHAO, that draw members from multiple CCOs. Then the Transformation Center could assist by disseminating success stories and successful integration models to CCOs and practices across the state. Additionally, leadership groups like IBHAO can help inform and change the policy landscape to make it more hospitable for integration.

The Transformation Center should also assist with integration by publicizing the new “integrated provider” contracting category and encouraging both primary care and mental health care practices to pursue this status. This assistance could help promote standard integration, integrating primary care in behavioral health organizations, and behavioral health home models within CCOs.

Other Areas for Assistance

The Transformation Center should further integration efforts by creating a common language for integration. For example, the term behavioral health clinician, rather than behaviorist (a term many do not like) could be clearly defined. Please refer to Peek’s Integration Lexicon as a start for a common language that could help standardize integration efforts:

<http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf>

The Transformation Center should support and encourage leaders in the state that are (1) conveners for behavioral health integration and (2) address the idea that integration diverts funding from programs that support the SPMI population, and (3) encourage collaboration to address resource scarcity and improving access.

The CCOs we studied were not able to clearly articulate their vision for behavioral health integration. The Transformation Center could help CCOs come up with a vision for integration and assist them with sharing their vision with all of their providers, staff, and members.

References

1. Institute of Medicine. Crossing the quality chasm: A new health system for the 21st century. Washington, D.C.: National Academy Press;2001.
2. The Center for Consumer Information and Insurance Oversight. Mental Health Parity and Addiction Equity Act (MHPAEA). 2008;
<http://cciio.cms.gov/programs/protections/mhpaea/index.html> Accessed December 1, 2012.
3. Goodson JD. Patient Protection and Affordable Care Act: Promise and Peril for Primary Care. *Annals of Internal Medicine*. 2010.
4. Stange KC. The paradox of the parts and the whole in understanding and improving general practice. *Int J Qual Health Care*. 2002;14(4):267-268.
5. Berwick DM, Nolan TW, Whittington J. The Triple Aim: Care, Health, And Cost. *Health Aff*. 2008;27(3):759-769.
6. Butler M, Kane RL, McAlpin D, et al. Integration of Mental Health/Substance Abuse and Primary Care No. 173 (Prepared by the Minnesota Evidence-based Practice Center under Contract No. 290-02-0009.) AHRQ Publication No. 09-E003. Rockville, MD: Agency for Healthcare Research and Quality; October 2008 2008.
7. Kwan B, Nease D, Jr. The State of the Evidence for Integrated Behavioral Health in Primary Care. In: Talen MR, Burke Valeras A, eds. *Integrated Behavioral Health in Primary Care*: Springer New York; 2013:65-98.
8. Miller BF, Petterson S, Brown Levey SM, Payne-Murphy JC, Moore M, Bazemore A. Primary Care, Behavioral Health, Provider Colocation, and Rurality. *The Journal of the American Board of Family Medicine*. 2014;27(3):367-374.
9. Miller WL, Crabtree BF. The dance of interpretation. In: Crabtree BF, Miller WL, eds. *Doing Qualitative Research* 2nd ed. Thousand Oaks, CA: Sage Publications; 1999:127-143.
10. Borkan J. *Immersion/Crystallization*. 2nd ed. Thousand Oaks, CA: Sage Publications; 1999.
11. Peek CJ, National Integration Academy Council. *Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus*. 2013.
12. Strosahl K. Building primary care behavioral health systems that work: A compass and a horizon. In: Cummings NA, Cummings JL, Johnson JN, eds. *Behavioral health in primary care: A guide for clinical integration*. Madison: Psychosocial Press; 1997:37-58.

13. Strosahl K. The integration of primary care and behavioral health: Type II change in the era of managed care. In: Cummings NA, O'Donohue WT, Hayes S, Follette V, eds. Integrated behavioral healthcare: Positioning mental health practice with medical/surgical practice. New York: Academic Press; 2001:45-70.

14. Strosahl K, Robinson P. The primary care behavioral health model: Applications to prevention, acute care and chronic condition management. In: Kessler R, Stafford D, eds. Collaborative Medicine Case Studies: Evidence in Practice. New York: Springer; 2008.

CCO 1 Summary

Background

CCO 1 is a new organization that operates in one county. Community partners include a health plan, an MHO, the county Health and Human Services Department, two hospital systems, multiple FQHCs, and several primary care practices. Prior to the CCO, this CCO did not have a strong managed care presence; only 40% of Oregon Health Plan (OHP) members received care from a managed care organization. The formation of CCO 1 is often described as a ‘grass-roots’ initiative, as it brought together several organizations to bridge gaps in patient care. For this reason, the CCO has a strong relationship with the community it serves.

Integration Financing

Integration efforts in CCO 1 have been primarily funded through grants and “physical health” dollars. When the CCO first formed, the health-plan partner provided 3.5 million dollars in grants to support changes in health care delivery. The CCO decided to use this money to initiate behavioral health and primary care integration in many of its practices. Then it used its Transformation Funds, in part, to continue supporting behavioral health integration across several practices. As integration efforts began, CCO 1 hired an outside consultant to help develop a financial strategic plan for behavioral health integration.

At the time of this study, the majority of the BHCs in CCO 1 were credentialed psychologists that billed health and behavior codes for a portion of the services they provide. However, when these BHCs were first embedded in the practices, they were entirely dependent upon grant funding because the psychologists were not yet licensed or credentialed. The initial grant from the health plan, followed by the Transformation Funds, helped to cover non-billable behavioral health integration expenses. Currently, primary care practices use a traditional fee-for-service model; however, CCO 1 planned to start an alternative payment methodology in quarter 1 of 2015 to help sustain and fund BHCs in primary care.

Integration Approaches and On-the-ground Activities

We learned about behavioral health and primary care integration that is taking place in eight practices in CCO 1. In addition to the integration activities described here, many of these practices have implemented SBIRT and depression screening.

1. Five of the eight practices began integrating through a partnership that the CCO has with a local university to hire four recent psychology graduates as BHCs. Two of the clinics share one BHC, half-time each, and three clinics each have a full time BHC. BHCs in four practices see between 5-17 patients a day—productivity varies by clinic. BHC sessions are 20 minutes, scheduled every 30 minutes, and 30-50% of BHCs’ time is left unscheduled for warm handoffs. The level of integration varies across the five practices. Some BHCs are described as co-located, while at least one BHC is fully integrated into the primary care team and uses a common EHR.

2. CCO 1 and a local university embedded another BHC into a maternal medical home. This person was embedded into the maternal medical home after the first wave of BHCs described above.
3. One CMHC embedded a nurse practitioner who is employed by a local FQHC to provide primary care services to SPMI patients. This provider sees six to eight patients a day and works off a separate EHR.
4. One FQHC works with a mental health organization to embed a BHC into a primary care practice. These two organizations worked together to integrate services prior to the formation of the CCO. The BHC uses the same EHR as primary care providers. This BHC, while part of a separate integration initiative, is invited to participate in the learning collaboratives for BHCs described above.

Some of the practices described above have conducted patient satisfaction surveys and provider satisfaction surveys to get feedback from both groups about integration. In some of the smaller clinics, they have tracked data that show fewer visits to the primary care provider following sessions with the BHC and fewer ED visits as well.

Additional CCO integration activities include:

1. The CCO is in the process of starting a practice that will have a co-located county mental health services office in the same building as primary care. This practice will also have dental and social services offices in the same building so patients can access a range of resources in one place.
2. The CCO, through the Health and Human Services Department, has contracts with five of the seven school districts to place qualified mental health professionals in the schools to do evaluations and assessments for students. These providers also do crisis debriefing, health coaching, and brief counseling. The schools pay a portion of the providers' FTE to provide these services.
3. CCO 1 is in the process of starting an outpatient pain clinic that will include a BHC.
4. Patients seen in the ED who receive a behavioral health assessment are linked back to their primary care practice with an appointment with the BHC there following their ED visit.

Training and Engagement

CCO 1 partners with a local university that trains and recruits many of the BHCs embedded in primary care practices. Before beginning work in primary care practices, BHCs that are embedded through the university-led initiative go through an intensive training on behavioral health and primary care integration. This intensive training focuses on introducing integration models, brief interventions, therapeutic practices, medical vocabulary, and information on common diagnoses the BHCs are likely to encounter in primary care settings.

The CCO and local university partnership provides a small amount of FTE for ongoing technical assistance to practices that are starting to integrate. The BHCs in these practices also attend monthly learning collaboratives where they come together with other BHCs to discuss difficult cases and integration issues.

Leaders from the CCO and university integration partnership gave presentations at each of the primary care practices to prepare PCPs and staff members for integration. These presentations were fairly short, but one of the BHCs at these practices initiated additional PCP engagement efforts by conducting a survey with the PCPs in the practice shortly after starting at the clinic. The BHC asked each of the providers to explain what makes their work challenging and difficult, and how the BHC could help with those issues.

Metrics and Data Reporting

CCO 1 has had difficulty extracting data from practices' EHRs to track and measure progress toward meeting the incentive measure benchmarks. They are currently working on improving this process. This CCO has had success implementing SBIRT in the practices because they've relied heavily on BHCs to do this work instead of PCPs, who often lack the time and bandwidth to conduct the intervention. The most challenging part of SBIRT here appears to be related to tracking and pulling the information the CCO needs to show that SBIRT was completed with a patient. In addition to providing SBIRT in primary care practices, this CCO is planning to conduct SBIRT in the emergency departments and has created a group that is focused on implementing that process.

CCO 2 Summary

Background

This CCO operates in one small county and shares a service area with another CCO. The region includes a city but is mostly rural. This CCO initially applied for CCO status in partnership with an established health plan. In its second year, CCO 2 became its own organization and now operates independently. CCO 2 collaborators include a health plan, two federally qualified health centers (FQHCs), a women's health center, a hospital system, a non-profit mental health organization (MHO), and an outpatient chemical dependency center.

CCO 2 governing boards and committees include representatives from mental health and drug and alcohol treatment organizations. Some of these organizations had long-standing relationships with each other prior to the formation of the CCO, and the MHO began initiating integrated services in the community prior to the formation of the CCO.

Integration Financing

CCO 2 pays for integration by billing services through the nonprofit MHO in the region and through the use of Transformation Funds. Transformation Funds supplement the budget to provide a Certified Alcohol and Drug Counselor (CADC) and a BHC at one FQHC. Transformation Funds also supplement the cost of a psychiatric nurse practitioner and an LCSW in another FQHC.

Integration Approaches and On-the-ground Activities

We learned about behavioral health and primary care integration that is taking place in four practices in CCO 2:

1. The nonprofit MHO placed a BHC into an FQHC. Patients are seen three to four times at the practice and then transitioned to the nonprofit MHO if long-term services are needed. The BHC provides brief therapy and is available for warm handoffs. A BHC is present in the practice part-time and spends the other part of his/her time providing traditional therapy at the nonprofit MHO. When long-term therapy is needed, patients often see that same BHC at the nonprofit MHO for traditional mental health services. The BHC has weekly consults with a psychiatrist to discuss complex and challenging patients. The BHC uses the nonprofit MHO's EHR, and is therefore on a separate system from the primary care providers in the FQHC. This FQHC has also implemented SBIRT and has an embedded CADC from an outpatient chemical dependency center.
2. The nonprofit MHO placed a BHC into a women's health center. The BHC is present every other week and regularly conducts SBIRT and depression screenings. If patients need more mental health services they are transitioned to the nonprofit MHO for services.
3. The other FQHC in the CCO has hired a Psychiatric NP and an LCSW. Both of these positions existed prior to the formation of the CCO and are full-time. The Psychiatric NP and LCSW share an EHR with the primary care providers. The LCSW provides traditional therapy

and the Psychiatric NP provides both therapy and medication management. There tends to be a long (approximately two-month) wait at this practice to see both of these providers. This practice is also consistently using the SBIRT screening tool.

4. CCO 2 and the other CCO in the region collaborate with the nonprofit MHO to place a PCP in a CMHC. Currently there is one part-time NP embedded in the CMHC, and there are plans to hire a second provider. This practice uses separate EHRs; providers have “real time” access to both charts.

Training and Engagement

CCO 2 leaders from the nonprofit MHO toured a number of different practices in and outside of Oregon to learn from others and gather information to inform their integration approaches. The CCO also provided a six-day training opportunity for providers and staff around Patient Centered Primary Care Homes (PCPCHs) and included behavioral health leaders and providers in those trainings. CCO 2 staff attended an Institute for Health Care Improvement (IHI) training offered by the Oregon Health Authority (OHA) and sent eight behavioral health and primary care providers to the training to develop a charter and measurement plan for a behavioral health integration project.

Metrics and Data Reporting

Practices in CCO 2 initially found implementing SBIRT challenging and had difficulty getting buy-in from providers who already felt overworked and were frustrated by the prospect of additional screening and documentation requirements. Meeting the metrics sometimes felt as though they were focusing on numbers instead of making changes to care delivery, and participants were concerned that meeting the benchmarks did not necessarily equate to better patient care. Some organizations hired new staff or changed workflows to guarantee staff were available to do the work that was necessary to meet the benchmarks. CCO 2 worked closely with practices to ensure they have changed their workflow and have the capacity to document and track the requisite data in their EHRs.

CCO 3 Summary

Background

This CCO serves one county and is the only CCO that operates in the region. CCO 3 is a subsidiary of a health plan and individual practice association which was the former Fully Capitated Health Plan (FCHP) in the region. When the CCO formed, it delegated the provision of behavioral health services to the former Mental Health Organization (MHO). Other community partners include a health system, a multi-specialty physician group, several hospitals and primary care practices. These community partners had a history of working together that preceded the CCO, and two community partner organizations began experimenting with integration with small grants and pilots prior to CCO 3 formation.

Integration Financing

CCO 3 uses Transformation Funds and additional funds from the county to support behavioral health integration startup expenses such as remodeling practice space. CCO 3 put out a request for Proposals for practices to apply for funding to start integrating care. They received eight RFPs and chose to fund all of them with funding from the CCO's global budget in the form of variable Per-Member-Per-Month (PMPM) payment. These funds are used to cover new staff or clinician FTE or non-billable integration activities such as huddles or care team planning time.

Integration Approaches and On-the-ground Activities

Behavioral health and primary care integration is taking place in eight practices in this CCO, including four primary care clinics and four behavioral health medical homes. In addition to the integration activities described here, all of these practices have implemented SBIRT and depression screening.

1. One practice embedded three part-time BHCs who are in the practice five days a week (2.0 FTE). BHCs are employed by a CMHC. BHCs have regularly scheduled appointments, but are also available for warm handoffs. Some PCPs utilize the BHCs more than others. Patients can have up to five sessions with a BHC. After that, patients transition to the CMHC if long-term therapy is needed. Referrals to this CMHC are a challenge because that organization is located in a different city. Even though transportation is free, the distance and time it takes to get to the other city is a barrier for some patients. This practice is considering co-locating specialty mental health services at its site to address this issue.
2. A CMHC embedded a PCP from the local primary care practice to work with its SPMI population. This CMHC used its start-up funding to remodel a new building to accommodate primary care.
3. The multi-specialty physician group is working with three mental health organizations to embed BHCs into its practice.
4. A different primary care practice in CCO 3 has a fully integrated BHC who works with 12 PCPs. The BHC is a practice employee and preceded formation of the CCO. This BHC is

available for interruptions, brief therapy, and warm handoffs. Primary care and behavioral health providers at this organization also have access to a psychiatrist who is available to assist with complex patients by reviewing patient records and making medication recommendations.

5. A local pediatric practice hired a child psychologist and a behavioral health care manager. They also have a full-time child psychologist resident working in their practice. In addition they have some consultation from child psychiatry.

6. The local CMHC hired and embedded a PCP, two nurses, a social worker, a patient coordinator, and some peer support specialists to work with SPMI patients.

7. A local agency that works with substance abuse patients and provides full detox services, residential treatment for women, as well as many outpatient services, established a small primary care clinic at their women's treatment center that is staffed by nurse practitioners. The agency used its start-up funds to renovate its space to accommodate primary care. They used their startup funds to renovate a new building space to accommodate a full primary care clinic on one floor and a rapid access behavioral health clinic on the other floor. Services now include physical health, mental health and substance abuse services 8am to 8pm weekdays and some Saturday hours.

Training and Engagement

When it first began its integration efforts, CCO 3 provided a week-long training for the new sites on providing integrated care with a national consultant. They also offered a visit from the external consultant to all eight pilot sites to help prepare for integration and identify potential challenges. CCO also hosts a monthly learning collaborative. Each session focuses on a new topic; past topics include SBIRT, smoking cessation, and addressing other health behaviors. Additional topics include the essential elements of integration, team based care, metrics and quality reporting, population health and alternative payment models. Representatives from each of the eight pilot sites meet monthly with each other and a CCO clinical leader to discuss challenges and what's working well in their practices.

Metrics and Data Reporting

CCO 3 has focused efforts on sharing CCO incentive metric data back with practices and providers to keep them informed and engaged about meeting the quality improvement benchmarks. Primary care practices throughout the CCO are conducting SBIRT and depression screening. One practice that has integrated behavioral health services screens patients who are enrolled in brief therapy every time they come in for a visit to see how patients are responding to therapy and to determine whether scores improve over time. Participants from CCO 3 reported there was a need to collect and track data on behavioral health integration to be able to show if these efforts are beneficial from a cost and patient outcomes perspective. The CCO has not yet decided what should be measured or how to collect that data, but it is discussing the issue and would like to start measuring its work in the future.

CCO 4 Summary

Background

CCO 4 operates in three counties and shares a service area with another CCO. This CCO is unique in that it is led by an integrated health plan, meaning both behavioral health and physical health services have been managed internally by the same organization. CCO 4 has several behavioral health providers in leadership positions. It also has a long history of working with the same network of providers and practices in the region.

Integration Financing

CCO 4 would like to incentivize and pay for integrated behavioral health and primary care. They have created an alternative payment methodology (APM) workgroup that is currently looking at ways to incentivize integration either through pay for performance mechanisms or by providing additional payments based on the level or degree of integration that's occurring in the practices. CCO leadership is aware that some of the primary care practices in its network are already integrating care and hopes to create payment structures that support this work. It is thinking about changing its fee schedules for certain codes to demonstrate support for integration. Currently, the CCO primarily uses a fee for service payment model and pays primary care practices an additional PMPM payment when they meet the incentive metrics. CCO 4 is also looking at ways in which they can financially support pilot projects like Project ECHO, which would train primary care clinicians to provide specialty mental health services.

Integration Approaches and On-the-ground Activities

This CCO is in the planning stage of integrating services. While some of the practices in this CCO's network have already started to integrate behavioral health and primary care, these initiatives were not led by the CCO. This CCO is strategically collecting information and learning about integration from others. Because they are an integrated health plan, some of their early efforts have started at the health plan level, rather than in the practices.

1. The health plan operates care management teams that include a patient navigator, a behavioral health specialist, a nurse specialist, and a care coordinator who work collaboratively with primary care providers in the practices to meet patient needs.
2. The health plan has an internal behavioral health team that manages patients that receive behavioral health services, specifically high needs patients and high utilizers. These behavioral health providers are co-located with physical health providers at the health plan.
3. The CCO has a new leadership role that is responsible for using a systems-of-care approach to identify gaps in services and barriers to care. This person also coordinates communication between the behavioral health and physical health providers at the health plan.
4. The CCO informally surveyed practices that were already integrating care to learn about what is working and what could be improved.

5. This CCO conducted an exploratory meeting with an in-network behavioral health organization to learn more about how they define behavioral health, the integration model they use, licensing and certification requirements, and to hear their perspective about the kinds of things the CCO could do to help and support integration.

Other planned activities include:

1. Providing consulting psychiatry services to primary care providers.
2. Piloting the integration of primary care in a behavioral health organization by partnering with specialty mental health agencies to bring primary care services to SPMI patients.
3. Connecting behavioral health and primary care providers that have an interest in integrated care.

Training and Engagement

CCO 4 sponsored presentations to local physicians associations on the Oregon Psychiatric Access Line about Kids (OPAL-K), a service that provides free, same-day child psychiatric phone consultation to primary care clinicians in Oregon. The presentation included a discussion about how the CCO might provide additional services to higher needs pediatric members. The CCO leadership has a main champion for integrated care. This person has researched integration approaches, innovative reimbursement models, and attended educational conferences on integration.

Metrics and Data Reporting

This CCO has health plan staff responsible for helping practices meet metrics. They specifically have staff who assist with the Follow-Up After Hospitalization for Mental Illness FUH measure by contacting patients after a hospitalization and coordinating needed services in the community. They currently provide a PMPM payment to primary care providers to incentivize meeting the metrics. Other metrics that would be valuable to this CCO include looking at physical health outcomes of patients with certain mental health diagnoses or addictions diagnoses. They also proposed new metrics such as incentivizing practices for providing integrated services.

CCO 5 Summary

Background

CCO 5 covers a large geographic area and operates in many counties, most of which are rural. Behavioral health and primary care initiatives vary across the counties, and a lot of decision making takes place at the county level. CCO 5 community partners include a health plan, a mental health organization (MHO), multiple hospitals, and primary care practices. The CCO majority owners are the health plan and MHO. Before the CCO started, the MHO had a strong presence in the region, but the health plan was new to many of the counties. CCO 5 has several leaders who support integrated care and hope to see more integration efforts in the practices; however, they are not leading a CCO-wide integration effort across the region, and CCO 5 has met some resistance from providers who are concerned there isn't enough funding to provide integrated services and continue to support the SPMI population. One of CCO 5's primary care practices began integrating behavioral health services years before the CCO formed.

Integration Financing

To encourage integration and other transformation efforts, CCO 5 provides a small per-member-per-month (PMPM) payment to Patient Centered Primary Care Home (PCPCH) Tier III practices. However, the majority of primary care practices receive fee-for-service reimbursement. CCO 5 conducted an RFP process to distribute their Transformation Funds. They decided to allocate a portion of that funding to each county for transformation efforts. Some counties chose to use their grants for integration.

Integration Approaches and On-the-ground Activities

We learned about the following integration activities taking place in CCO 5. Integration approaches vary by county. The practices that are beginning to integrate chose to contract with their Community Mental Health Centers (CMHCs) to embed BHCs in primary care. In addition to the activities described below, some of these practices have implemented SBIRT and depression screening.

1. One primary care practice embedded three BHCs who are employed by the local CMHC. The BHCs are in the practice every day to equal a combined 1.0 FTE. They share an EHR with primary care, sit in a pod, and act and feel like part of the team. This practice conducts systematic depression screening, and BHCs are available for warm handoffs. This practice started integration prior to CCO formation.
2. One CMHC embedded two part-time BHCs into a primary care practice. The BHCs in this practice conduct mental health assessments and schedule 50 minute appointments.
3. One pediatric practice hired a psychiatric nurse practitioner from the local CMHC. This practice receives a PMPM payment to help cover those services.

5. One CMHC embedded a BHC into three different primary care practices. The BHC is at each practice one day per week.
6. Prior to the formation of the CCO, the MHO worked with OHA's Medical Assistance Program (MAP) on a pilot project to identify high-risk patients who may benefit from care management and additional services. Some counties chose to continue these hot-spotting efforts after the initial pilot.
7. Two counties provide behavioral health services in school based programs.

Training and Engagement

CCO 5 hosts an annual clinical summit which has included trainings on behavioral health related topics such as Screening, Brief Intervention, Referral to Treatment (SBIRT), chemical dependency and buprenorphine, and trauma informed care. The MHO also hosts a large spring conference on behavioral health services. Some CCO leaders and providers have attended Q-Corp led trainings on integration. To engage primary care practices and assess their readiness for integration, CCO 5 has met with providers throughout the region to discuss integration options. The CCO agreed to provide integration training to practices that wished to start integrating care.

Metrics and Data Reporting

CCO 5 is working to meet the incentive metrics, but some are more challenging than others. Participants reported that the Follow-Up After Hospitalization for Mental Illness (FUH) metric was especially difficult because CCO 5 borders another state. In this region, patients are sometimes hospitalized out of state making communication with primary care practices more difficult. Additional work is also required to reconcile missing encounter data when a patient is hospitalized outside of Oregon. CCO 5 has an employee who reviews the pre-authorizations for hospitalizations and then follows-up with the hospitals to see if a patient has been released. When the patient is released, that person calls the CMHC to notify them that a mental health assessment is needed. This process appears to be working well and helping CCO 5 meet this benchmark. Metric data is reported back to the practices, but it's aggregated for the whole CCO. Providers would like to see county specific data on the incentive metrics, since that's how the CCO is organized, and they would like to use that information to improve their practices.

Appendix 14

OHA Measures Matrix

Measures ¹	2015 CCO Incentive Measures	Quality and Access "Test" Measures	OHA Core Performance Measures	2015 Medicaid Adult Quality Measures	2015 CHIPRA Measures	PEBB Measures	House Bill 2118 (2013) Recommended Measures	Comprehensive Primary Care Initiative Measures	PCPCH Quality Measures	Oregon Insurance Division Measures ²	CMMI Core Measures
Hospital 30-day mortality rate: HF, AMI, COPD, and PN (NQF 0229, 0230, 1893, and 0468)											x
3-item care transition measure (NQF 0228)											x
Ability for providers with HIT to receive lab data electronically directly into their EHR system as discrete searchable data (NQF 0489)											x
ACE inhibitor or ARB therapy – diabetes and/or LVSD (NQF 0066)											x
Activity measure for post-acute care (AM-PAC) – CMS DOTPA short term, public domain version (NQF 0429, 0430)											x
Adherence to antipsychotics for individuals with schizophrenia (NQF 1879)				x							
Adolescent well care visits	x	x			x	x			x		
Body mass index assessment				x ³					x		x ⁴

¹ See table at the end of this document for sources.

² For 2015 rate filings, OID has not required the data reported for these measures to be calculated with uniform specifications, so measure may not exactly match the NQF reference.

³ Adults ages 18 to 74.

Measures ¹	2015 CCO Incentive Measures	Quality and Access "Test" Measures	OHA Core Performance Measures	2015 Medicaid Adult Quality Measures	2015 CHIPRA Measures	PEBB Measures	House Bill 2118 (2013) Recommended Measures	Comprehensive Primary Care Initiative Measures	PCPCH Quality Measures	Oregon Insurance Division Measures ²	CMMI Core Measures
Adult weight screening and follow up (NQF 0421)											x
Alcohol or other substance misuse (SBIRT)	x	x	x			x	x		x		
Ambulatory Care: Outpatient and Emergency Department Utilization	x ⁵	x	x		x ⁶	x ⁷	x ⁸				
HIV viral load suppression				x							
Annual monitoring for patients on persistent medications				x							
Antidepressant medication management (NQF 0105)				x							
Appropriate opioid dose							x				
Appropriate testing for children with pharyngitis (NQF 0002)		x							x		
Appropriate treatment for children with upper respiratory infection (NQF 0069)											

⁴ Children ages 3 to 17.

⁵ Emergency department visits only.

⁶ Emergency department visits only.

⁷ Emergency department visits only.

⁸ Emergency department visits only.

Measures ¹	2015 CCO Incentive Measures	Quality and Access "Test" Measures	OHA Core Performance Measures	2015 Medicaid Adult Quality Measures	2015 CHIPRA Measures	PEBB Measures	House Bill 2118 (2013) Recommended Measures	Comprehensive Primary Care Initiative Measures	PCPCH Quality Measures	Oregon Insurance Division Measures ²	CMMI Core Measures
Asthma pharmacologic therapy (NQF 0047)											x
Avoidance of antibiotic treatment in adults with acute bronchitis (NQF 0058)											
Breast cancer screening (NQF 0031)				x ⁹				x		x	
CAHPS adult and child composite: Access to care	x	x	x	x ¹⁰	x ¹¹	x	x ¹²			x	x ¹³
CAHPS adult and child composite: Satisfaction with care	x	x	x	x ¹⁴	x ¹⁵	x					x ¹⁶
CAHPS: Rating of Health Plan				x ¹⁷	x ¹⁸		x				x ¹⁹
CAHPS adult/child health status			x	x ²⁰	x ²¹						x ²²

⁹ For women ages 50 - 74. May not be comparable to other measures.

¹⁰ 2015 Medicaid Adult Quality Measures include the entire CAHPS Health Plan Survey, which includes this item.

¹¹ 2015 CHIPRA Measures include the entire CAHPS Health Plan Survey, which includes this item.

¹² Only adult members who "always" got care as soon as needed.

¹³ CMMI Core Measures include the entire CAHPS health plan survey, which includes this item.

¹⁴ 2015 Medicaid Adult Quality Measures include the entire CAHPS Health Plan Survey, which includes this item.

¹⁵ 2015 CHIPRA Measures include the entire CAHPS Health Plan Survey Child Version, which includes this item.

¹⁶ CMMI Core Measures include the entire CAHPS health plan survey, which includes this item.

¹⁷ 2015 Medicaid Adult Quality Measures include the entire CAHPS Health Plan Survey Adult Questionnaire, which includes this item.

¹⁸ 2015 CHIPRA Measures include the entire CAHPS Health Plan Survey Child Version, which includes this item.

¹⁹

²⁰ 2015 Medicaid Adult Quality Measures include the entire CAHPS Health Plan Survey Adult Questionnaire, which includes this item.

Measures ¹	2015 CCO Incentive Measures	Quality and Access "Test" Measures	OHA Core Performance Measures	2015 Medicaid Adult Quality Measures	2015 CHIPRA Measures	PEBB Measures	House Bill 2118 (2013) Recommended Measures	Comprehensive Primary Care Initiative Measures	PCPCH Quality Measures	Oregon Insurance Division Measures ²	CMMI Core Measures
Care transition record transmitted to health care professional				x			x				x
Cervical cancer screening (NQF 0032)		x		x					x		
Cesarean rate for low-risk first birth women (NQF 0471)											x
Child and adolescent access to primary care practitioners		x			x						
Child and adolescent major depressive disorder: suicide risk assessment					x						
Childhood immunization status (NQF 0038)		x			x		x		x		x
Chlamydia screening in women ages 16-24 (NQF 0033)		x		x	x ²³		x				
Cholesterol management for patients with cardiovascular conditions: LDL-C screening											
Cholesterol management for patients with cardiovascular conditions: LDL-C control											
Colorectal cancer screening	x	x				x ²⁴	x	x ²⁵	x		x

²¹ 2015 CHIPRA Measures include the entire CAHPS Health Plan Survey Child Version, which includes this item.

²² CMMI Core Measures include the entire CAHPS health plan survey, which includes this item.

²³ Ages 16 to 20.

Measures ¹	2015 CCO Incentive Measures	Quality and Access "Test" Measures	OHA Core Performance Measures	2015 Medicaid Adult Quality Measures	2015 CHIPRA Measures	PEBB Measures	House Bill 2118 (2013) Recommended Measures	Comprehensive Primary Care Initiative Measures	PCPCH Quality Measures	Oregon Insurance Division Measures ²	CMMI Core Measures
Comprehensive diabetes care: Eye exams (NQF 0055)						x	x				x
Comprehensive diabetes care: Foot exams (NQF 0056)											x
Comprehensive diabetes care: HbA1c poor control	x	x		x		x	x	x	x		
Comprehensive diabetes care: HbA1c testing (NQF 0057)		x		x			x		x	x	
Comprehensive diabetes care: LDL-C Screening (NQF 0063)		x							x		
Comprehensive diabetes care: nephropathy assessment (NQF 0062)							X				x
Continuity assessment record and evaluation (CARE) tool											x
Controlling high blood pressure (NQF 0018)	x	x		x		x	x	x	x		x
Coronary Artery Disease (CAD) composite (NQF 0055, 0067, 0070, 0074)									x		x

²⁴ HEDIS specifications. OHA specifications for the CCO incentive measures and "test" measure deviate significantly from HEDIS for CY 2013. These data will not be comparable.

²⁵ NQF 0034. EHR-based quality measure. These data will not be comparable to OHA and PEBB/OEBB measures.

Measures ¹	2015 CCO Incentive Measures	Quality and Access "Test" Measures	OHA Core Performance Measures	2015 Medicaid Adult Quality Measures	2015 CHIPRA Measures	PEBB Measures	House Bill 2118 (2013) Recommended Measures	Comprehensive Primary Care Initiative Measures	PCPCH Quality Measures	Oregon Insurance Division Measures ²	CMMI Core Measures
Cost measures: <ul style="list-style-type: none"> • Total care (excluding PBM Rx, chiro, CAM, behavioral health) • Inpatient facility • Outpatient total (e.g., imaging, lab, other) • Professional total • Primary care • Specialty care/referral • Other 										x	
Dental sealants on permanent molars for children	x				x ²⁶						
Developmental screening in the first 36 months of life (NQF 1448)	x	x	x		x	x	x		x	x	
Diabetes long-term complications (NQF 0274)											x
Diabetes: Blood Pressure Control <140/90 (NQF 0061)								x	x		
Diabetes: LDL-C Control (NQF 0064)								x	x		
Documentation of current medications in the medical record											x

²⁶ Dental sealants for 6 to 9 year-old children at elevated caries risk.

Measures ¹	2015 CCO Incentive Measures	Quality and Access "Test" Measures	OHA Core Performance Measures	2015 Medicaid Adult Quality Measures	2015 CHIPRA Measures	PEBB Measures	House Bill 2118 (2013) Recommended Measures	Comprehensive Primary Care Initiative Measures	PCPCH Quality Measures	Oregon Insurance Division Measures ²	CMMI Core Measures
Effective contraceptive use among women not desiring pregnancy	x		x			x	x				
Electronic Health Record adoption	x	x				x					
Falls: screening for future falls risk (NQF 0101)								x			
Fibrinolytic therapy received within 30 minutes of ED arrival (NQF 0288)											x
Fibrinolytic therapy received within 30 minutes of hospital arrival (NQF 0164)											x
Flu vaccinations for adults age 18 and older from CAHPS (NQF 0039) * Adults ages 18 to 64				x*			x ²⁷				
Follow-up after hospitalization for mental illness (NQF 0576)	x	x	x	x	x	x				x	x
Follow-up care for children prescribed ADHD medications (NQF 0108)		x			x				x		
Frequency of ongoing prenatal care (NQF 1391)					x						x
Healthy term newborn (NQF 0716)											x

²⁷ Adults age 50 and over.

Measures ¹	2015 CCO Incentive Measures	Quality and Access "Test" Measures	OHA Core Performance Measures	2015 Medicaid Adult Quality Measures	2015 CHIPRA Measures	PEBB Measures	House Bill 2118 (2013) Recommended Measures	Comprehensive Primary Care Initiative Measures	PCPCH Quality Measures	Oregon Insurance Division Measures ²	CMMI Core Measures
Heart failure: beta blocker therapy for left ventricular systolic dysfunction (NQF 0083)								x			x
Hospital ED visit rate that did not result in hospital admissions, by condition											x
Human papillomavirus vaccine for female adolescents					x						
Immunization for adolescents (NQF 1407)		x			x		x		x		
Influenza immunization (NQF 0041)								x	x		x
Initiation and engagement of alcohol and other drug treatment (NQF 0004)			x	x							x
Ischemic vascular disease: complete lipid profile and LDL control (NQF 0075)								x			x
Maternity care behavioral health risk assessment					x						
Median time to transfer to another facility for acute coronary intervention (NQF 0290)											x
Medical assistance with smoking and tobacco use cessation from CAHPS (NQF 0027)		x		x			x				
Medicare spending per beneficiary, risk-adjusted, and price standardized											x
Medication management for people with asthma					x		x				

Measures ¹	2015 CCO Incentive Measures	Quality and Access "Test" Measures	OHA Core Performance Measures	2015 Medicaid Adult Quality Measures	2015 CHIPRA Measures	PEBB Measures	House Bill 2118 (2013) Recommended Measures	Comprehensive Primary Care Initiative Measures	PCPCH Quality Measures	Oregon Insurance Division Measures ²	CMMI Core Measures
Mental, physical, and dental health assessments within 60 days for children in DHS custody	x		x ²⁸								
Patient safety for selected indicators (NQF 0531)											x
Patient-Centered Primary Care Home (PCPCH) enrollment	x	x				x					
PC-01: Elective delivery before 39 weeks (NQF 0469)		x		x							x
PC-02: Cesarean section					x		x				x
PC-03: Antenatal Steroids (NQF 0476)				x							
Pediatric Central-line Associated Bloodstream Infections–Neonatal Intensive Care Unit and Pediatric Intensive Care Unit (NQF 0139)					x						
Plan all-cause readmission (NQF 1768)		x	x	x		x	x				x
Pneumococcal vaccination status for older adults (NQF 0043)									x		x
Pneumonia vaccination (NQF 0044)									x		

²⁸ Mental health assessments only.

Measures ¹	2015 CCO Incentive Measures	Quality and Access "Test" Measures	OHA Core Performance Measures	2015 Medicaid Adult Quality Measures	2015 CHIPRA Measures	PEBB Measures	House Bill 2118 (2013) Recommended Measures	Comprehensive Primary Care Initiative Measures	PCPCH Quality Measures	Oregon Insurance Division Measures ²	CMMI Core Measures
Post-discharge continuing care plan created (NQF 0557)											x
Post-discharge continuing plan transmitted to next level of care provider upon discharge (NQF 0558)											x
Potentially avoidable emergency department visits (Medi-Cal methodology)			x								
Potentially avoidable hospital admissions for chronic conditions											
PQI 01: Diabetes, short term complication admission rate (NQF 0272)		x	x	x							
PQI 05: Chronic obstructive pulmonary disease admission rate (NQF 0275)		x		x							x
PQI 08: Congestive heart failure admission rate (NQF 0277)		x		x							x
PQI 09: Low birth weight (NQF 0278)			x		x						
PQI 11: Bacterial pneumonia admission rate (NQF 0279)											x
PQI 12: Urinary tract infection admission rate (NQF 0281)											x
PQI 14: Uncontrolled diabetes admission rate (NQF 0638)			x								

Measures ¹	2015 CCO Incentive Measures	Quality and Access "Test" Measures	OHA Core Performance Measures	2015 Medicaid Adult Quality Measures	2015 CHIPRA Measures	PEBB Measures	House Bill 2118 (2013) Recommended Measures	Comprehensive Primary Care Initiative Measures	PCPCH Quality Measures	Oregon Insurance Division Measures ²	CMMI Core Measures
PQI 15: adult asthma admission rate		x		x							x
PQI 92 – Prevention quality chronic composite							x				
Prenatal and postpartum care: Postpartum care rate (NQF 1517)		x		x			x		x		
Prenatal and postpartum care: Timeliness of prenatal care (NQF 1517)	x	x			x	x	x		x		
Percentage of eligibles who received preventive dental services (ages 1 to 20)					x						
Proportion of days covered: 5 rates by therapeutic category (NQF 0541)											x
Provider access questions (3) from the Physician Workforce Survey <ul style="list-style-type: none"> To what extent is your primary practice accepting new Medicaid/OHP patients? Do you currently have Medicaid/OHP patients under your care? What is the current payer mix at your primary practice? 		x									
Rate of obesity among members			x				x				
Rate of tobacco use among members			x				x				

Measures ¹	2015 CCO Incentive Measures	Quality and Access "Test" Measures	OHA Core Performance Measures	2015 Medicaid Adult Quality Measures	2015 CHIPRA Measures	PEBB Measures	House Bill 2118 (2013) Recommended Measures	Comprehensive Primary Care Initiative Measures	PCPCH Quality Measures	Oregon Insurance Division Measures ²	CMMI Core Measures
Reminder system for mammograms (NQF 0509)									x		
Screening for clinical depression and follow-up plan (NQF 0418)	x	x	x	x		x	x	x	x		x
Tobacco use assessment and tobacco use cessation intervention (NQF 0028)								x	x		x
Use of appropriate medications for people with asthma (NQF 0036)								x	x		
Use of aspirin or another antithrombotic (NQF 0068)											x
Use of imaging studies for low back pain (NQF 0052)											
Utilization buckets: <ul style="list-style-type: none"> • ED utilization/1,000 • ED utilization/1,000 by top 10 diagnoses • Inpatient med/surg days/1,0000 • Advanced imaging (i.e., PET, CT, MRI, nuclear medicine) • Primary care visits/1,000 • Specialty care visits/1,000 										X ^{Error!} Bookmark not defined.	

Measures ¹	2015 CCO Incentive Measures	Quality and Access "Test" Measures	OHA Core Performance Measures	2015 Medicaid Adult Quality Measures	2015 CHIPRA Measures	PEBB Measures	House Bill 2118 (2013) Recommended Measures	Comprehensive Primary Care Initiative Measures	PCPCH Quality Measures	Oregon Insurance Division Measures ²	CMMI Core Measures
Weight assessment and counseling for nutrition and physical activity in children/adolescents: body mass index assessment for children/adolescents (NQF 0024)					x		x	x	x		x
Well-child visits in the 3rd, 4th, 5th and 6th years of life (NQF 1516)					x				x		x
Well-child visits in the first 15 months of life (NQF 1392)		x			x				x		x

For more information about this measures matrix, please contact Sarah Bartelmann at sarah.e.bartelmann@state.or.us.

Measure Set	Source
2015 CCO Incentive Measures, Quality and Access “Test” Measures	http://www.oregon.gov/oha/analytics/CCOData/2015%20Measures.pdf
OHA Core Performance Measures	http://www.oregon.gov/oha/analytics/MetricsDocs/MeasurementStrategy.pdf
2015 Medicaid Adult Quality Measures	http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf
2015 CHIPRA Measures	http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-and-CHIP-Child-Core-Set-Manual.pdf
PEBB Measures	Public Employees’ Benefit Board, <i>Quality Metrics Update</i> . March 17, 2015.
House Bill 2118 (2013) Recommended Measures	http://library.state.or.us/repository/2014/201406021322111/
Comprehensive Primary Care Initiative Measures	http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/CPC_CQM_InstructionGuide.pdf
PCPCH Quality Measures	http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_409/_tables_409/409-055-0040_1-16-15.pdf
Oregon Insurance Division Measures	http://www.oregon.gov/oha/pcpch/Documents/TA-Guide.pdf
CMMI Core Measures	http://innovation.cms.gov/Files/x/PriorityMsrMontEval.pdf

Appendix 15

Sustainability Plan

**Oregon State Innovation Model Project
Sustainability Plan**

			Will these objectives continue post SIM?	Brief description of sustainability plan post SIM
Overarching Oregon SIM Aims and Goal	Aim 1: Spread key elements of the Coordinated Care Model to: State employees; Dual eligibles and other Medicare beneficiaries; Plans on exchange and Oregon Educators.	Goal: 2 million or more Oregonians receiving coordinated care	Yes	Oregon's health transformation activities will continue post SIM funding as they have been built upon existing infrastructure and efforts. While SIM has been invaluable for fueling their initiation, much of the work will be supported through existing and various new strategies. Oregon's goal is to maintain current achievements in cost reductions and health system transformation, and invest in continued efforts to seek additional opportunities to achieve the triple aim of better care, better health and lower costs.
	Aim 2: Reduce per member, per month (PMPM) cost trend while maintaining or improving quality: Maintain or reduce Medicaid PMPM trend; Maintain or reduce public employee PMPM trend; Maintain or reduce PMPM trend for duals.			
SIM Driver 1: Improving care coordination at all points in the system with an emphasis on patient-centered primary care homes				
Patient Centered Primary Care Homes				
Post SIM key objectives	<ol style="list-style-type: none"> 1. Provide technical assistance for practice transformation 2. Health systems increasingly make use of recognized PCPCHs 3. Conduct verification visits 4. Increased numbers of clinics recognized and recertified as PCPCHs 		Yes	The Patient-Centered Primary Care Program is a cornerstone of the coordinated care model. The program will continue to provide technical assistance to support clinics' application processes, and re/certification efforts. Verification activities will continue. These activities will be supported by state general funds post SIM.
Health Information Technology				
Post SIM key objectives	<ol style="list-style-type: none"> 1. Spread awareness of HIT 2. Identify new technology and approaches and implementation for HIT/HIE Phase 2 business framework 		Yes	Health information technology and health information exchange activities will continue post SIM, supported by state general funds, federal funds and other resources as identified and available.
Long Term Supports and Services				
Post SIM key objectives	<ol style="list-style-type: none"> 1. Continue collaboration between long term care innovator agents, community stakeholders, coordinated care organizations and the Oregon Health Authority to identify opportunities for systems change 2. Continue reporting on long term supports and services metrics 		Yes	Adults and People with Disabilities Division of the Department of Human Services is continuing to explore opportunities to utilize Medicaid administrative match to sustain activities and goals post SIM.

Medicare/Medicaid Dual Eligibles

Post SIM key objectives	<ol style="list-style-type: none"> 1. Integrated appeals notices and streamlined plan info 2. Expand CCO model to Medicare 3. Medicaid/Medicare alignment activities achieved 	Yes	The work to integrate delivery for dually eligible populations will continue post SIM. Oregon is exploring incorporating portions of this body of work into the upcoming Medicaid waiver renewal discussions.
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SIM Driver 2: Implementing alternative payment methodologies to focus on value and pay for improved outcomes

Alternative payment methodologies

Post SIM key objectives	<ol style="list-style-type: none"> 1. Continue to offer technical assistance to CCOs to support implementation of APMS as reflected in their Transformation Plan 2. Continue support for FQHC APM pilots 3. APMs and cost control measures included in plans offered on health insurance exchange 4. Coordinated care model key delivery elements included in Oregon Educators Benefit Board contracts 	Yes	The Transformation Center and the Oregon Health Authority will continue to lead and support delivery system efforts to adopt alternative payment models across payers and populations. This work will continue post SIM, supported by state general funds, community support as well as other resources as they are identified and available. New SB 231 includes a legislatively directed multi-payer collaborative. OHPB's work on CCM alignment will continue to support OEBC efforts. Conversations underway with the Department of Consumer and Business Services (DCBS) and the Insurance Marketplace for future qualified health plan procurement strategies linked to the coordinated care model.
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SIM Driver 3: Integrating physical, behavioral and oral health care with community health improvement

Health Equity Initiatives: DELTA Training, Regional Health Equity Coalitions and Health Care Interpreters

Post SIM key objectives	<ol style="list-style-type: none"> 1. Continue to offer the DELTA leadership program 2. Conduct quarterly regional equity coalition site visits 3. Coalitions execute strategic plans 	Variable	The DELTA project is exploring a fee based sustainability solution (charging tuition for participants). The regional equity coalitions are pursuing private funding. The three founding coalitions are independently funded and the three started with SIM resource are already experiencing very encouraging results for grant funding. The Office of Equity and Inclusion will support all six coalitions post SIM with modest state general funds support. The Healthcare Interpreter Project was always intended to be a time and resource limited activity. The investment of SIM resources will produce 150 new professional healthcare interpreters across the state to jumpstart improved access and quality.
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Population Health			
SIM key objectives	<ol style="list-style-type: none"> 1. Execute Oregon's State Health Improvement Plan 2. Continue to identify and conduct community prevention projects as resources are available 3. Continue to conduct and disseminate Medicaid BRFSS results 4. Continue to conduct and disseminate Oregon Healthy Teen results 5. Continue to conduct and disseminate BRFSS racial/ethnic oversample results 	Yes	Oregon has adopted and released the State Health Improvement Plan supported in part by SIM. The Public Health Division and the Oregon Health Authority will continue to focus strategies and activities to achieve the goals established in this plan post SIM. Oregon's public health system is undergoing a legislatively mandated modernization effort to align and integrate population health and health system transformation goals and strategies. Ninety percent of the Public Health Division's funding flows through federal resources.
Early Learning Councils			
Post SIM key objectives	<ol style="list-style-type: none"> 1. Continue to develop collaborations between coordinated care organizations and early learning hubs 2. Continue to drive toward kindergarten readiness 	Yes	Collaboration between coordinated care organizations and early learning hubs will continue. The work will be overseen by the joint Oregon Health Policy Board/Early Learning Council workgroup, and conducted under the Maternal/Child Health Program within the Public Health Division. Funding resources are still to be determined, but likely a combination of state and federal funding streams.
SIM Driver 4: Standards and accountability for safe, accessible and effective care			
Translating Evidence to Practice: Health Evidence Review Commission			
Post SIM key objectives	Develop or adapt clinical decision tools for spread to CCOs, health plans, health systems, providers including a set of patient decision support materials	Yes	Translating evidence for provider and patients will remain a key focus post SIM. Ongoing updates of guides for evaluating best tools is under consideration for potential funding strategies.
SIM Driver 5: Testing, acceleration and spread of effective delivery system and payment innovations			
Transformation Center			
Post SIM key objectives	<ol style="list-style-type: none"> 1. Operate a learning management system focused on rapid cycle learning by offering learning collaboratives and technical assistance 2. Improve rate of clinical innovation 3. Spread the coordinated care model to other payers and populations 4. Implement the Transformation Center sustainability plan 	Yes	The Transformation Center will continue to provide technical assistance and support for adoption and spread of the coordinated care model across payers and populations post SIM. The Oregon Health Authority requested, and the legislature appropriated state general funds to continue the Center with it's current staffing and level of resources through at least June 2017. Sustainability planning for the Transformation Center will continue during SIM demonstration period three.

Testing, Analysis and Evaluation

Post SIM key objectives	1. Continue to apply analytic tools for improvement 2. Continue to publish coordinated care organizations quarterly dashboard 3. Continue to publish multi-payer quarterly dashboard	Yes	The Office of Health Analytics will continue post SIM with a focus on measuring and publishing performance data. The All Payers/All Claims database is a key resource to compile and analyze use and quality data and will continue post SIM, supported by state general funds.
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Appendix 16

**July 2015 through September
2016 Timeline and Milestones**

**Appendix 12, Revised July 2015
Oregon State Innovation Model Project
July 2015 through September 2016 Timeline and Milestones**

		July-Sept 2015	Oct-Dec 2015	Jan-March 2016	April-June 2016	July-Sept 2016	October 2016 & beyond
Overarching Oregon SIM Aims and Goal	Aim 1: Spread key elements of the Coordinated Care Model to: State employees by January 2015; Dual eligibles and beneficiaries by January 2016; Exchange participants and Oregon Educators by September 2017.						2 million or more Oregonians receiving coordinated care
	Aim 2: Reduce per member, per month (PMPM) cost trend while maintaining or improving quality: Reduce Medicaid PMPM trend 2 percentage points (p.p.) by FY 2015; Reduce public employee PMPM trend 2 p.p. by FY 2016; Reduce PMPM trend for duals 1 p.p. by 2016.						
SIM Driver 1: Improving care coordination at all points in the system with an emphasis on patient-centered primary care homes							
Responsible Lead: Nicole Merrithew		Patient Centered Primary Care Homes					
Key objectives by demonstration period		1. Continue to provide technical assistance for practice transformation 2. Health systems increasingly make use of recognized PCPCHs 3. Review and refine criteria 4. Conduct verification visits for a total of 50 over the period 5. 500 Clinics recognized as PCPCHs	1. Continue to provide technical assistance for practice transformation 2. Health systems increasingly make use of recognized PCPCHs 3. Conduct 50 verification visits 4. 600 Clinics recognized as PCPCHs				
Technical assistance	PCPCH Institute providing TA and practice transformation assistance	X	X	X	X	X	X
	Coordinate ongoing technical assistance, including PCPCH Learning Collaboratives, through Patient-Centered Primary Care Institute	X	X	X	X	X	X
Communications	Update and align PCPCH communications plan and stakeholder engagement strategy		X				X
	Maintain and update PCPCH web content	X	X	X	X	X	X
Administration	Manage relational PCPCH database for program administrative needs	X	X	X	X	X	X
Verification	Continue site visit clinical consultant TA pilot project, continuing post SIM	X	X	X	X	X	X
	Schedule, coordinate, and conduct at least 50 PCPCH verification site visits each period, continue verification visits post SIM	X	X	X	X	X	X
	600 clinics recognized as PCPCHs by the end of SIM and continued growth going forward					X	X
Evaluation	Conduct ongoing PCPCH program evaluation and analysis		X				X
	Develop annual PCPCH program report			X			X
Responsible Lead: Susan Otter		Health Information Technology					

		July-Sept 2015	Oct-Dec 2015	Jan-March 2016	April-June 2016	July-Sept 2016	October 2016 & beyond
Key objectives by demonstration period		1. Continue to spread awareness of HIT 2. Launch telehealth pilots 3. Continue to identify new technology and approaches and implementation for HIT/HIE Phase 2 business framework	1. Spread awareness of HIT 2. Evaluate telehealth pilots 3. Identify new technology and approaches and implementation for HIT/HIE Phase 2 business framework				
Stakeholder Engagement	Stakeholder planning on governance, sustainability, Phase 2	X	X	X	X	X	X
Spread Awareness of HIT and Triple Aim	Develop materials and provide training on health information technology	X	X	X	X	X	X
	Spread awareness about HIT and how it can be used in various setting to advance the triple aim.	X	X	X	X	X	X
	Train Transformation Center staff on HIT as a tool to accelerate transformation	X	X	X	X	X	X
Emergency Department Information Exchange (EDIE)	EDIE implemented in all 59 hospitals	X	X	X	X	X	X
	Continue EDIE Plus Utility operations	X	X	X	X	X	X
PreManage program	Continue availability of PreManage to CCOs, plans, providers	X	X	X	X	X	X
CareAccord	CareAccord and Flat File Directory continues; continue work on trust communities	X	X	X	X	X	X
	CareAccord enhancements and outreach implemented	X	X	X	X	X	X
Telehealth Pilot Projects	Telehealth/mobile device pilots implemented in the field	X	X	X			
	Evaluate effectiveness of pilots, issue final report					X	
Provider directory, and clinical quality metrics registry	Prioritize development of provider directory and clinical quality metrics registry. Implementation underway with contracted vendors	X	X	X	X	X	X
	Contract with consultant(s) to identify new technology and provide expert advice on approaches and implementation for HIT/HIE Phase 2 business framework	X	X	X	X	X	X
Responsible Lead: Naomi Sacks	Long Term Supports and Services						
Key objectives by demonstration period		1. Continue to foster collaboration between long term care innovator agents and OHA innovator agents to identify opportunities for systems change 2. Finalize LTSS metrics	1. Continue collaboration between long term care innovator agents and OHA innovator agents to identify opportunities for systems change 2. Continue reporting on LTSS metrics 3. Complete evaluation of housing with services pilot				
Long Term Supports and Services Innovator Agents	In collaboration with OHA Innovator Agents, act as liaisons in the field providing linkages and support to LTSS agencies and CCOs	X	X	X	X	X	X
	Foster collaboration opportunities to identify need for systems change between LTSS Innovator Agents and OHA Innovator Agents	X	X	X	X	X	X

		July-Sept 2015	Oct-Dec 2015	Jan-March 2016	April-June 2016	July-Sept 2016	October 2016 & beyond
LTSS coordination and outcomes-shared accountability	Finalize LTSS metrics and plan implementation	X					
	Data collection begins for LTSS metrics	X	X	X	X	X	X
	LTSS metrics reporting begins		X	X	X	X	X
	Continue implementation of study group project plan recommendations	X	X	X	X	X	X
	Study Group Project Plan implemented		X	X	X	X	
	Assess readiness to begin evolution of the Memoranda of Understanding (MOU) between AAAs, DHS, and CCOs	X					
	Evolve the MOU tool to align with needed improvements		X	X	X	X	X
Housing with Services Project	Continue housing with services project	X	X	X	X	X	X
	Complete evaluation of housing with services pilot		X	X	X	X	
Responsible Lead: Jennifer Valentine	Medicare/Medicaid Dual Eligibles						
Key Objectives by demonstration period		1 Dual eligible individuals enrolled by choice to CCO and aligned Medicare Advantage plans 2. Expand CCO model to Medicare 3. Medicaid/Medicare alignment without wavier achieved	1. Integrated appeals notices and streamlined plan info				
Medicaid/Medicare alignment activities requiring waivers:	Integrated appeals notices		X	X	X	X	X
	Align to Medicare to ease confusion and more seamless handling of Dual noticing	X	X	X	X	X	X
	Integrated and streamlined plan summary info for enrollees and potential enrollees		X	X	X	X	X
	Develop communications to increase awareness of benefits to accessing MA and OHP in managed care/CCO	X	X	X	X	X	X
	Implement strategies to reduce barriers to CCO enrolment	X	X	X	X	X	X
	Implement strategies to align EOB and overcome barriers	X	X	X	X	X	X
Delivery system reforms	Increase number of Dual Eligible Individuals enrolled by choice into CCO and affiliated MA plan (See strategies for streamlined plan info above)	X	X	X	X	X	X
	Expansion of the CCO model to Medicare population and use Inno Agents to work with CCOs to disseminate best practices for serving dually eligible individuals.	X	X	X	X	X	X

		July-Sept 2015	Oct-Dec 2015	Jan-March 2016	April-June 2016	July-Sept 2016	October 2016 & beyond
	Use Innovator Agents to promote subcontracting strategies for Medicare Advantage delivery systems that are aligned with CCO strategies.	X	X	X	X	X	X
	Use CMS/State alignment workgroup to promote subcontracting strategies for Medicare Advantage delivery systems that are aligned with CCO strategies.	X	X	X	X	X	X
Medicaid/Medicare alignment activities not requiring waivers:	Appeals			X			X
	Member materials/outreach	X	X	X	X	X	X
	Quality improvement/reporting	X	X	X	X	X	X
	Integrated oversight	X	X	X	X	X	X
	Shared accountability for long term care	X	X	X	X	X	X
	Integrated Medicare/Medicaid data analysis	X	X	X	X	X	X
	Medicaid-Medicare administrative alignment	X	X	X	X	X	X
SIM Driver 2: Implementing alternative payment methodologies to focus on value and pay for improved outcomes							
Responsible Leads: Chris DeMars	Alternative payment methodologies						
Key objectives by demonstration period		1. CCOs implementing APMs as reflected in their Transformation Plans; 2. PEBB incorporating APMs 3. Continue assessment of FQHC APM pilots for spread opportunities 4. Continue work with hospital association to prepare smaller hospitals for transformation.	1. CCOs implementing APMs as reflected in their Transformation Plan 2. Continue assessment of FQHC APM pilots for spread opportunities 3. APMs and cost control measures included in plans offered on Marketplace 4. Coordinated care key delivery elements included in Oregon Educators Benefit Board contracts Oct 2017				
Engaging stakeholders	Transformation Center consults with payment reform experts to inform and advise the state and stakeholders on payment approaches	X	X	X	X	X	X
	Multi-Payer Strategy Workgroups in partnership with Oregon Health Leadership Council for engagement and collaboration on APMs with regular feedback and evaluation of impact during implementation	X	X	X	X	X	X
	Ongoing engagement of providers, health systems, hospitals re APMS for input and assessing impact	X	X	X	X	X	X
	Work with CCOs and private payer stakeholders to assess their need for information and assistance on payment reform within their network	X	X	X	X	X	X
Implementing Alternative Payment Methodology (APM) Strategies	CCOs implementing APM per transformation plans	X	X	X	X	X	X
	Monitor use of APMs and cost control measures by PEBB vendors	X	X	X	X	X	X

		July-Sept 2015	Oct-Dec 2015	Jan-March 2016	April-June 2016	July-Sept 2016	October 2016 & beyond
	Continue assessment of FQHC alternative payment pilots for potential spread more widely	X	X	X	X	X	X
Preparing small hospitals for transformation	Continue work with Oregon Association of Hospitals and Health Systems to prepare smaller hospitals for transformational changes	X	X	X	X	X	X
Elements of Coordinated Care Model in Public Employees (PEBB) contracts for 2015 benefit year and maintain going forward	PEBB contracts negotiated and executed	X (completed)			X		X
Elements of Coordinated Care Model in Oregon Educator Benefit Board contract renewals for 2017 benefit	Governor appoints four new members to OEGB Board	X					
	Orient new OEGB members to the coordinated care model	X	X				
	Develop and execute a stakeholder engagement strategy and timeline for contracting with plans		X	X	X		
	Estimate OEGB RFP Posted				X	X	
	Estimate proposals evaluated and selected						November 2016
	Estimate OEGB contract negotiated and executed						March 2017
	APMs and cost control measures in OEGB contracts starting Sept 2017						Sept 2017 & onward
	Coordinated care delivery key elements in OEGB contracts						Sept 2017 & onward
SIM Driver 3: Integrating physical, behavioral and oral health care with community health improvement							
Responsible Lead: Carol Cheney	Health Equity Initiatives: DELTA Training, Regional Health Equity Coalitions, Health Care Interpreters						
Key objectives by demonstration period		1. Complete DELTA cohort #3 2. Train 50 new professional health care interpreters 3. Conduct quarterly regional equity coalition site visits 4. Coalitions produce strategic plans including sustainability	1. Launch DELTA cohort #4 2. Train 100 new professional health care interpreters 3. Conduct quarterly regional equity coalition site visits 4. Coalitions develop and execute strategic plans, including sustainability plans				
DELTA Training Project	Complete DELTA cohort 3	X					
	Recruit and launch DELTA cohort 4	X		X	X	X	
	Provide follow up coaching and mentoring	X				X	
	Complete DELTA evaluation					X	
Regional Equity Coalitions Project	Conduct REC site visits quarterly	X		X		X	
	Convene statewide meetings for coalition trainings (in-person, webinar)	X		X		X	
	Provide health equity technical assistance	X	X	X	X	X	
	Each coalition produces a strategic plan, including sustainability					X	
Equity Health Care Interpreter Project	Conduct health care interpreter learning collaborative	X	X	X	X	X	

		July-Sept 2015	Oct-Dec 2015	Jan-March 2016	April-June 2016	July-Sept 2016	October 2016 & beyond	
	Conduct training for providers on the role and utilization of HCIs	X		X		X		
	150 new professional health care interpreters operating in the field					X		
Responsible Leads: Michael Tynan, Cara Biddlecom	Population Health							
Key objectives by demonstration period		1. Continue community prevention projects 2. Add data sets to OPHAT 3. Conduct data collection and analyze Medicaid BRFSS data 4. Administer Oregon Healthy Teens survey analyze data 5. Conduct data collection and analyze BRFSS racial/ethnic oversample 6. Complete development of the State Health Improvement Plan (satisfies PH Roadmap SIM deliverable)	1. Publish and begin implementation of State Health Improvement Plan 2. Complete and evaluate community prevention projects 3. Disseminate Medicaid BRFSS results 4. Disseminate Oregon Healthy Teen results 5. Disseminate BRFSS racial/ethnic oversample results					
SIM public health roadmap	Release State Health Improvement Plan (SHIP)	X						
	Conduct population health improvement activities as described in SHIP	X	X	X	X	X		
	Develop post SIM sustainability plan		X	X	X	X		
Community prevention projects	Continue implementation and complete evaluation	X	X	X	X	X		
Oregon Public Health Analytic Tool	Add datasets to the Oregon Public Health Analytic Tool (OPHAT), develop training plan for local users of the tool for the purposes of supporting community health assessments. Develop plan for adding new datasets to OPHAT by January 2015 and implement	X	X	X				
Oregon Healthy Teens	Analyze OR Health Teen data	X	X					
	Summarize and disseminate OHT results			X	X			
BRFSS Racial/Ethnic Oversample	Conduct data collection for BRFSS racial/ethnic oversample	X	X	X	X			
	Weight and analyze BRFSS racial/ethnic oversample				X			
	Summarize BRFSS racial/ethnic oversample results					X		
Public Health Policy Institute	Conduct and evaluate policy institute	X						
Billing Services	Broker relationships between local public health and commercial plans	X	X					
Responsible Lead: Kate Wilcox	Early Learning Councils							
Key objectives by demonstration period		1. Develop at least two collaborations between CCOs and ELC 2. Achieve kindergarten readiness	1. Develop at least two collaborations between CCOs and ELC 2. Achieve kindergarten readiness					
	Monitor collaborations between CCOs and Early Learning Council to achieve kindergarten readiness	X	X	X	X	X		
	Coordinate screening, services, and data across CCOs and early learning hubs	X	X	X	X	X		

		July-Sept 2015	Oct-Dec 2015	Jan-March 2016	April-June 2016	July-Sept 2016	October 2016 & beyond
SIM Driver 4: Standards and accountability for safe, accessible and effective care							
Responsible Lead: Darren Coffman		Translating Evidence to Practice: Health Evidence Review Commission					
Key objectives by demonstration period		Develop or adapt clinical decision tools for spread to CCOs, health plans, health systems, providers including 3 sets of patient decision support materials	Develop or adapt clinical Decision tools for spread to CCOs, health plans, health systems, providers including 3 sets of patient decision support materials				
	Implement recommendations of Oregon Health Sciences University, Center for Evidenced Based Policy review of the process to develop evidence-based clinical decision tools and recommend improvements	X	X	X	X	X	X
	Develop set of Patient Decision Support Materials		X			X	
SIM Driver 5: Testing, acceleration and spread of effective delivery system and payment innovations							
Responsible Lead: Chris DeMars		Transformation Center					
Key objectives by demonstration period		1. Operate a learning management system focused on rapid cycle learning by offering learning collaboratives 2. Improve rate of clinical innovation by conducting a learning program for the Council of Clinical Innovators 3. Provide technical assistance □	1. Operate a learning management system focused on rapid cycle learning by offering learning collaboratives 2. Improve rate of clinical innovation by conducting a learning program for the Council of Clinical Innovators 3. Spread the CCM to other payers and populations 4. Develop and implement the Transformation Center sustainability plan				
Strategic Planning	Develop and implement two year strategic plan for Transformation Center 2.0	X	X	X	X	X	X
Learning Collaboratives and Quality Improvement Training	Establish and maintain an online learning platform. Ongoing	X	X	X	X	X	X
	Align learning collaborative activities with strategic plan, launch and deliver new learning collaboratives	X	X	X	X	X	X
	Continue Quality and Health Outcomes learning collaborative ongoing	X	X	X	X	X	X
	Continue Improvement Science Community of practice learning collaborative	X	X	X	X	X	TBD
	Collect and analyze learning collaborative evaluation data and provide a report		X		X		TBD
	Plan and conduct annual Coordinated Care Model conference	X	X				TBD
Clinical Innovation	Conduct second cohort of Council of Clinical Innovators program	X	X	X	X		TBD
Technical Assistance and Outreach	Conduct outreach activities, ongoing	X	X	X	X	X	X
	Operate Technical Assistance Bank, provide targeted ongoing support to improve performance	X	X	X	X	X	X
	Complete analysis and compile data related CCO documents. Create and maintain searchable database	X	X	X	X	X	X

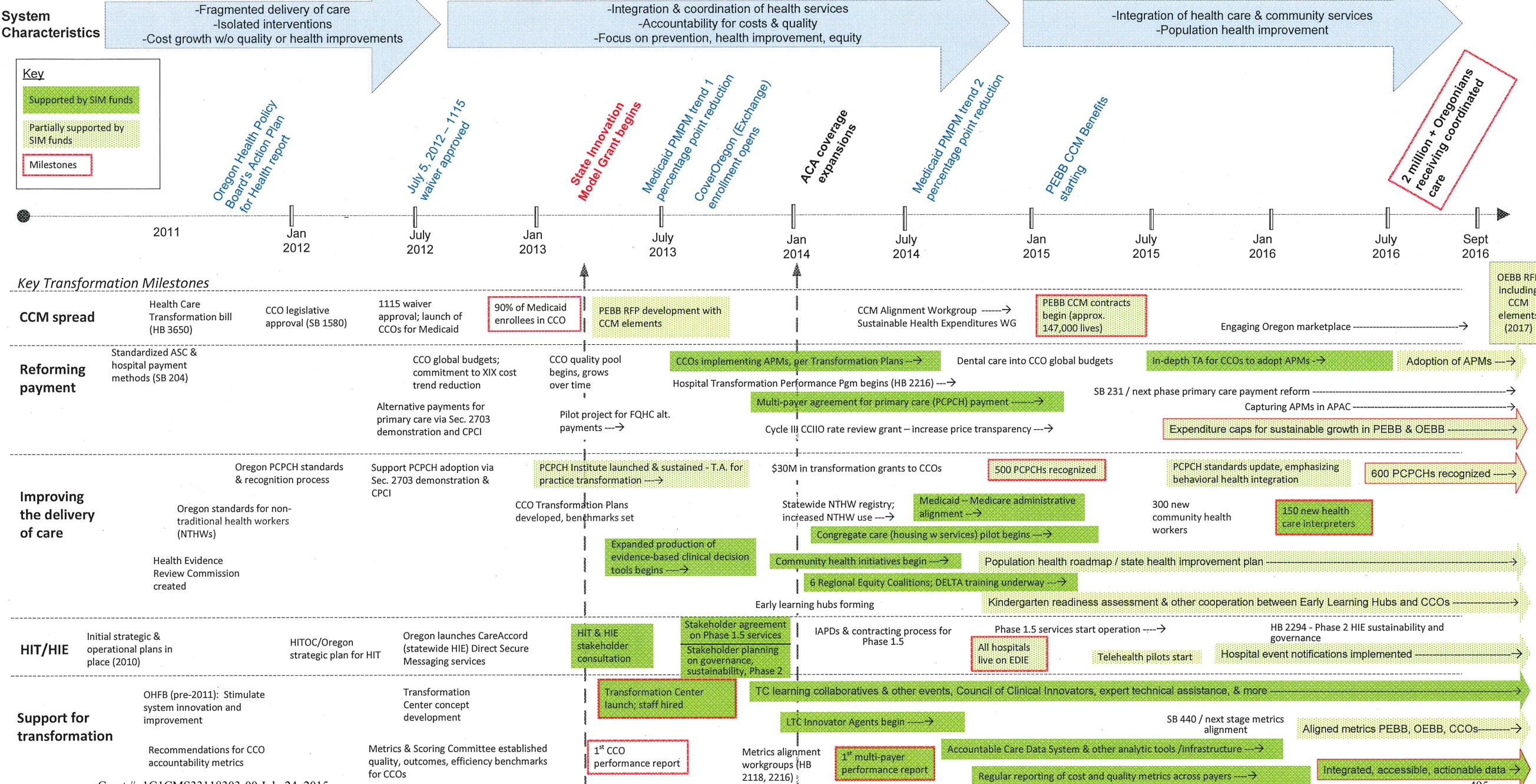
		July-Sept 2015	Oct-Dec 2015	Jan-March 2016	April-June 2016	July-Sept 2016	October 2016 & beyond
Sustainability	Develop and execute Transformation Center Sustainability Plan	X	X	X	X	X	X
Communications	Implement master communications plan. Ongoing	X	X	X	X	X	X
	Maintain Transformation Center website, updates ongoing	X	X	X	X	X	X
Responsible Leads: Lori Coyner, Jonah Kushner	Testing, Analysis and Evaluation						
Key objectives by demonstration period		1. Continue to apply analytic tools for improvement 2. Continue to publish CCO quarterly dashboard 3. Begin publishing multi-payer quarterly dashboard 4. Track degree and spread of CCM	1. Continue to apply analytic tools for improvement 2. Continue to publish CCO quarterly dashboard 3. Continue to publish multi-payer quarterly dashboard 4. Contract for independent analysis of spread 5. Contract for independent analysis of association between CCM key elements and changes in cost or quality 6. Complete analysis and evaluation of individual initiatives				
Integration of data across platforms to support all evaluation, metrics, and analytic functions	Analytic tools for improvement (e.g. hot spotter reports)	X	X	X	X	X	X
	Develop and maintain an online data hub. 1. Contract for expertise in developing business case and procurement 2. Develop and post RFP for vendor to develop online data hub 3. Maintain data hub going forward to increase access to data by stakeholders	X	X	X	X	X	X
Spearhead collection of key data elements needed for evaluation of CCM spread & ROI:	Incorporate Medicare FFS data into APAC for cross-payer analytics; test and validate	X	X	X	X	X	X
	Annual fielding of CAHPS survey, expand sample for CCO-level estimates			X			TBD
	Conduct 3rd round of Oregon Health Insurance Survey			X			TBD
	Publish CCO Health System Transformation dashboard with quality, utilization and financial data, ongoing	X	X	X	X	X	X
	Publish Multi-payer dashboard with quality, utilization and financial data, ongoing	X	X	X	X	X	X
	Produce and publish integrated, accessible actionable data				X	X	X
Comprehensive Evaluation Activities	Monitor costs and savings against projected ROI (ongoing)	X				X	
Evaluation Objective #1 Assess the success of CCM in Medicaid and Evaluation Objective #3: Assess the degree to which individual CCM elements contribute to success of model	Quarterly tracking and reporting of quality and cost for Medicaid	X (Aug)	X (Nov)	X (Feb)	X (May)	X (Aug)	ongoing

		July-Sept 2015	Oct-Dec 2015	Jan-March 2016	April-June 2016	July-Sept 2016	October 2016 & beyond
Evaluation Objective #2: Assess the degree and pace of spread of CCM to other payers and populations and Evaluation Objective #3: assess the degree to which individual CCM elements contribute to the success of the model	Regular assessment of spread of CCM into non-Medicaid markets		X			X	ongoing
	Quantitative analysis of spread (or "spillover") of CCM into non-Medicaid markets	X	X	X	X		
Responsible Lead: Beth Crane	SIM Grant and Business Management						
Key objectives by demonstration period		1. Continue coordination of grant activities and communications 2. Continue timely and accurate reporting to federal funders 3. Continue to provide tools for grant and program management	1. Continue coordination of grant activities and communications 2. Continue timely and accurate reporting to federal funders 3. Continue to provide tools for grant and program management 4. Conduct grant close out activities				
Coordinate grant activities	Regular communication and updates with CMMI SIM Project Officer, ongoing	X	X	X	X	X	X
Conduct grant management activities	Quarterly Progress and Financial Reporting	30-Jul	30-Oct	30-Jan	30-Apr	30-Jul	
	Submit Non-Competing Continuation Application	3-Aug					
	Submit Final Report						30-Dec
	Coordinate grant activities, applications, reports, ongoing	X	X	X	X	X	
	Ongoing work with SIM Steering Committee and OHA leadership to align SIM activities, address needs, concerns, issues necessary to successfully complete SIM operational plan	X	X	X	X	X	
	Ongoing monitoring for risks to successful completion of SIM activities and assess need to activate risk mitigation strategies	X	X	X	X	X	
	Conduct SIM Operations meetings, ongoing	X	X	X	X	X	
	Disseminate CMMI webinar and technical assistance products. Post Oregon products to CMMI collaborative site, ongoing	X	X	X	X	X	
	Develop, execute and monitor budget, ongoing	X	X	X	X	X	
	Provide quarterly financial reports	X	X	X	X	X	
	Develop, coordinate and monitor SIM related contracts, ongoing with scrutiny to prevent fraud and abuse	X	X	X	X	X	
	Provide SIM related human resource services for recruitment and hiring with ongoing monitoring of needs over the test years in collaboration with OHA HR dept.	X	X	X	X	X	
	Process SIM expenditures for payment, ongoing	X	X	X	X	X	
	Plan, coordinate and execute close out activities				X	X	

Appendix 17

Oregon Health System Transformation High-Level Timeline

OREGON HEALTH SYSTEM TRANSFORMATION HIGH-LEVEL TIMELINE



Appendix 18

The Evolution of Coordinated Care Models across Multiple Markets

	2013	2014	2015	2016	2017	2018
Target Convergence Date: 2017 >>						
Oregon Health Plan CCO	CCO v 1.0	CCO v 1.0	CCO v 2.0	CCO v 2.0	CCO v 3.0	CCO v 3.0
Oregon PEBB (with local govt. option*)	PPO/KP	PPO/KP				
		RFP including CCMs	CCMs	CCMs	CCMs	CCMs
Oregon OEGB (Oct. Plan Year) (with local govt. option*)	PPO / HMO	PPO & HMO plans	PPO & HMO plans	PPO & HMO plans	CCM elements	
					RFP incl. CCMs	CCMs
Oregon Marketplace						
<i>Individual</i>	Pre-operational	QHPs 1.0	QHPs 1.0	QHPs 1.0		
<i>Small Group</i>				Under discussion	Potential start -->	
<i>School District HIX Option ^</i>			None	TBD	TBD	TBD
Other Market Segments[#] (Commerical market outside Cover Oregon, self-insured, Medicare)	Various	Intro. elements via CCM Alignment grp -->	Intro. elements via CCM Alignment grp -->	Intro. elements via CCM Alignment grp -->	Continue to work with other market segments	Continue to work with other market segments
Target Convergence Date: 2017 >>						
* See HB 2279 (2013 OR Legislative session). Local governments may elect to participate in PEBB or OEGB.						
^ See HB 4164 (OR Laws 2012, Chapter 38) and HB 2128 (2013 OR Legislative Session). School districts may participate in the Marketplace starting in 2015.						
[#] See also Governor Kitzhaber's July 1, 2013 letter to Secretary Sebelius.						

Appendix 19

Risk Mitigation Plan

Risk Factors	Prioritized Risk Mitigation Strategies	Priority Resources	Lead Entity/Person	Relevant Workgroups	Next Steps	Timeline
Request for proposals for Oregon Educators Benefits Board (OEBB) is delayed due to unforeseen complexity issues, which in turn delay completion of contract negotiations with successful bidders	1. Fill vacant four vacant positions on the OEBB board; 2. Orient new board members to the benefits of the coordinated care model and the expected return on investment; 3. Develop community engagement strategies with new board with relevant lessons learned from the Public Employee Benefits Board (PEBB) process and consultation from CMMI 4. Develop timeline and milestones; 5. Implement community engagement strategies; 6. Implement request for proposal (RFP) process ; 7. Evaluate proposals, negotiate and award contracts	High	Kathy Loretz/Denise Hall	OEBB Board; appointments coordinated with the Governor's Office	Fill four vacant positions on OEBB board. Orient new members to the coordinated care model.	October 2015
Request for proposals for Oregon Educators Benefits Board (OEBB) is delayed due to unforeseen administrative issues, which in turn delay completion of contract negotiations with successful bidders	Implement request for proposal (RFP) process with lessons learned from PEBB and with consultation from CMMI, and Establish a timeline with milestones and adequate time for posting the RFP, evaluating responses and conducting negotiations	High	Kathy Loretz/Denise Hall	OEBB Board, with OHPB Coordinated Care Alignment workgroup & OHP staff; OHA Comms staff and Transformation Center	1) Adjust timeline with leadership to reflect new RFP release date and educate new OEBB board members; and 2) Complete work underway on best messaging to members and employers on CCM	August 2015 start, ongoing through December 2015
CCO governing board unwilling to pursue broader APM without multi-payer involvement	OHA encourages APM adoption by incorporating APM requirements in PEBB and OEBB contracts	High	Kathy Loretz/Denise Hall	PEBB and OEBB	Finalize OEBB request for funding proposal to specify APM plans	Spring 2016
CCO governing board unwilling to pursue broader APM without multi-payer involvement	Oregon Health Policy Board (OHPB) and the Transformation Center respond to the Center for Evidence Based Practice APM survey results and recommendations	High	1) Chris DeMars, 2) Nicole Merrithew & DCBS	OHPB, Transformation Center, PCPCH program, DCBS	1) Transformation Center proceeds with Center for Evidence Based Policy work with interested CCOs to pursue community multi-payer conversations with 2-3 pilot sites; and 2) Implement SB 231 primary care investment reporting and statewide learning collaborative	Summer & Fall 2015
CCO governing board unwilling to pursue broader APM without multi-payer involvement	OHA Health Analytics continues to monitor APM implementation at CCO level, partnering with DCBS and the PCPCH program re SB 231 reporting on Primary Care APMs	Medium	Jonah Kushner & Nicole Merrithew	OHA Office of Health Analytics & PCPCH program with DCBS	Analyze CCO quarterly financial reports, develop new private sector reporting for SB 231	July 2015 and ongoing
Dashboard is not functional due to technical issues	Working with Oregon Health Policy Board (OHPB) and other stakeholders to obtain feedback from purchasers on content and design	Medium	Lori Coyner	All Payers all Claims (APAC) workgroup; OHPB's Coordinated Care Alignment Committee	OHPB workgroup continues to provide feedback; Sustainable Expenditures WG Phase 2 work	December 2015
Dashboard is not functional due to technical issues	Assembling group of technical advisors to examine output both in metrics and using APAC	Medium	Lori Coyner	n/a	Issued membership agreements to technical advisors, advisory groups continues to refine dashboard and metrics development	Fall 2015
Dashboard is not functional due to technical issues	Dashboard piloted with CCOs before spread to other payers	High	Lori Coyner	Metrics technical advisory group (TAG) ; APAC advisory group; OHPB	Generating APAC quarterly reports with Leading indicators dashboard; continued development of Triple Aim Dashboard underway	Ongoing through Year 3
State work streamlining administrative inefficiencies for dual eligibles is insufficient	Coordinate education and outreach to dual eligibles to make informed decisions	Medium	Don Ross	Don Ross, Trevor Douglas, and Jennifer Valentine	Support to ongoing analysis; consideration if any adjustments next waiver renewal; adjust to new Enrollment system as comes on board that will resolve some issues	Ongoing through Year 3
State work streamlining administrative inefficiencies for dual eligibles is insufficient	Analyze metrics to identify disparities for dual eligible and create interventions accordingly	Medium	Don Ross	Don Ross, Trevor Douglas, and Jennifer Valentine	Coordinate efforts with metrics team	Ongoing through Year 3