State Innovation Model Operational Plan Update 2015

State of Oregon

Table of Contents

Oregon State Innovation Model Operational Plan Update Foreword

As we complete Demonstration Year 2, we want to thank CCMI for the contributions the State Innovation Model (SIM) resources have made this past year and look forward to a continued partnership as we move into Year 3. The CMMI investment in Oregon through the SIM award accelerates the pace of health transformation in our state. The SIM grant fuels the spread of the coordinated care model (CCM) from the Medicaid population to other payers and populations more quickly and effectively than if the SIM resources were not available to support these pioneering efforts.

The Coordinated Care Model is proving to be effective in transforming how care is delivered in Oregon. Our 2014 Health System Transformation report[1] continues to document improvements in areas such as enrollment in patient-centered primary care homes, decreased emergency department visits and hospital admissions from chronic diseases. This is the second report to show quality pool payments for our Medicaid Coordinated Care Organizations (CCOs). All of Oregon's CCOs showed improvements in a number of quality measures and 13 of 16 CCOs earned 100 percent of their quality pool payments in 2014.

Additionally, financial data indicates that CCOs are continuing to hold down costs. Oregon is staying within the budget that meets its commitment to the Centers for Medicare and Medicaid Services (CMS) to reduce the growth in spending by 2 percentage points per member, per year. These metrics offer proof that Oregon's model of health system transformation is continuing to improve care for Oregonians who need it most.

Spreading the Coordinated Care Model

Demonstration Year 2 of SIM support brought the spread of the CCM to Oregon's state employees with our Public Employees Benefit Board (PEBB) actively purchasing benefits through contracts with health plans and CCOs for state employees that incorporate the expectations of the key CCM elements that are in our Medicaid CCO contracts. Work also begins as we enter into Year 3 with our Oregon Educators Benefit Board (OEBB) as they move toward similar active purchasing and contracts based on the CCM.

Oregon's new Governor, Kate Brown, has directed continued support for health system transformation as she took office this year. Our Legislature just concluded its recent session that highlighted continued support and refinement of the CCM in Medicaid, and furthered spread to PEBB and OEBB with a similar trend cost cap of 3.4 % and directed alignment of performance metrics across the populations. Other legislation and agency budgets that support collaborative efforts include ongoing work to develop multi-payer strategies to support primary care infrastructure and continued support of transformation efforts.

---

[1] Full report can be found at http://www.oregon.gov/oha/metrics/Pages/index.aspx

Coordinated care model elements – what we're doing and what we're testing

Key elements of the CCM include:

- Best practices to manage and coordinate care
- Shared responsibility for health
- Transparency in price and quality
- Measuring performance
- Paying for outcomes and health
- A sustainable rate of growth

SIM funding has allowed Oregon's health system transformation work to go further and faster and is critical for us to touch more Oregonians and move beyond Medicaid, which our CMS waiver initiated as the first application of the CCM. SIM also provides funding for a range of evaluation efforts that will help other states learn what key steps and tools work to transform the delivery system and achieve the triple aim of better health, better care and lower costs. Highlights from demonstration year 2 include:

- SIM funds enabled Oregon to operate a robust Transformation Center which provides technical assistance, tools and training and valuable resources, like learning collaboratives, which are available to CCO staff, community advisory councils and other payers and providers across the state. The Center works to ensure evidence-based and emerging best practices along with lessons learned are widely and swiftly disseminated. The Center has been vital for helping good ideas to travel faster and foster a culture of innovation.

- With SIM funding, we have recognized 550 clinics as Patient-Centered Primary Care Homes (PCPCHs), exceeding our SIM Year 2 target of 500 clinics. Approximately 2,200 primary care providers are practicing in a PCPCH, caring for over 2 million Oregonians.

- SIM funding allows Oregon to continue to assist primary care clinicians across the state by providing support to the Oregon Patient-Centered Primary Care Institute (PCPCI), which works in collaboration with the Transformation Center to spread best practices and support the adoption of the primary care home model, a core element of Oregon's model.

- Since payment drives change, SIM has made it possible to bring all of the commercial and public payers to the table to achieve consensus on Oregon's multi-payer strategy to support primary care and begin working toward implementing alternative payment models through the duration of the SIM project.

- SIM resources have supported the development of 13 new clinical champions for practice change through the Transformation Center's Council of Clinical Innovators. This first graduating cohort will be leading clinical change efforts on the ground across the state.

- The Center for Evidence-based Policy's process improvement report on the work of the Health Evidence Review Commission (HERC) was released and discussed at the

commission's retreat in October. As a result, HERC has already been able to refine their coverage guidance development process by two months, without eliminating opportunity for stakeholder input. HERC is in the midst of conducting its first open topic nomination process.

- Oregon has continued to press forward to reduce health disparities, increase access and improve the quality of health care for underserved populations. SIM resources have expanded the number of regional health equity coalitions across the state advising CCOs on best practices, trained two cohorts of diverse leaders on establishing and achieving equity goals, and created infrastructure to increase the number of professional health interpreters.

- Five innovative telehealth projects have been selected and are being implemented across the state. These projects are supporting new approaches to the critical issues of expanding dental access to children, pharmacist consultations with HIV/AIDS patients in rural Oregon, secure direct-to-home specialty dementia care, hospital-based community paramedics delivering telehealth services among high-risk patients, and real-time tele-mental health services via videoconferencing for vulnerable youth in rural Oregon.

- The Transformation Center engaged CCOs and providers from across the state to assess the extent of integration of behavioral and primary health systems. The Center compiled information on strategies and resources currently being used, successes, and barriers to further development and also asked how to support further implementation efforts resulting in an integrated care technical assistance plan.

The focus of our innovation and spreading the coordinated care model

Oregon's SIM grant focuses on delivery system transformation in three areas - innovation and rapid learning, delivery models, and payment models. Oregon's SIM activities include:

- Integrating and coordinating care among primary care, mental and behavioral care, specialty care and oral health care providers
- Engaging patients and consumers in their own care for better outcomes
- Engaging providers in health system transformation
- Improving community health through local partnerships that support promotion and prevention activities, including funding pilot projects in local health departments to promote integration of public health and health care, innovation and healthy communities
- Implementing more effective health care payment models that incentivize better health outcomes
- Encouraging consensus building to support primary care payment and other payment reform
- Measuring access to and quality of care and sharing the results of data analysis to improve performance
- Implementing and sharing innovations and best practices that reduce health disparities across Oregon

- Supporting health information technology and exchange – building on other funding in Oregon with SIM investments and technical assistance to ensure innovation and successful implementation
- Improving quality and health outcomes for those eligible for Medicaid, Medicare and state employee health benefits
- Improving system efficiencies by better aligning and coordinating Memoranda of Understanding between CCOs, community partners and the Area Agencies on Aging.

Key activities that support transformation beyond Medicaid:

- Developing a State Health Improvement Plan (Oregon's Population Health Roadmap) that engages CCOs, PEBB, OEBB, qualified health plans and providers in efforts to improve population health
- Technical assistance in the areas of consumer and provider engagement
- Improving the state's analytic infrastructure and tools to improve integration, coordination and access to data in a secure environment. This provides more transparency of health care data and supports analytical needs at multiple levels.
- Implementation and evaluation support for the housing with services program – a new model moving forward to incorporate housing and social services to improve health outcomes for low-income, single adults and people with disabilities.
- Coordination with early learning councils and hubs, focusing specifically on kindergarten readiness to integrate education efforts with health reform.
- Coordination with CMMI and the Medicare Medicaid Coordination Office (MMCO) to develop improved and integrated materials for dually eligible individuals enrolled in CCOs and affiliated Medicare Advantage Plans.

SIM funding allows assessment of:

- Success of the overall model in Medicaid, where it was first implemented, which will guide efforts to spread the model to other markets
- The degree and pace of spread of the CCM to other payers and populations
- Best practices and learning for other states

As detailed in Oregon's October 2013 Operational Plan, updated in 2014 and again in 2015, the SIM grant supports the OHA and its Transformation Center in coordinating implementation, spreading health care innovations and lessons learned, and evaluating the CCM. This 2015 update of our SIM Operations Plan highlights some of Oregon's accomplishments supported or enhanced by SIM funding and outlines any variations from our original and previously updated operational plans.

Section A	**Governance, Management Structure and Decision-making Authority**

Overview

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

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

Oregon's commitment to the CCM is demonstrated through an intentional coordinated and strategic multi-year planning and implementation process that included extensive public discussion across the state and active engagement by the past and current Governors, Legislature and OHA and in partnership with the Oregon Insurance Division. This high level of coordination in planning and implementation continues today, now fueled by the SIM grant, to extend the CCM across the delivery system in Oregon. Oregon has achieved many significant mileposts during the first demonstration periods and anticipates continued forward momentum in Year 3.

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

Year 2 accomplishments

Governor and legislative engagement in oversight and implementation

The Governor's Office continues to meet with leadership from the OHA, the Department of Human Services and the Oregon Insurance Division to continue strategic policy development that will ensure that both public and private health care purchasing are increasingly aligned around the CCM. Oregon's new Governor, Kate Brown, took office in early 2015 and has emphasized continued support for healthcare transformation with her health policy advisor and to the OHA's new Director, Lynne Saxton. The Legislature has continued to push forward and refine the model in Medicaid, and further the spread to PEBB and OEBB. Legislatively-directed, Oregon's health insurance exchange has transitioned into the Department of Consumer and Business Services agency, which also houses the Insurance Division where staff have partnered with OHA staff to continue to align efforts for spread of the model as Oregon's marketplace continues to evolve. Please see Appendix 1 for a summary of media coverage of Oregon's health transformation efforts over the course of demonstration period 2.

Oregon Health Policy Board

The Oregon Health Policy Board (OHPB) is the nine-member, citizen-led policy-making and oversight body for the OHA. Formed by the same legislation that created the health authority, the health policy board has a broad mandate for health care transformation and its membership includes key leaders from the provider community, labor, insurance and large and small businesses. The Oregon Health Policy Board's membership has shifted over the past year due to terms expiring and members changing professional lives. The OHA director and OHPB chair are actively working to identify new members. The current members, whose brief biographies are included below, were selected to ensure regional and cultural diversity and broad insight into a variety of sectors that are impacted by health system transformation.

- *Zeke Smith,* Chair – Zeke Smith is currently the Chief Impact Officer of the United Way of the Columbia Willamette.

- *Carla McElvey, M.D.,* Vice Chair — A pediatrician in private practice at the North Bend Medical Center in Coos Bay, Dr. Carla McElvey also is the immediate past president of the Oregon Medical Association.

- *Lisa Watson* – Lisa Watson is the owner and founder of Cupcake Jones, a Portland-based bakery that opened in 2007 and today employs ten people. Lisa is a native Oregonian and a tribal member of the Confederated Tribes of Grande Ronde.

- *Carlos Crespo, M.S., Dr.P.H.* — Carlos Crespo is Professor and Director of the School of Community Health at Portland State University. He received the 1997 U.S. Secretary of Health Award for Distinguished Service as part of the Salud para su Corazon campaign and in 2003 became a Minority Health Scholar from the National Institutes of Health.

- *Brian DeVore* — Director of Healthcare Ecosystem & Strategy at Intel, Brian DeVore provides strategic guidance and oversees the national and local partnership efforts of Intel necessary to provide health care to its employees.

- *Felisa Hagins* — Political Director for the Service Employees International Union (SEIU) Local 49, Felisa Hagins represents the largest union nationally with more than two million members and the largest union in Oregon with more than 50,000 members.

- *Joe Robertson, M.D., M.B.A.* — Dr. Joe Robertson is President of Oregon Health & Science University (OHSU).

In January 2015, the OHPB attended a board retreat to discuss a work plan and priorities for 2015-2016, guided by input from the Governor's Office. The five previous recommendations have been folded into three key priority areas for the next biennium:

1. Monitor and track the successes and challenges of health system transformation. Ensure that (1) CCOs are held accountable to OHA's expectations and goals, and (2) overall

health system transformation is moving Oregon forward in improving care, improving health, and reducing costs.

2. Behavioral health system policy development and oversight: Physical health care (including oral health care) and behavioral health care (including mental health, substance use and addiction services) is seamlessly coordinated for Oregonians so that everyone is able to receive the right care, in the right place, at the right time.

3. Public health system policy development and oversight: foundational public health services, responsibilities, and enforcement capabilities are consistent in quality and access across Oregon.

The Coordinated Care Model Alignment Work Group (consisting of representatives from Public Employees' Benefit Board, Oregon Educators' Benefit Board and Oregon's Marketplace as well as private and public purchasers) was initially established in September 2013 to guide the OHPB in spreading the CCM beyond Medicaid. The CCM Alignment Work Group's 2013 progress report set the foundation for the evolution of this work going forward.

On the recommendation of the OHPB following the CCM Alignment Work Group, the Sustainable Health Expenditure Work Group (SHEW) was formed in July 2014 to continue this effort. The new work group is responsible for sharing best practices and ensuring CCM alignment across organizations and their respective health plan contracts over the course of the next few years. Oregon has embedded the care model principles in Public Employees' Benefit Board purchasing starting this year, and continues to press forward to do the same for Oregon Educators' Benefit Board purchasing and incorporated in individual and small group commercial plans sold in Oregon. See Appendix 2 for the charter of the continuation work group.

The SHEW was also tasked to develop a methodology for establishing a statewide health care cost growth benchmark for health entities and health plan premiums. The long-term goal was to consider ways to share statewide accountability for a sustainable, predictable rate of growth in health care spending. The group has representatives from multiple payers and health care sectors, as well as economic and actuarial expertise. The SHEW met five times in 2014 in order to develop a methodology for determining a sustainable rate of growth. Using SIM funds, OHA contracted with John McConnell, a health economist at the Center for Health Systems Effectiveness to help guide this work. The SHEW provided an update on their work in November 2014 before producing a final report and presentation in December 2014. More information is available online at http://www.oregon.gov/oha/Pages/srg.aspx

The SHEW concluded its initial work as outlined by OHPB in December 2014. The OHPB has decided to incorporate a second phase of the SHEW into the Coordinated Care Model Alignment Work Group as a time-limited subcommittee focused on refining and recommending adjustments to the methodology, clearly defining the purpose and determining appropriate uses for the total health care expenditure calculations, and developing recommendations for accountability mechanisms and policies to ensure steady progress in cost containment. The group will continue to work collaboratively with Dr. John McConnell and Oregon Health & Science University Center for Health Systems Effectiveness to complete and further refine the measurement

framework. As additional data is available, the calculations will need to be adjusted to account for any fluctuations in health care spending. Brian DeVore, OHPB member, will serve as the group's liaison to the Board.

Oregon Health Policy Board partnership with the Early Learning Council

A joint committee of the OHPB and the Early Learning Council (ELC) was established in 2012 to make recommendations for aligning early learning and health system transformation. The Joint Subcommittee recognizes that kindergarten readiness is an important foundation for realizing the goals of the Tripe Aim as well as positive education outcomes and adopted this as a shared goal. In order to identify measures of shared success toward this goal, the Joint Subcommittee convened the Child and Family Well-Being Measures Workgroup in September 2014, to develop a library of measures across multiple domains that can be used for performance accountability or community monitoring. With the assistance of a contractor with national experience in measurement efforts, Michael Bailit Health Purchasing, LLC, the Workgroup has met monthly since September 2014 and is nearing completion of a recommended set of measures (anticipated by fall 2015). Although the principal consumers of the measures are expected to be the CCOs and the Early Learning Hubs (EL Hubs), the Workgroup has included representatives from a broad spectrum of child-and family-serving systems to ensure alignment of measurement efforts across sectors.

Beginning in 2013, the Early Learning Council supported the development of 16 community-based Early Learning Hubs (EL hubs) which serve as coordinating bodies to make supports more available, more accessible and more effective for children and families. Currently all 16 EL Hubs have executed their contracts with the ELC. Across the state, coordination across EL hubs and CCOs have been rapidly evolving in order to ensure improved outcomes for Oregon's children and prevent future, chronic health conditions.

Health information technology leadership

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

Additionally, our partnership with the Oregon Health Leadership Council has supported the development and implementation of the EDIE, a web-based communication technology that enables intra- and inter-emergency department communication. EDIE has been supported by SIM funds and continues to progress further in its implementation. As of May 2015, 95 percent of Oregon hospitals have live feeds, sending data and receiving notifications. The EDIE Governance Committee and Operations Subcommittee meet frequently and recently gained

approval from the Health Leadership Council and for a proposed financing strategy that would support ongoing costs and expansion of EDIE through a shared utility model. See Section E for further details on HIT exchange and technology leadership, progress and planning for the next period.

Mechanisms to coordinate public and private efforts

Work continues to develop strategies for payment reform beyond the primary care consensus already accomplished. Several more Federally Qualified Health Centers (FQHC) or Rural Health Clinics (RHC) are now participating in an ongoing alternative payment methodology demonstration with OHA. With CMS approval, via a state plan amendment, the participating FQHCs are receiving payments prospectively, rather than retrospectively using the PPS methodology. This provides more predictable funding and allows health centers to implement new models of team-based care and patient engagement, as well as to enhance provider recruitment and retention. As of June 2015, the demonstration includes eight FQHCs/RHCs and approximately 120,000 Medicaid lives. OHA has contracted with an actuarial firm for analysis of the demonstration's impact on total cost of care. The Oregon Primary Care Association and its partners have a grant from the Robert Wood Johnson Foundation for a qualitative assessment of the effect on the model of care, workflow and provider satisfaction.

Outreach to stakeholders

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

Oregon's Public Employees' Benefit Board

In September, Oregon's Public Employees' Benefit Board (PEBB) conducted open enrollment for more than 130,000 public employees. PEBB developed communications to educate beneficiaries about their plan options and the CCM. In January 2015, the new plans began offering elements of the CCM across the state bringing better care, better health and lower costs to public employees.

PEBB is currently focusing efforts on:

- Developing year two reporting requirements for APMs and health system transformation efforts
- Reviewing alignment with CCO metrics and finalizing technical issues for all claims-based measures
- Working closely with Oregon's Office of Health Analytics to align more of the non-claims based measures (e.g., EHR adoption measure for the PEBB network)

- Developing baseline year for all carriers (CY 2015) to establish benchmarks and performance targets for carriers for CY 2016. The Board will then engage carriers in discussions regarding incentives and risk pool.

Oregon's Educators Benefit Board

Building upon the successful PEBB Request for Proposals (RFP) process and technical assistance provided through SIM, the Oregon Educators Benefit Board (OEBB), which provides coverage to 147,000 teachers, their dependents and retirees is preparing their RFP for the 2017 Benefit year. It is designed to further strengthen the coordinated care principles and supports transformation efforts. OEBB's major carrier, MODA, is a major partner in one of the Medicaid CCOs in Eastern Oregon and provided a new plan offering for PEBB and OEBB employees in 2015 in both Eastern Oregon and in the Willamette Valley with CCM elements.

There are currently 900 different employee groups in OEBB, including an estimated 500 collective bargaining units, some of whom are represented by the Oregon Education Association and Oregon School Employees Association, representing 45,000 educators / 20,000 education employees. OEBB represents 247 employers, including school districts, educational service districts and community colleges. The Board has had significant turnover, with three new members and two new appointees after this fall's legislative session. The complexity and composition of this group, along with board member transitions and vacancies, has led the Board to postpone its RFP for one year (2017-2018 plan year). A revised timeline is currently being developed and will likely be released at the next Board meeting in October.

The Board wants to ensure the procurement will result in OEBB being able to offer plans that meet OEBB members' needs and promote and support better care, better health and lower costs for OEBB members and Oregonians overall.

Specific objectives of the OEBB RFP include:

- Expand the CCM based health plan offerings and availability in Oregon counties
- Contract with health plan partners committed to transforming Oregon's healthcare system to achieve the Triple Aim for OEBB members and Oregonians.
- Include in the RFP language questions specific to the elements outlined in the Framework for Contracting and Procurement developed by the Coordinated Care Model Alignment Work Group. The OEBB RFP asks the plan to:
  - Auto-assign Primary Care Providers (PCPs) to members enrolled in the PCPCH if PCP is not selected (must notify)
  - Describe clinical guidelines used in provider engagement efforts
  - Care transformation assistance the plan currently provides to PCPs and providers including a description of the assistance provided to support practices in achieving PCPCH certification and examples of the plan's support of community public health care initiatives and direct benefits to OEBB members
- Share responsibility for health – The OEBB RFP ask the plan to describe:
  - Patient engagement and patient activation methods
  - Member education efforts on the plan's total cost and member's share of cost
  - Decision-making tools available to members before receiving services for certain preference-sensitive conditions
  - Abilities and limitations of the online health assessment

- Pay for outcomes and health – The OEBB RFP asks the plan to describe how payment methodologies used:
  - Promote the Triple Aim
  - Provide comprehensive coordination
  - Create shared responsibility across provider types and levels of care to promote use of PCPCH model
  - Provide financial support based on PCPCH tier level
  - Align financial incentives for use of evidence-based and best emerging practices and support outcomes based treatments
- Provide price and quality information to patients and providers – The OEBB RFP asks the plan if they currently have online provider quality and cost rating tools including:
  - Member self-service tool(s) that detail provider pricing and quality information
  - Quality measures available to both individual providers and facilities

The draft OEBB RFP available at
http://www.oregon.gov/oha/OEBB/MeetingDocuments/OEBB%20Board%20Handout%204-28-2015.pdf

Legislation

Oregon's 2015 legislative session concluded on July 7th and featured several measures related to payment and delivery system reform in Oregon:

- *SB 231 – Primary care multi-payer bill.* This bill will require major insurers and CCOs to report the percentage of their total health care expenditures that are directed toward primary care, similar to Rhode Island's model. The specific services to be counted as primary care would be defined in rule by OHA and the Oregon Insurance Division. Further, the OHA would convene a voluntary learning collaborative, protected from anti-trust laws that are only applicable to conversations occurring in state-supervised public meetings, where insurers and providers could share best practices in primary care alternative payment methodologies and develop strategies for coordinated technical assistance. Please see
  https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/SB231/Enrolled

- *SB 440 – Multi-payer metrics alignment*. SB 440 is Oregon's next step on aligning metrics and improving the availability of health plan performance data. The bill requires the OHPB to develop a strategic plan for the collection and use of health care data by September 2016 and, beginning in 2017, creates a new Health Plan Quality Metrics Committee under the OHPB to adopt and report on quality measure for CCOs, PEBB, OEBB and state-regulated commercial plans. Please see:
  https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/SB440/Enrolled

- *HB 2294 – Oregon HIT Program*. This bill has three main components: 1) It formally establishes the Oregon HIT Program within OHA and grants OHA authority to provide optional HIT services to support health care statewide (e.g., beyond the Medicaid program). It also authorizes user fees to cover the costs of expanding OHA's HIT services. 2) It grants OHA flexibility in partnering with stakeholders and participating in

partnerships or collaboratives that provide statewide HIT services, including the ability to vote on governance boards for such services, and ability to enter into agreements to support and provide funding for the appropriate Medicaid share of statewide HIT services. 3) It updates the statute for Oregon's HIT Oversight Council (HITOC), bringing it under the OHPB and solidifying its role in providing strategic and policy recommendations and oversight on the progress of Oregon HIT efforts. Please see https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/HB2294/Enrolled

- *SB 832 – Behavioral health homes*. This bill requires OHA to prescribe by rule standards for behavioral health homes. This work had been planned before the legislation was introduced and a series of advisory committee meetings on Patient-Centered Primary Care Home standards—including standards for behavioral health integration and behavioral health-focused medical homes—began in June 2015. Please see: https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/SB832/Enrolled

- HB 3396 – *Healthcare workforce*. This bill requires the OHPB to conduct a study of effectiveness of existing Oregon health care provider recruitment and retention incentives (e.g. loan repayment, tax credits, etc.) and to make recommendations about the feasibility of a broad range of other possibilities including direct subsidies, a retirement plan for health care professionals, GME financing, and others. It also combines a range of existing incentive programs into a single fund, effective in 2018. The Legislature expects to use the OHPB's report, which is due in September 2016, to prioritize appropriations for the combined fund. Please see: https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/HB3396/Enrolled

Year 3

Changes in leadership

The State of Oregon and the OHA have experienced transitions in leadership during this past year. In December 2014, Governor Kitzhaber named Lynne Saxton as the interim director for OHA. In February 2015, the executive branch of state government was transferred to Governor Kate Brown. On March 4, Governor Brown released a statement in support for the confirmation of Lynne Saxton as the Director of the Oregon Health Authority. "Lynne's collaborative leadership style and commitment to serving Oregonians makes her an outstanding choice for Director of the Oregon Health Authority," said Governor Brown. "My vision for OHA is an agency that supports our successful health reform efforts in the most efficient, effective, and transparent way possible. I look forward to her quick confirmation and working with Lynne to produce outcomes for Oregonians." Ms. Saxton was legislatively confirmed as the Director on March 10, 2015.

Ms. Saxton previously served as Executive Director of Youth Villages Oregon, a provider of mental health and social services for children and families. Her successful and distinguished career includes leadership roles at ChristieCare, a children's mental health provider before it merged with Youth Villages; Portland General Electric; and other positions in the public and private sector. Director Saxton is undertaking broad reorganization and change management

initiatives to more fully align the functions and resources of the agency to accomplish health transformation.

The changes in leadership have occurred smoothly, thanks to a great deal of supportive guidance and collaboration amongst staff, current and previous leadership. In her initial months, Ms. Saxton has conducted multiple face-to-face meetings with staff to introduce herself, discuss priorities and increase communication and transparency. Sean Kolmer remained the Governor's Health Policy Advisor under Governor Brown, and has led the legislative efforts throughout the recently concluded legislative session to further the implementation and spread of the CCM, and has worked closely with Ms. Saxton as she has taken on her new role.

In the OHA, leadership transitions are also occurring as Oregon enters Year 3.

- Leslie Clement continues her previous duties as the chief of Health Policy and Analysis division in the agency's new structure, reporting directly to Ms. Saxton. She is also currently serving as interim Medicaid Director, with the departure of Judy Mohr Peterson from state service in June 2015, while an active search for a new Medicaid director is underway.

- Dr. Jeanene Smith, OHA chief medical officer and the current SIM principal investigator lead, has accepted an exciting consulting position to assist other states and delivery systems with their transformation efforts and will be leaving OHA in August 2015. However, Chris DeMars, the Director of Systems Innovation at OHA's Transformation Center, will assume the Principle Investigator role of SIM through the remainder of the grant, ensuring a smooth transition. Before joining the Transformation Center, Ms. DeMars spent eight years as a Senior Program Officer at the Northwest Health Foundation, where she managed the Foundation's health reform work, which included providing support for Oregon's delivery system reform and a multi-year health reform advocacy initiative. Prior to joining the Foundation, Ms. DeMars was a Senior Health Policy Analyst for the U.S. Government Accountability Office (GAO), where she spent six years developing reports for Congress on Medicaid, Medicare and private health insurance payment policy. She has a Master of Public Health degree from the University of Michigan School of Public Health. Ms. DeMars has led the Transformation Center throughout most of Year 2 SIM, and has played a lead role in the Center's transformation efforts since it was created at the beginning of Oregon's SIM grant.

- To assist Ms. DeMars, as she has assisted Dr. Smith during Demonstration Year 2, Lisa Krois will serve in the role of Deputy Principle Investigator of the SIM grant. She was formerly the International Communications and Reporting Officer for the United Nations Food and Agriculture Organization and spent five years prior to that as the Project Director of the Oregon Health Research and Evaluation Collaborative for the State of Oregon's Office for Health Policy and Research. She was the Co-Principle Investigator of the Children's Access to Healthcare state-wide survey and has a Master of Public Health degree from Portland State University. She, along with the OHA's Office of Health Analytics staff, will work with CMMI on reporting Oregon's self and external, national evaluation.

- Lori Coyner and her team in the OHA Office of Health Analytics continue to support the SIM efforts to demonstrate the effectiveness of the CCM through extensive metric reporting and database oversight and analysis.

- For Year 3, Jonah Kushner is the lead on measurements and metric reporting. He, along with Sarah Kleinschmit and Lisa Krois, will continue work on Oregon's self-evaluation and will provide assistance to the national evaluation underway.

- Leslie Clement along with Chris DeMars and Lori Coyner, will lead the SIM Steering Committee and oversee the grants management team, working closely with the Project Director and the Deputy Principal Investigator.

- In addition to this executive level oversight, the SIM project director, Beth Crane, convenes a monthly SIM operations team meeting to coordinate activities and actively problem solve as necessary to maintain progress on SIM milestones. See Appendix 3 for a revised SIM organizational structure diagram.

| Section B | Coordination with Other CMS, HHS, and Federal or Local Initiatives |

Overview

In Oregon, many CMS, HHS, CMMI and other federal initiatives have been operating as transformation has been underway. Tying these initiatives into the work being done through SIM provides vital alignment that supports a more efficient, sustainable and unified health care system. Coordination occurs through direction and guidance from advisory committees, public-private partnerships, the Governor's Office and the Oregon Legislature, all supported by the OHA. Below is an update and status report on many of these previously outlined in our 2013 Operational Plan and 2014 update. Also see Appendix 4 for a visual representation of connections between key stakeholders for health system transformation in Oregon.

Year 2 accomplishments

Medicaid demonstration and ACA expansion into the Oregon Health Plan

The implementation of the Affordable Care Act and Oregon Medicaid expansion has resulted in 434,000 additional Oregonians enrolled in the Oregon Health Plan (Medicaid) since January 1, 2014, for a total of 1.1 million enrollees, with the majority joining CCOs for their care. Oregon has been successful in offering the CCM to the dually eligible with over 50 percent of dually eligible persons enrolled in a CCO. Since 94 percent of Oregon providers see Medicaid and Children's Health Insurance Program enrollees, efforts to fulfill our waiver obligations through the CCOs will echo throughout the delivery system and further support extension of the model across all payers. For complete results of the latest metrics, please see the full 2014 Health System Transformation report, available at: http://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx. Oregon is examining the any need for any adjustments to its current 1115 Waiver as it moves toward the final years of the Waiver Demonstration period, as well as preparing for a

renewal by mid-year 2017. As the CCOs have been operating for three years, further refinement of the braided budgets to ensure sustainability and continued innovation and transformation is critical. Alignment of metrics and incentive pools for CCOs and hospitals will ensure close collaboration and synergy of efforts. OHA leadership will continue work closely to with CMS on these efforts as they develop.

Cycle 3 CCIIO grant

SIM funding, along with some funding from a Cycle III rate review grant from the Center for Consumer Information & Insurance Oversight, has allowed OHA to collaborate with the Oregon Insurance Division (OID) to enhance the data collected by Oregon's All-Payer, All-Claims Reporting Program (APAC) and make APAC data accessible to OID. This project will improve the usefulness of APAC for evaluating health care reform in Oregon and enable OID to prepare insurance rate review reports using APAC data.

From October 2014 through May 2015, OHA convened a stakeholder Technical Advisory Group (TAG) to recommend new data fields that should be collected by APAC. The TAG recommended and provided input on technical specifications for 10 new data fields, as well as a new data file to capture information about premiums for commercial and Medicare Advantage health plans. APAC will begin collecting the new data fields in July 2015, with the first submission covering the first year of expanded coverage under the Affordable Care Act, and will begin collecting premium data in January 2016. These data will make possible analysis of utilization and spending trends in different segments of the commercial insurance market, more accurate analysis of the financial burden of health care coverage on Oregonians, and use of APAC data for OID rate review beginning in spring 2016.

To make data accessible to OID, OHA is working with its APAC contractor to implement query tools and risk adjusters needed for rate review reports. OHA also provided APAC orientation training to OID analysts and policy staff, and will provide OID with guidance on policies and procedures needed to release APAC data to the public in accordance with state and federal privacy, antitrust, and trade secrets laws and regulations.

In addition, OHA has provided APAC data and technical assistance to the Oregon Health Care Quality Corporation (Q Corp), which is preparing rate review reports for Department of Consumer and Business Services (DCBS), and coordinating on APAC data validation with Q Corp. Going forward, OHA plans to leverage the technical expertise of payers and data users on the TAG to prepare recommendations for capturing information about alternative payment methodologies in APAC.

Federal primary care initiatives: health homes and comprehensive primary care

Multi-payer consensus on primary care

While payments available through Oregon's Medicaid Health Home ACA Section 2703 ended just at the start of Year 2, OHA and the state are committed to sustaining resources toward primary care transformation. Thanks to SIM funding, OHA and the Oregon Health Leadership

Council convened a series of meetings in fall 2013 that brought together the majority of payers in the state and representatives from provider and hospital associations, which resulted in a commitment to support primary care. This consensus, signed by those participating, agreed to use Oregon's Patient-Centered Primary Care Home recognition as a common definition of a "medical home" as well as provide financial support based on that recognition. The agency is currently working with payers and other stakeholders to assess implementation progress. Since the consensus was signed, numerous payers have implemented alternative payment model pilot projects for primary care practices. However, pilot project parameters and payer participation vary widely.

The governor and the OHPB recognized the need to invest in the state's primary care system and recommended a bill that aims to ensure that sufficient resources are allocated to support transformation. Senate Bill 231 passed and requires commercial insurers and CCOs to report the percentage of their total medical expenditures that are directed to primary care. The OHA must report results to the legislature during the February 2016 legislative session. In addition, the OHA will convene a learning collaborative with the purpose of sharing best practices on primary care alternative payment methodologies and initiative alignment.

Comprehensive Primary Care (CPC) initiative

In Oregon, 552 providers in 67 clinics (with 52,172 Medicare beneficiaries) are participating in the CMS-funded Comprehensive Primary Care (CPC) Initiative. Participating payers include CareOregon, Oregon Health Authority, Providence Health Plans, Regence BlueCross/BlueShield, Teamsters Multi-Employer Taft-Hartley Funds and Tuality Health Alliance.

CPC is intended to reduce Medicare fee for services (FFS) expenditures by reducing patients' need for high cost services such as hospitalizations and emergency department (ED) visits and improve the quality of care. A Mathematica Policy Research evaluation found that across all seven regions participating in CPC in the first year, early results suggest that CPC has generated enough savings in Medicare health care expenditures to nearly cover the CPC care management fees paid by CMS for attributed Medicare FFS beneficiaries, although not enough to generate net savings. CPC also generated reductions in hospitalizations, outpatient ED visits, primary care physician visits, and specialist visits. In Oregon, outpatient ED visits declined by 6 percent for all CPC patients. Clinics are also evaluated across five dimensions of primary care. In Oregon, clinics rated highest on care coordination, continuous data-driven improvement and risk-stratified care management.

Participation in the initiative has allowed OHA to better coordinate multi-payer discussions around sustainability of primary care transformation more broadly through support of the state's Patient-Centered Primary Care Home Program. Recognition by the program is one of the milestones that each clinic must meet to continue participation in the comprehensive primary care initiative. Sustainability of the multi-payer consensus group that was convened as a part of SIM activities will be the focus of the participating payers' work over the course of the next year.

CMS Health Commons Grant initiative with Health Share

The Health Commons Grant, an award of $17.3 million over three years from the CMS Innovation Center, has served as a springboard for Health Share of Oregon to create a regional system to better serve the high acuity Medicaid population in the Portland metro area. Through the implementation and/or expansion across the community of five complementary care model interventions, improved care coordination, enhanced systems for learning and collaboration and a sustainable system of care across our community has been developed.

As Health Share nears the end of the project in June 2015, sustainability strategies for nearly all interventions have been developed. Key to this success has been the focus on continuous evaluation and learning. Additionally, they have received feedback from community partners that the discipline the grant has demonstrated around using data for continuous learning and process improvement has helped them push some of that discipline into their own organizations. The grant has also proved to community partners that collaboration can be successful in serving an identified population. Modeling from the grant in both of these arenas is helping the community advance its transformation agenda significantly.

Other federal initiatives

Our 2013 Operational Plan and our 2014 update outlined many other federal initiatives that Oregon is participating in and that are complementary to spread of the CCM activities under SIM. A few updates include:

Dually eligible populations

In addition to improving and integrating materials for dually eligible individuals, initiatives identified in the work plan for implementation in 2014 and beyond include, but are not limited to, working with CMS to:
- Develop integrated denial notices for individuals enrolled in aligned Medicare/Medicaid plans which include all Medicare and Medicaid required appeal rights and processes
- Review Medicare and Medicaid appeals processes and alignment options
- Discussing opportunities to provide information for new Medicare eligibles with Medicare –Medicaid alignment information, which doesn't violate federal marketing regulations, that would decrease confusion and that could be used by multiple entities for outreach
- Develop limited standard text for integrated OHA and CCO member handbooks and develop Oregon Administrative Rules to require clarifying language for duals payment and billing, as well as care coordination within CCO member and potential member communication standards

Additionally, the Medicare/Medicaid Analyst, in collaboration with identified partners and data analysis, has been examining barriers to enrollment in aligned plans for dually eligible individuals and has developed a policy paper for Medical Assistance Programs (MAP) & OHA leadership to examine opportunities to decrease duals confusion, increase duals enrolled in CCOs to take advantage of the CCM and improve duals specific communications.

The Medicare/Medicaid Analyst is collaborating with Senior Health Insurance Benefits Assistance (SHIBA) and Aging and People with Disabilities (APD) to develop training and other supporting materials for caseworkers and benefit counselors to ensure the provision of accurate information to dually eligible individuals and encourage aligned enrollment. The Medicare/Medicaid Analyst is also working with DHS to identify and implement mechanisms for shared accountability between CCOs and LTSS, including support provided to CCOs and long term care agencies to be reflected in revisions to their memoranda of understanding documents going forward.

CDC initiatives

The Public Health Division has submitted numerous federal grant applications in the last year which align with and support Oregon's SIM Operations Plan. One such federal grant is the CDC Prescription Drug Overdose State Supplemental grant, which, if awarded, would invest in the implementation of community-level interventions within counties that have the highest burden of prescription drug overdose. This grant would allow local health departments, CCOs, providers and other stakeholders to institutionalize opioid prescribing guidelines, offer non-opioid pain treatment therapy, institutionalize Prescription Drug Monitoring Program guidelines and engage health systems to utilize a data-driven approach to prevent prescription drug overdose. This will be a valuable resource to the CCOs as they work with their communities, as they have chosen opioid management as the topic of focus for the 2015-2017 Statewide Performance Improvement Project (PIP). The Statewide PIP is a required activity of Oregon's 1115 Waiver.

Another federal grant Oregon has applied for is the HHS Office of Adolescent Healthy Teen Pregnancy Prevention grant. If funded, this grant would provide capacity building support to three eastern Oregon counties with the highest teen pregnancy rates.

In the last year, the Public Health Division received supplemental funding from the CDC State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke cooperative agreement. This provides funds to local public health authorities, CCOs and chronic disease self-management program providers to participate in a series of three learning institutes designed to link clinics with community self-management resources and develops quality improvement strategies to address high blood pressure, diabetes and pre-diabetes. Over the past year, the Public Health Division has engaged numerous stakeholders to identify statewide priorities for the HRSA Title V Maternal and Child Health Block Grant. Many of the selected maternal and child health priorities and measures for 2016-2020 align with and support SIM-funded efforts. The Title V priorities include: well-woman care, adolescent well-visits, medical homes for children and youth with special health care needs, transitions for children and youth with special health care needs, oral health preventive care, culturally and linguistically responsive service delivery, tobacco use by pregnant women and children's tobacco exposure, breastfeeding and child physical activity.

Over the next year, Oregon will continue to work to leverage new federal grant funds and priorities in order to implement the Population Health Plan and will continue to engage CCOs, PEBB, OEBB, qualified health plans and providers in efforts to improve population health.

CMS Adult Medicaid Quality grant

OHA's Adult Medicaid Quality (AMQ) grant, originally received in December 2012, supports collection and analysis of data on the CMS Adult Core Measures (19 to date and more by January 2015), two quality improvement projects and OHA staff training to improve capacity for data analysis and reporting. Both of the performance improvement projects focus on integrating primary care and behavioral health, a key component of the CCM.

The first quality improvement project is a statewide collaborative among all CCOs on "Diabetes Monitoring for People with Diabetes and Schizophrenia or Bipolar Disorder." This project is in the final stages of completion.

The second quality improvement project aims to increase access to patient-centered medical homes in two ways:

1) The Patient Experience of Care Learning Collaborative has been working with nine primary care practices through practice-level facilitation and technical assistance to field the CAHPS Clinician and Group Survey with the Patient-Centered Medical Home Item Set and uses the results to inform individual rapid-cycle improvement projects intended to advance each clinic's own transformation goals.

2) The Behavioral Health Home Learning collaborative has been working with ten mental health and chemical dependency treatment programs from across the state on "reverse" integration, bringing primary care into behavioral health settings. Participating agencies are receiving practice coaching and intensive technical assistance individualized improvement projects, along with specialized training in care management and team-based care intended to increase their capacity to provide whole-person care to their population with severe and persistent mental health and substance abuse use issues. Direct work with the participating sites will conclude in December; work to analyze data and produce final evaluation of this project will continue into January 2016. Please see Appendix 5 for the latest Adult Medicaid Quality Grant progress report submitted July 2015.

State and local non-federally funded initiatives

Our 2013 Operational Plan and the 2014 update outlined several areas of collaboration. One update to highlight is further progress on our Emergency Department Information Exchange (EDIE) project with our partners in the Oregon Health Leadership Council. This is a solution to exchange information among emergency departments to identify frequent users and create care plans to help determine if there is a more appropriate care setting. The update is described in Section E and also noted in Section A.

Oregon state transformation funds

In the 2013 session, Oregon's legislature appropriated $30 million dollars in state general funds to support 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. Each project is designed to be innovative, scalable, transferable and related to CCO transformation plans. The diversity of projects across the 16 CCOs reflects the individual strengths and needs of each CCO community.

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. 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.

Projects are grouped in the following theme areas:

- 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.

A detailed summary of the 120 projects, including aims, metrics, status and preliminary results and highlights of health and health system outcomes selected from the thirty projects in an advanced stage of implementation are included in the a full report delivered to the Legislature in May 2015. Please see Appendix 6 for that report.

Year 3

Oregon will continue to look for opportunities to coordinate between SIM-funded activities and others. In March 2014, Congress passed the *Excellence in Mental Health Act* – an eight-state demonstration project. This legislation aims to improve quality and access to behavioral health services through the creation of federal criteria for Certified Community Behavioral Health Clinic (CCBHC) as entities to serve individuals with serious mental illness and substance use disorders. Twenty-five million dollars in planning grants are available to states to develop applications to participate in the 2-year demonstration project. Only states awarded a planning grant are eligible to apply for the demonstration project grant.

Oregon has elected to apply for a planning grant, as the demonstration project aligns with the state's broader health care transformation efforts, and will enable Oregon to further advance behavioral health care for Oregonians. The planning grant application must be submitted to the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration by August 5, 2015. OHA staff from several divisions have formed a steering committee to collaborate on the application.

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

Section C	Outreach and Recruitment

Overview

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

Year 2 accomplishments

Systems-level outreach

Oregon's strategies to leverage public purchasing capabilities and influence health care market offerings toward the CCM have been successful in the current SIM demonstration period. Much of our success to date is due to the SIM-funded Transformation Center, which has become a hub of outreach and recruitment as planned, working through Innovator Agents, health systems, health plans and providers to spread best practices and engage the delivery system in transformation. See Section G of this update for details of its activities during Year 2. Supported by the SIM investment in analytics, the OHA has begun publishing regular information about system-level performance, particularly related to the Medicaid CCOs but also an initial dashboard across all markets featuring All-Payer, All-Claims data. The Transformation Center

and analytical work will proceed as previously described in our October 2013 Operational Plan, the 2014 update and this 2015 update.

Medicaid CCOs

The Transformation Center has had a targeted focus on outreach to Community Advisory Council (CAC) members because they are the primary consumer voice for Medicaid transformation and connect the CCOs to relevant community-based organizations. As outlined in Section G, the Transformation Center has held learning collaboratives for the CCOs' CACs. These advisory bodies, composed of 51 percent consumer members, assist the CCOs in providing culturally competent services relevant to local communities and act as connectors to community-based leaders and stakeholders. The Transformation Center hosted monthly conference calls to provide ongoing leadership development for the members and webinars including an introduction to motivational interviewing and an overview of logic models to support implementation of the CACs' Community Health Improvement Plans.

OHA convened a second CAC summit in June of 2015 where participants learned how to diversify their CACs. National expert Ignatius Bau presented on data collection beyond race, ethnicity, and language. Attendees learned about strategies that can be used to effectively recruit, onboard and retain members for more effective community representation. The webinar is available at: http://tinyurl.com/qz5ytvg. Finally, the Transformation Center recently began publishing a CAC Bulletin, an electronic communication compiling professional development and funding opportunities relevant to CAC members across the state.

In early December 2014, the Transformation Center hosted the Coordinated Care Model Summit, which included facilitated roundtable discussions for CAC members on five topics pertinent to their work. The Transformation Center also hosted facilitated discussions for general CAC members, CCO CAC Coordinators and CAC Chairs/Co-Chairs.

Under the direction of the Governor, the Task Force on Individual Responsibility and Health Engagement was formed in the fall of 2013 and was responsible for developing recommendations to the Legislature to establish mechanisms to meaningfully engage Oregon Health Plan members in their own health, disease prevention and wellness activities. The Transformation Centre's director of systems innovation, Chris DeMars, staffed the task force. The Task Force built upon Oregon's Medicaid Advisory Committee's recent extensive review of strategies and best practices for engaging individuals and their families enrolled in the Oregon Health Plan. Since the conclusion of that Task Force, the majority of the recommendations were directed to the Transformation Center. To date, the Center has done the following (please see Appendix 7 for the full task force report):

- Developed a resource guide on evidence-based member engagement practices that CCOs and others can use to support their planning and execution of patient engagement strategies;

- Worked with the Oregon Medical Association to promote the use of the *Choosing Wisely* campaign as a shared decision-making tool to facilitate engagement among OHP members, providers and CCOs; and
- Conducted a survey to identify barriers to CCOs' use of traditional health workers to foster engagement.

Public Employees' Benefit Board

As noted above and in our October 2013 Operational Plan and again in our 2014 update, ccommunications have been ongoing and extensive both through the Transformation Center and across OHA in coordination with local efforts. See Section Q, Communications Plan, for further details. As Oregon moves into Year 3, this work will continue with increased efforts to inform state employees about their new choices that include more CCM elements across the plans and intensive efforts to assist enrollees, in both Medicaid and PEBB, to better understand their benefits and available services.

Year 3

The Oregon Health Authority is currently administering three communication related contracts under SIM to better understand and improve overall client communications, explore provider communications and their understanding of CCM, and how to communicate the concepts of CCM spread to key stakeholders. These activities will continue and conclude in Year 3.

Client communication (OHP, PEBB & OEBB)

The first communication contract explores ways to improve communication with people covered by or eligible for the OHP, PEBB and OEBB. The goal is to ensure clarity of messaging and most effective communication channels and tools, so that all members have the information they need to enroll in and use their coverage.

OHA contracted with the Metropolitan Group in May 2015 and has since completed the first stage of this work to engage stakeholders and gain input and insight on key communication needs as well as thoughts about the most effective messaging and outreach for the populations they serve. Next steps will explore focus groups directly with OHP, PEBB and OEBB clients to gain deeper understanding of communication needs.

Provider communication

The second communication contract aims to better understand what health care providers know and believe about CCOs and the CCM and better understand how best to communicate with providers moving forward. Work is underway to develop a pre-set of discovery questions for an online survey among health care providers before beginning a deeper dive through focus groups.

Spreading the coordinated care model

OHA is also exploring how best to communicate about the CCM more broadly to employer groups/purchasers, employees, local governments and insurance brokers to encourage the spread of the CCM. This work will inform a toolkit that OHA could offer purchasers to assist them in implementing aspects of the CCM in plans they offer. Work began in May to engage stakeholders and gain insight on how best to motivate these audiences toward adopting the CCM.

OHA is convening a stakeholder panel called the Health IT/Health Information Exchange Community & Organizational Panel (HCOP) that will bring together leaders in Oregon to discuss on-the-ground issues facing health care entities as they implement health IT or health information exchange projects. Representatives include local health information exchanges and other organizations with health information technology and exchange efforts such as health systems and CCOs. This panel will inform the HITOC and OHA as it works to support health information technology and exchange efforts through guidance, policy, alignment, sharing best practices and monitoring the environment. OHA held the first meeting with stakeholders in May 2015. Please refer to Section E for additional information.

Oregon Integrated Care Environmental Scan Summary

The OHA Transformation Center, in collaboration with OHSU researchers, conducted an "listening tour" to determine the extent of behavioral and physical health integration activity and how integration efforts could be further supported. Staff visited communities across the state, interviewing integration leaders and provider teams such as the Integrated Behavioral Health Alliance of Oregon, the Trillium Integration Incubator Project, the Behavioral Health Home Learning Collaborative and the Children's Health Alliance Integration Work Group. The OHSU research team conducted semi-structured interviews with 4-10 key stakeholders in 5 CCOs that were selected on the basis of variation in size, organizational structure, geographic location, and experience delivering integrated care. Interviewees included CCO leaders, behavioral health (BH) and primary care (PCP) providers. Please refer to section G for more information.

Integrated systems of care are being implemented throughout Oregon, although the manner and breadth of integration varies widely. Behavioral Health Homes (BHH), aiming to provide care for the SPMI and more severe Substance Use Disorder populations, have been launched in a number of communities around the state. Ten sites participated in the first year of the OHA sponsored BHH Learning Collaborative. Keys to further development and spread of integrated care include refinement of integrated care standards and increasing application of alternative payment models. Please refer to section G for more information.

In the most recent Legislative session the OHA was directed to conduct a minimum of five behavioral health focused community meetings in a variety of geographic locations across the state. The goal of the community meetings is to capture, understand, and report to the Legislature on the experience of children, adolescents, and adults experiencing mental illness and their ability to access timely and appropriate medical, mental health and human services to support

their success in the community. The meetings shall not be restricted to publicly financed services or individuals eligible for public benefits. The focus will be on the entirety of the Oregon mental health system, both public and private.

Issues to be considered should include but not be limited to:

- Access to child and adolescent services
- Boarding in hospital emergency rooms
- Access to housing, addiction, and recovery services
- Family support services
- Waiting periods for services
- Workforce capacity
- Affordability for non-covered individuals to access mental health services
- Coordination between behavioral health and physical health services

The Oregon Health Authority shall consult and coordinate with stakeholders to plan and conduct the community meetings. The Oregon Health Authority is expected to report progress and findings to the appropriate legislative committees and the 2016 Legislature.

| Section D | **Information Systems and Data Collection Setup** |

Overview

Oregon continues to make progress on planning and designing efforts for data integration, data collection and data intake, thanks to SIM funding. We have outlined this extensively in our October 2013 Operational Plan and subsequent updates. We have made progress, as described in our quarterly reports, and continue to work to achieve our objectives that support the spread of the CCM.

Year 2 accomplishments

Measurement reporting mechanisms

Oregon continues to demonstrate commitment to accountability and transparency. We have begun publishing regular dashboard reports – both a statewide multi-payer performance report with quality measures, utilization statistics and expenditure trends by major payer category, and a CCO performance dashboard, including quality measures and cost and utilization trends for Medicaid. OHA published the multi-payer dashboard in March and June of 2014, and again in April 2015. The CCO dashboard was published in November 2013, February 2014, June 2014 and June 2015. These reports are viewable at: http://www.oregon.gov/oha/Metrics/Pages/index.aspx.

The 2014 Health System Transformation Report[2], which covers calendar year 2014 and includes expanded information on the new Oregon Health Plan members who have joined since Jan. 1, 2014, such as enrollment in patient-centered primary care homes, decreased emergency department visits and hospital admissions from chronic diseases.

Final 2014 data show large improvements:

- Emergency department visits by people served by CCOs have decreased 22 percent since 2011 baseline data.
- The rate of adult patients (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.
- The rate of adults (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.
- Patient-centered primary care home enrollment has increased 56 percent since 2011. Primary care costs continue to increase, indicating more services are happening within primary care rather than emergency departments.
- Two CCOs exceeded the Screening, Brief Intervention, and Referral to Treatment (SBIRT) benchmark. Initiation of alcohol and drug treatment has also increased. However, engagement of treatment has held steady, indicating room for improvement.

Oregon intends to continue producing both of these dashboard reports on a regular basis throughout Year 3, integrating additional measures and more clinical data over time as technology allows. Oregon also intends to leverage both in-state and national work toward aligned measure sets. This will not only reduce the provider and health plan reporting burden but it will also increase cross-market consistency for quality improvement and help Oregon monitor the impact of SIM activities throughout the grant period.

Clinical quality metrics registry

OHA continues progress this year toward the implementation of a state-level clinical quality metrics registry. The foundational component for the registry is the creation of a new process for data collection, including a transition from claims-based reporting methods to using data captured within an electronic health record (EHR). To support a successful transition, OHA is undertaking a phased approach with an initial focus on three of the 17 CCO incentive measures. For Program Years One (2013) and Year Two (2014), the CCOs completed technology plans to outline how they are developing the ability to electronically report clinical quality data for three CCO incentive measures: depression screening, diabetes control and hypertension control. These technology plans are a first step toward ensuring that CCOs can leverage certified EHR technology to access individual-level electronic clinical quality measure data on their beneficiaries from providers.

---

[2] Full report can be found at http://www.oregon.gov/oha/metrics/Pages/index.aspx

New to this report are results from the three clinical quality measures, which include control of diabetes, control of high blood pressure, and depression screenings. CCOs are beginning to build their capacity to report on these measures from EHR systems and the 2014 results are promising.

Common credentialing

In 2013, Senate Bill (SB) 604 created the Oregon Common Credentialing Program, a key building block of developing a statewide provider directory, under OHA to simplify and centralize the administrative processes associated with credentialing health care practitioners.

Starting in 2013, OHA convened the Common Credentialing Advisory Group (CCAG). Membership includes individual practitioners and representatives from urban and rural credentialing organizations, large and small Health Care Regulatory Boards (HCRBs), provider practices and a large malpractice insurance carrier. Meetings for CCAG have been conducted monthly and have resulted in the development of a list of health care practitioners who would be expected to participate in the Common Credentialing System (CCS), identification of accrediting entity requirements for credentialing, and a Request for Information (RFI) that was released in January 2014. OHA worked with stakeholders to determine the common credentialing solution functionality and fully developed the requirements working with a quality assurance vendor in April 2015.

Although SB 604 (passed in a previous session) mandates an operational CCS by January 1, 2016, OHA and the Legislature wanted to ensure a successful implementation and that a rushed effort is avoided. Therefore, SB 594 passed this Legislative Session, allows OHA to specify the implementation date by rule, providing required participants are given at least six months notice. This will allow OHA to methodically implement a successful solution and credentialing organizations and health practitioners will have ample time to provide feedback and are thoroughly informed of program requirements prior to the implementation date. Please see: https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/SB594/Enrolled

Data systems

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

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

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

Year 3

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

- Acquisition of Medicare fee-for-service data, which will be included in the All-Payer All-Claims database to develop a full picture of the health care delivery system. Oregon has received data for years 2010-2013 and the data have been integrated into the All-Payer All-Claims database as of June 2015. OHA will submit payment and request data for years 2013-2015 in the summer of 2015.

- OHA will continue to engage the All-Payer All-Claims technical advisory group (also noted in Section A) that will assist with further development of this important data source by making recommendations related to new data fields and files, validation practices, and analytic tools such as groupers or risk adjusters.

- The Oregon Health Insurance Survey Recontact Study was fielded in 2014, with initial findings reported in October 2014. The study describes changes in health insurance coverage for uninsured individuals between 2013 and 2014. The study contacted 964 households where an individual self-identified as uninsured in the 2013 OHIS study, and 73% reported gaining coverage. More information can be found at: http://www.oregon.gov/oha/OHPR/RSCH/Pages/Insurance_Data.aspx.

- The next full Oregon Health Insurance Survey began fielding in April 2015. Initial data analysis and reports of findings will be completed in early 2016. The survey is Oregon's primary method for monitoring health care coverage, and the 2015 survey will provide important information about the impact of ACA coverage expansions in the context of the coordinated care model.

- Development of online dynamic web tools, which will provide an efficient, centralized location for the data elements, metrics and measures that are currently reported through segmented channels. More significantly, it will provide the viewer with the ability to filter the data elements to create automated custom reports using aggregate data. Initial stakeholder feedback has been collected and a high-level project plan and strategy has been developed. The project is currently in review by state agencies prior to beginning the procurement process.

Section E	Alignment with State HIT Plans and Existing HIT Infrastructure

Overview

Oregon's CCM and its spread require essential tools that can improve care coordination and quality while reducing the cost of care. Health information technology and the electronic exchange of information are some of those key tools. Oregon's efforts, as planned and described

in our October 2013 Operational Plan and the 2014 update, have proceeded to support and accelerate statewide health information technology initiatives.

Year 2 accomplishments

Strategic work

State HIT business plan framework

In June 2014, the OHA finalized a strategic plan to advance health information technology and health information exchange services in the state. These services will support the transformation of Oregon's health system and help improve health outcomes and quality of care and reduce costs. Please see Appendix 8 for the strategic plan.

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

This stakeholder process led to a vision for Oregon of a transformed health system where health information technology and exchange efforts are utilized to optimize the delivery and experience of health care for Oregonians. "HIT-optimized" health care is more than the replacement of paper with electronic or mobile technology; the three goals of this optimization are that: 1) providers have access to timely, accurate, meaningful information at the point of care; 2) health care systems have access to aggregated data to improve quality and manage population health; and 3) individuals are empowered by access to their own health information.

The OHA continued its efforts toward achieving this vision through a suite of HIT services that will enable health information exchange at a state-level. The majority of these services are anticipated to support the Medicaid program initially. Recently passed, HB 2294 has three main components: 1) It formally establishes the Oregon HIT Program within OHA and grants OHA authority to provide optional HIT services to support health care statewide (e.g., beyond the Medicaid program). It also authorizes user fees to cover the costs of expanding OHA's HIT services. 2) It grants OHA flexibility in partnering with stakeholders and participating in partnerships or collaboratives that provide statewide HIT services, including the ability to vote on governance boards for such services, and ability to enter into agreements to support and provide funding for the appropriate Medicaid share of statewide HIT services. 3) It updates the statute for Oregon's HIT Oversight Council (HITOC), bringing it under the OHPB and

solidifying its role in providing strategic and policy recommendations and oversight on the progress of Oregon HIT efforts. Please see:
https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/HB2294

OHA Deeper Dive "Listening Tour" – meetings with CCOs

OHA conducted in-person meetings with each CCO during summer 2014 to gain a deeper understanding of each CCO's health information technology initiatives and coordinate around Phase 1.5 HIT/HIE statewide services in development at the state level. The aim was to ensure that (1) the state's health information technology 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. As a result, in the winter of 2014-15, OHA produced CCO profile documents summarizing each CCO's HIT/HIE 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. These individual documents will be compiled and an overall summary will be produced by summer 2015. This summary will help inform the status of HIT/HIE across the state and will be presented to Health Information Technology Oversight Council (HITOC) to inform them of the current efforts, including barriers and challenges. Please see Appendix 9 for the summary document.

Other activities

As discussed in Section C, OHA is convening the Health Community and Organizational Panel (HCOP) to inform HITOC and OHA. OHA anticipates that HCOP will identify common barriers and begin to (1) assist OHA and HITOC in gaining a better understanding of real-world HIT/HIE implementation efforts; (2) identify opportunities for HITOC to consider regarding providing guidance and/or developing policy to better support HIT/HIE efforts in Oregon; and (3) provide insights to OHA regarding OHA's statewide HIT/HIE initiatives, concerns or implications for implementation and opportunities for improvement and support.

Phase 1.5 of the State Health Information Technology Plan

OHA developed consensus on HIT/HIE Phase 1.5 services and, in 2014, received CMS approval on funding for technical assistance to eligible professionals and hospitals, technology and implementation for expanded Provider Directory services, Clinical Quality Measures Registry and Systems Integrator. Oregon also received approval from CMS for our state Medicaid Health IT plan in April 2015.

Emergency Department Information Exchange

As reported in the previous Operations Plan and mentioned in earlier sections, OHA implemented the EDIE in partnership with the Oregon Health Leadership Council (OHLC), Oregon hospitals and health systems. EDIE alerts emergency department clinicians in real time when a patient who has been a high utilizer of emergency department services registers in their emergency department. These real-time alerts reduce duplicative services and assist clinicians in

directing high utilizers to the appropriate care setting. All of Oregon's hospitals have engaged with this project and 95 percent have gone live and are receiving notifications.

To sustain this effort, the EDIE Utility was developed to create a financing and governance model for EDIE. The EDIE Utility adds inpatient data to the existing data infrastructure to improve the accuracy of alerts. The OHLC and OHA have collaborated closely to develop the business plan for the EDIE Utility which was approved by the OHLC Board and the 16 CCOs in July 2014. The business plan established EDIE Plus as a statewide utility, which would be supported by OHA, all hospitals, the OHLC and its member health plans, and CCOs in Oregon. The plan details the performance goals and metrics for the utility, the finance model, governance structure and implementation plan.

A subscription-based product called PreManage will also allow regional health information exchanges, providers, health plans and CCOs to access EDIE data as real-time notifications when their member or patient has a hospital event. OHA is exploring a potential subscription to PreManage for the Medicaid program. OHA used SIM funds to support a pilot for this subscription for Assertive Community Treatment (ACT) teams that support clients with severe and persistent mental illness. This pilot will provide ACT teams with real-time hospital notifications for their clients. The pilot work began in March 2015 and is expected to conclude in February 2016.

Statewide Direct secure messaging

CareAccord, Oregon's statewide health information exchange operated by OHA, will expand capabilities to better serve and expand interoperability with the Oregon health information exchange community. CareAccord offers Direct secure messaging Health Information Service Provider (HISP) services via a web portal. OHA is developing a pilot to integrate CareAccord into the EHRs of organizations that do not have Health Information Service Provider (HISP) services currently integrated into their EHR to facilitate Direct secure messaging. This would assist the coordination of patient care, as well as enables those organizations attesting for Meaningful Use Stage 2 to meet requirements for transitions of care.

OHA continued progress with the expansion of CareAccord capabilities with Direct secure messaging by developing a pilot program for a statewide Flat File health information exchange provider directory. This Flat File directory allows Oregon organizations participating in DirectTrust access to addresses of other Direct secure messaging users. The directory went live July 2014 and has more than 3,400 users with Direct secure messaging addresses.

State-level clinical quality metrics registry

OHA continues progress toward implementing a state-level clinical quality metrics registry, as described in Section D. The slower than anticipated upgrade to 2014 certified systems has continued to prevent stakeholders from leveraging functionality available through 2014 certified electronic health records, specifically the ability to report clinical quality measures in standard formats. For this reason, a manual data submission process was utilized for Program Year Two and is anticipated to continue for Program Year Three.

Provider directory

As reported in the previous SIM Ops Plan, OHA is developing a state-level Provider Directory as part of the HIT/HIE Phase 1.5 services. Provider Directory services (PDS) will allow healthcare entities access to a state-level directory of healthcare provider and practice setting information. It will seek to leverage data existing in current provider databases and add critical new information and functions. The project comprises design, development, implementation, and maintenance of the technical solution as well as operations and ongoing management and oversight of the program. It can be used by health plans, CCOs, healthcare practitioners (including providers, clinics, hospitals, and researchers), long-term care entities, social service organizations, OHA/DHS and other state programs, Health Information Exchanges (HIEs) and HISPs to support operations, analytics, and the exchange of health information.

In Year 2, OHA formed the Provider Directory Subject Matter Experts Work Group. The work group met during Year 2 and provided guidance on scope, uses, problems, and parameters for provider directories. Their work informed and shaped OHA's requirements for the request for information and funding request to CMS.

Following the work group, OHA convened the Provider Directory Advisory Group (PDAG) in early 2015 and tasked it with providing guidance on policy and program considerations, as Oregon moves forward to implement statewide provider directory services.

PDAG will work closely with Common Credentialing Advisory Group (CCAG), described in Section D, to identify areas where each other's work can be leveraged. OHA staff is working closely together on both efforts and anticipates implementation of the Provider Directory to begin in 6-12 months.

Systems integrator

To ensure the multiple Medicaid health information technology efforts (provider directory, common credentialing, clinical quality metrics registry, etc.) are designed, implemented and managed as an integrated, interoperable system of systems, OHA will contract with a vendor to manage the projects' risk, procurement, design, development, and implementation and to ensure that the operations of the projects is the best strategy to ensure successful implementation and ongoing processes while meeting proposed timelines and budgets. OHA's efforts to engage a systems integrator have begun in Year 2 and will continue through Year 3.

Technical assistance

OHA has made progress in providing technical assistance to Medicaid eligible professionals and hospitals to adopt and meet Meaningful Use. At the beginning of April 2015, OHA posted a technical assistance request for proposals (RFP) that closed in May 2015. SIM is helping support technical assistance beyond the Medicaid providers to help with outreach and education on HIT and interoperability as a portion of the anticipated contract.

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

Other HIT/HIE work

Telehealth efforts

OHA has established a partnership with the Office of Rural Health (ORH) at Oregon Health & Sciences University to administer our SIM-funded telehealth pilot projects. The Request for Grant Proposals was announced in October 2014 and generated 67 letters of interest. OHA and ORH invited 14 organizations to apply and 13 were able to submit full applications.

OHA and ORH selected 5 organizations to receive grant funding and in March of 2015, CMMI approved funding for all of the proposed projects. All grant agreements were executed in May 2015, and the pilot projects will launch in summer of 2015.

Each project will work to address a unique population and system challenge in areas such as behavioral health, youth dental, dementia care, HIV services and connecting paramedics to clinics in rural areas.

OHA is also addressing the lack of widely available information regarding telehealth resources and state and federal telehealth policies by using SIM funding to support a telehealth inventory project. OHA established a partnership with the Telehealth Alliance of Oregon (TAO), a non-profit organization focusing on advancing telehealth in Oregon, to develop this project. TAO is planning to develop a web-based, searchable inventory of telehealth services in Oregon, a policy analysis of state and federal telehealth laws and regulations, and a gaps analysis of the current state of telehealth in Oregon.

Patient Engagement

OHA is supporting patient engagement with their health information by supporting the spread of OpenNotes across Oregon starting in summer of 2015. OpenNotes is a national initiative working to give patients access to their provider's clinical notes to bring more transparency to medical records.

OHA has created an internal Behavioral Health Information Sharing Advisory Group to help improve care coordination. Many providers and CCOs have identified barriers in exchanging behavioral health information (including mental health, addictions, and substance abuse) between providers, primarily due to the confines of the federal 42CFR, Part 2 restrictions around substance abuse information. The Advisory Group has identified short, medium, and long-term solutions that will improve behavioral health information sharing and compliance with applicable state and federal privacy and confidentiality laws. Ongoing feedback and engagement with the CCOs, providers, and other stakeholders will help tailor solutions to be able to share information electronically for better patient care.

Year 3

Year 2 saw significant activity around Phase 1.5 health information exchange and related work and OHA expects Year 3 efforts to continue, as described below.

Strategic work

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

OHA will continue to work with our stakeholder workgroups HCOP and HITOC to address barriers and improve support.

Phase 1.5 work

OHA will continue work to implement the provider directory, common credentialing system and clinical quality metrics registry. OHA anticipates that the provider directory, common credentialing and the clinical quality metrics registry to be fully operational by January 2017. OHA also anticipates that CareAccord's Flat File Directory and HISP integration pilots will continue throughout Year 3. Technical assistance is expected to continue in Year 3 with provider outreach and communication activities, such as webinars or user groups, to increase the meaningful use of EHRs and interoperability. The ACT pilot testing use of PreManage is expected to wrap up activities at the end of February 2016. PreManage is expected to be adopted by the majority of health plans and CCOs by the end of 2016.

Other HIT/HIE work

Telehealth Efforts

By end of Year 3, OHA expects the telehealth pilots to conclude and the evaluation period to end. The pilot sites will report on their efforts and present findings and lessons learned. OHA plans to share this information at the December 2016 CCO Summit.

By the end of Year 3, OHA also expects to have a fully operational web-based inventory available for public use, updated information about state and federal telehealth rules and regulations, and a telehealth gaps analysis completed.

Patient Engagement

We anticipate that our work to support the spread of OpenNotes throughout Oregon will be more expansive through Year 3.

Section F	**Enrollment and Disenrollment Processes**

Not applicable.

| Section G | Model Intervention, Implementation and Delivery |

Overview

Model intervention

As outlined in our October 2013 Operational Plan and the 2014 update, the test under Oregon's SIM project is the coordinated care model, which focuses on delivery system redesign and payment reform to improve quality, value and outcomes. The interventions supported by SIM include a wide range of policies and activities designed to drive: 1) improved care coordination at all points, emphasizing patient-centered primary care; 2) adoption of value-based payment methods; 3) integration of care across silos, including bridging medical care with population health; and 4) accountability for safe and effective care. Testing and accelerating the spread of effective innovations in each of those areas is the fifth and unifying aspect of Oregon's SIM project. (See Appendix 10, Oregon SIM Driver Diagram.)

The model to be tested and the majority of Oregon's implementation and dissemination plans have not changed since the state submitted its original SIM application and 2013 Operational Plan and the 2014 update. However, some activities have been adjusted and some new strategies for model implementation and spread have been identified in the interim. This section provides a brief review of significant model intervention accomplishments during Year 2 and updates on plans for Year 3. As in the original operational plan, this section is organized primarily around the multiple levers Oregon is using to implement and spread the model: financial, legal/regulatory, structural and cooperative. Throughout, we also highlight our efforts to engage government, CCOs and health system partners, communities and consumers in the health system transformation that SIM supports.

Model implementation

As CMMI is aware, Oregon's coordinated care model was initially designed for and first implemented in the Medicaid program. With implementation of the Affordable Care Act and Oregon's Medicaid expansion, approximately 434,000 additional Oregonians have enrolled in the Oregon Health Plan, for a total of 1.1 million. With close to a quarter of the state's population already participating in the intervention through Medicaid and 133,000 more covered lives through the Public Employees' Benefit Board (PEBB), currently 1,102,851 lives are covered across the state, representing 27.8 % of the total population. The next population to enter the model will be the 147, 000 lives covered under Oregon Educators' Benefit Board (OEBB).

Using financial levers to implement and spread the model

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

Paying for value in Medicaid

OHA released the sixth report on quality measures for Oregon's CCOs. Under the coordinated care model, OHA held back 3 percent of payments to CCOs in an incentive "pool". To earn their full payment, CCOs had to meet benchmarks on at least 12 of the 17 incentive measures and have at least 60% of their members enrolled in a patient-centered primary care home. All CCOs showed improvements in some number of measures and 13 out of 16 CCOs earned 100 percent of their quality pool payments in 2014.

Overall, the model continues to show improvements, even with the inclusion of the more than 434,000 additional Oregonians who have enrolled in the OHP since January 1, 2014. Areas the model shows large improvements in:

- Emergency department visits by people served by CCOs have decreased 22 percent since 2011 baseline data.
- The rate of adult patients (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.
- The rate of adults (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.
- Patient-centered primary care home enrollment has increased 56 percent since 2011. Primary care costs continue to increase, meaning more services are happening within primary care rather than emergency departments.
- Two CCOs exceeded the Screening, Brief Intervention, and Referral to Treatment benchmark. Initiation of alcohol and drug treatment has also increased. However, engagement of treatment has held steady, indicating room for improvement.

Finally, financial data indicates CCOs are continuing to hold down costs. Oregon is continuing its efforts to transform the health delivery system. By measuring progress, sharing it publicly and learning from successes and challenges, we can see clearly where we started, where we are, and were we need to go next. The full report is available at:
http://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx

Active purchasing

As the purchaser of health care benefits for more than 133,000 Oregonians, the PEBB uses its buying power to get the best health care available from health plans that serve its members. The board explicitly designed its 2015 benefit year request for proposals and resulting contracts in alignment with the coordinated care model. The recently executed contracts hold health plans accountable for the way they provide care, requiring reporting on a standard set of quality measures and attaching penalties/bonuses to performance starting in 2016. Contracted plans will be held to a fixed rate of growth, through improvements and efficiencies rather than increasing employee premium or cost share, similar to the rate that Oregon has committed to achieving in Medicaid. As direct evidence of coordinated care model spread, the new PEBB plans include two

entities that also serve the Medicaid population as CCOs. In addition, the other PEBB-contracted commercial insurers are close key partners in the governance of two other Medicaid CCOs.

Using legal and regulatory levers to implement and spread the model

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

Metrics alignment

Establishing standards and holding plans and providers accountable for quality performance are important elements of the CCM. But aligning metrics across payers is critical to send consistent signals to providers and reduce the measurement burden on all parties. Oregon's 2015 legislative session included this bill about metrics alignment (these are also described in Section A):

- *SB 440 – Multi-payer metrics alignment*. SB 440 is Oregon's next step on aligning metrics and improving the availability of health plan performance data. The bill requires the OHPB to develop a strategic plan for the collection and use of health care data by September 2016 and, beginning in 2017, creates a new Health Plan Quality Metrics Committee under the OHPB to adopt and report on quality measure for CCOs, PEBB, OEBB and state-regulated commercial plans. Please see: https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/SB440/Enrolled

In another example of metrics alignment, the state's first year of a unified kindergarten assessment was completed in October 2013 and continues to be implemented annually. Kindergarten assessment data provides a proxy for kindergarten readiness among Oregon's children.

A measure for kindergarten readiness continues to be targeted as a potential future CCO incentive metric. The Child and Family Well-Being Measures Workgroup was convened in September 2014 to develop a library of measures across multiple domains that can be used for performance accountability or community monitoring. With the assistance of a contractor with national experience in measurement efforts, Michael Bailit Health Purchasing, LLC, the Workgroup has met monthly since September 2014 and is nearing completion of a recommended set of measures (anticipated by fall 2015). Although the principal consumers of the measures are expected to be the CCOs and the Early Learning Hubs, the Workgroup has included representatives from a broad spectrum of child-and family-serving systems to ensure alignment of measurement efforts across sectors.

As stated earlier, in a step toward metrics alignment for the broader commercial market, both inside and outside the exchange, Oregon's Insurance Division asked carriers to report their performance on five metrics when submitting their 2015 rates for approval. The measures align closely with the CCO incentive measures and measures recommended by the HB 2118 Health Plan Quality Metrics Work Group. This is the first time carriers have been asked to report quality

information with rate requests and the policy is a direct result of the Governor's 2013 request to enhance the rate review process and consider opportunities to spread the CCM. At this stage, the metrics will be used for informational purposes only, to promote market wide transparency and alignment (see: www.oregonhealthrates.org).

Contracting language and standards

Oregon has already reported earlier in this section and elsewhere in this update that OEBB is working to incorporate a number of CCM elements in 2017 plan year contracts.

Another example of contracting language that is helping to spread the CCM is the requirement for CCOs to complete community health assessments and develop and implement community health improvement plans. In keeping with the model's emphasis on integrating health care with community health improvement, CCOs were required to work closely with local public health departments, hospitals, service providers and community groups to develop a comprehensive assessment and plan for action. It is important to note that these assessments and plans are to address the entire population within a CCO service area and are not limited to CCO members. The CCO community health progress reports were due to OHA June 30, 2015 and will be under review by staff from the Transformation Center, the Public Health Division and the Office of Equity and Inclusion.

Themes and opportunities for technical assistance were incorporated into technical assistance offerings over the past year, including a community health improvement plan breakout session at the December 2014 Coordinated Care Model Summit and the May 2015 CCO learning collaborative focused on tobacco prevention and cessation.

In winter 2015, the Transformation Center and Public Health Division developed resources, including population health data and evidence-based practices, to assist CCOs with the implementation of their community health improvement plans. These resources were publicized on webinars with Community Advisory Council coordinators, chairs and members.

Formal mechanisms for connecting reform across sectors

As part of Oregon's Early Learning System transformation efforts, the Early Learning Council supported the development of 16 community-based Early Learning Hubs (EL hubs) which serve as coordinating bodies to make supports more available, more accessible and more effective for young children and families. Currently all 16 EL hubs have executed contracts with the ELC. Coordination across EL hubs and CCOs have been rapidly evolving with a focus on improving performance, ensuring outcomes for children and preventing future, chronic health conditions. Oregon's new EL Hubs are directed by statute to accomplish three specific goals: 1) create an early childhood system that is aligned, coordinated and family-centered; 2) ensure that children arrive at school ready to succeed; and 3) ensure that Oregon's young children live in families that are healthy, stable and attached. The Child Well-being Team works closely with the Early Learning Division/Department of Education to provide technical assistance and information sharing to support the coordination between CCOs and EL hubs.

A Health and Early Learning Forum, scheduled for November 2015, will bring together CCOs and EL hubs to: 1) identify collaborative opportunities to support early learning and children's health, 2) inspire and strengthen cross sector connections, and 3) learn about existing CCO/EL Hub initiatives, projects and policies that can be replicated in other regions of Oregon.

In order to support CCOs in meeting their success metrics and further align cross-sector collaboration, OHA has supported three community grants to communities using SIM funds. These grants incentivize partnership and collaboration across health, education, early learning and other sectors. All three grants assist CCOs in meeting their success metrics, collaborating with EL Hubs and other community organizations, and testing innovations that can be replicated elsewhere in the state. The three projects/grantees selected for this funding are:

- Blue Mountain Early Learning Hub: Partnership with rural Eastern Oregon CCO to implement training activities around children's oral health, parent education and developmental screening.
- Oregon Solutions Network: Partnership between Trillium CCO, institutions of higher education and other partners to explore options for developing nurse practitioner and physician's assistant training programs in Lane County.
- Oregon Solutions Network: Partnership between Cascade Health Alliance CCO and a wide variety of partners in Klamath County to develop a school-based health center.

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

By September 2014, all 2014-2015 MOUs were executed and implementation work begun. Substantial progress has since been made establishing procedures for and launching care coordination meetings throughout most regions of the state. Some partners are exploring tracking measures to report changes in costs and service utilization after care conferences.

An example of successful care coordination practice was shared in a presentation at the 2014 Coordinated Care Model Summit. The parties presented their process for exchanging information to prioritize high needs members and develop protocols on how to use this information for care coordination. Care transition work includes a variety of efforts from forums bringing together health and social service organizations influential in care transitions to clarifying roles and responsibilities and developing procedures to schedule staffing meetings for consumers experiencing transitions.

First year activities included cross training, developing relationships, sharing roles and responsibilities, rules, policies, procedures and learning about organizational cultures.

Completion of shared accountability mechanisms documented in the MOUs is reported quarterly and show positive progress over time. MOUs are required to be renewed annually as part of the CCO contract. CCOs and APD/AAA offices have recently completed all 16 MOUs for 2015-2016.

Using structural levers to implement and spread the model

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

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

Coordinated Care Model Summit

In December 2014, the Transformation Center, in partnership with the Northwest Health Foundation, sponsored the second CCM Summit. Former Governor Kitzhaber provided opening remarks and members from the community advisory councils were brought together for networking and support for development of the advisory councils. The summit was well attended with about 1,200 participants, and evaluations reflected a high value for the learning opportunities provided.

Learning collaboratives and other technical assistance

Thanks to SIM support, the Transformation Center convenes seven learning collaboratives:

1) Quality and Health Outcomes Committee learning collaborative includes CCO medical directors, behavioral health directors, oral health directors, and quality improvement coordinators;
2) Community advisory council learning collaborative includes consumers and community partners including some local public health agencies;
3) Complex Care Collaborative includes multiple provider disciplines;
4) The Improvement Science in Action collaborative;
5) Council of Clinical Innovators, a program for emerging provider leaders across the state;
6) Health equity learning collaborative, including CCO staff and CAC coordinators; and
7) The Quality Improvement Community of Practice.

As described earlier in this update, the Transformation Center graduated a cohort of Council of Clinical Innovators in summer 2015. These 13 providers from across the state serve as champions of change and support the implementation of the coordinated care model through their innovation projects and provider-to-provider conversations. Their local innovation projects

address behavioral health integration, care transitions, teledermatology, health literacy, care coordination, oral health care access in rural communities, obesity prevention in Latino communities, trauma informed care and payment reform for behavioral health. In January 2015, the Clinical Innovators submitted six-month progress reports describing the status of their projects and feedback on their experience of the program to date. All 13 Innovators indicated that the program was very valuable or valuable for supporting their work. The second cohort for Year 3 was selected in May 2015. The second cohort's year-long learning experience, beginning in July 2015, will develop and refine their skills in leadership, quality improvement, and implementation and dissemination science. Detailed information on the first cohort of Clinical Innovators and their projects is available at: http://www.oregon.gov/oha/Transformation-Center/Pages/Council-Clinical-Innovators-Fellows-2014-2015-Bios.aspx.

OHA contracted with the Institute for Healthcare Improvement to offer an online course for system change agents called the Science of Improvement for Managers. The training was attended by OHA leaders and the quality improvement coordinators working for the CCOs to implement the transformation projects supported by state general funds. In 2015, the Transformation Center offered *Quality Improvement for Managers*, a three-month online course offered by the Institute for Health Care Improvement. The target audience for participation was the CCO improvement portfolio managers and key OHA staff. A follow-up round of webinars and conference calls will be offered for another 3 months to support ongoing implementation of the principles and practices of the science of improvement.

OHA convened a second Community Advisory Council (CAC) summit in June 2015. Participants learned how to diversify their CACs. National expert, Ignatius Bau presented on data collection beyond race, ethnicity, and language. Profile grids are one tool to ensure CACs reflect the diversity of their local communities. Attendees viewed a CAC 101 webinar that can be used to effectively recruit, onboard and retain members for more effective community representation. The webinar is available at: http://tinyurl.com/qz5ytvg
The Patient-Centered Primary Care program expanded its capacity for technical assistance for primary care transformation by contracting with 10 clinical consultants to provide technical assistance and act as clinical champions for practice transformation and by hiring five positions (three supported by SIM funds) to provide consultation, technical assistance and evaluation services through clinic site visits as well as develop strategic communication and marketing strategies.

The Patient-Centered Primary Care Institute (PCPCI) offered 15 webinars for nearly 600 attendees on topics such as "Empanelment: What Do You Do After Every Patient Has an Assigned Care Team" and "Strategies for Rural, Small Independent Practices." From July 2014 to May 2015, 24 practices representing over 280 providers and 115,000 patients participated in a series of Learning Collaborative hosted by PCPCI, each one facilitated by a technical assistance (TA) partner from across the state. The practices received in-person training, technical assistance and practice coaching to support the adoption of the PCPCH model. Learning Collaborative topics include: "Improving Patient Experience of Care," "Improving Access Through a PCPCH," and "Patient-Centered Communication Skills, Behaviors and Attitudes." Webinar recording and supporting materials are located at www.pcpci.org

Long Term Services and Supports accomplishments

Long Term Services and Supports (LTSS) has had several accomplishments this period including their ongoing work with the CMS CCO Alignment group to share care coordination practices and outcomes as well as health promotion, prevention and self-management program partnerships between CCOs and Area Agencies on Aging (AAA) and the Agency for People with Disabilities (APD).

The purposeful positioning of an AAA employee at a CCO in order to increase member referrals, enrollment and completion of health promotion classes is another example of the unique partnerships being piloted between AAA/APD offices and CCOs.

Progress has been achieved through updating Memorandum of Agreements between CCOs and either Aging or People with Disabilities or Area Agency on Aging offices, whichever administers long-term services and supports in the geographic area. These agreements have five required domains of activity including establishing member care teams, individualized service plans, prioritization of high needs members, care transitions and member engagement and preferences. In addition, two pilot projects to address improved care coordination for high needs consumers have been approved and funded through the APD Innovations Fund. Evaluations of these efforts are expected by January 2016.

LTSS has partnered with the Oregon Geriatric Education Center to apply for a grant that will enhance joint geriatric education, communication and coordination between primary care, APD/AAA offices and LTSS consumers to all regions of the state. LTSS Innovator Agents are now finalizing a proposal for MOU related metrics to be reviewed with CCOs and approved by OHA.

In addition, two pilot projects to address improved care coordination for high needs consumers have been approved and funded through the APD Innovations Fund. One project lead by Multnomah County Aging and Disability Services provides services to vulnerable, hard to reach consumers with very high medical and social service needs. The second project, to Oregon Cascades West Council of Governments Area Agency on Aging, was matched by Samaritan's InterCommunity Health Network CCO for their Intensive Case Management pilot program. The project is piloting services aimed at preventing unnecessary hospitalizations and emergency department use. Evaluations of these efforts are expected by January 2016.
Finally, LTSS plans to convene a discussion in the fall of 2015 to gather feedback, review and revise the MOU guidance in preparation for 2016-2017 MOUs and the evolution of care coordination. Additional grants are being sought to fund and create sustainable funding streams for health promotion and health prevention programs in partnerships with CCOs. APD expects to re-engage in the recommendations of the LTSS-CCO integration study final report, and use SIM funds to help review care coordination practices and develop LTSS metrics.

Housing with Services Accomplishments

Housing with Services has been established as a legal entity with a variety of agreements and contracts governing level of partnership, participation and service contracts with a wide range of health and social service organizations. From its initial plan of four buildings, it has grown to include eleven buildings and from an initial estimated 436 residents to over 1500 potential participants. Accounting and family metrics software is in place to track costs and service utilization. The health and wellness center opened and includes a primary care clinic, an ElderPlace program and a variety of classes including health promotion/prevention and self-management classes on site. Some classes are designed for and specialize in serving members of ethnic and racial minority groups. Health navigation, referral and health care coordination services are provided on site in the buildings by health care professionals and para-professionals. Mental health services are also now available on site as well. A Resident Council is operating and advises on the Housing with Services program as well as a resident volunteer program and a food bank. Finally, a first round of evaluation including a self-reported needs assessment and a qualitative study of the Housing with Services consortium development was completed, see Appendix 11 for those reports. In addition, APD has convened a Housing Policy Workgroup and legislation is pending to either define or convene an official Task Force on Housing with Services in Oregon. The intent is to identify any regulatory or consumer protection needs as the model spreads. The SIM-funded Housing with Services pilot staff is participating in this workgroup.

Duals alignment accomplishments

Some accomplishments for year 2 include:

- CMS Alignment workgroup has been reviewing and discussing communications for duals during this period and has drafted an Oregon version of the Integrated Delivery Network (IDN) which integrates Oregon Notice of Action requirements. This will be submitted for CMS approval in the near future, after which individual CCOs/MA plans can look at opportunities to use to simplify duals noticing.

- Health Analytics and OHSU are working to produce duals-specific data for CCOs and FFS members in 2015. Enrollment data is now produced monthly as of January 2015. An updated duals fact sheet is being produced and should be completed by end of June 2015.

- A duals data project funded by SIM with OHSU Center for Health Systems Effectiveness began June 2015 to examine Medicare and Medicaid claims for dual-eligibles and use these data to examine the influence of CCOs on cost and quality of care for dual-eligibles. Anticipated work will include assessments of the ways in which access, utilization, and the quality of care varies for dual-eligibles in coordinated care organizations vs. those in a fee-for-service plan. A duals enrollment policy paper is in process to assist MAP leadership in examination of options to address identified barriers and meet OHA targets for increasing duals enrollment in CCOs.

- Promote subcontracting strategies for Medicare Advantage that are aligned with CCO strategies promoting care coordination, goals to meet triple aim and increase emphasis on patient-centered primary care homes.

- Technical assistance tool created to share with CCOs. Tool highlights a wide variety of best practice opportunities for CCOs and community partners for meeting duals coordinated care objectives in areas such as communication, engagement, population health management, care coordination, care transitions, administrative policy, health promotion and health equity. This TA tool allows work with plans from where they are to assist them in moving forward with reasonable actions that address duals alignment and ultimately impact CCO performance metrics and outcome goals for the triple aim.

Advancing health equity and population health

OHA selected three proposals to establish Regional Health Equity Coalitions (RHECs), bringing the total number of operational coalitions to six across the state. The six regional health equity coalitions have been fully established thanks to SIM support, and the Office of Equity and Inclusion has completed two rounds of site visits to each of the coalitions this year.

Through a collaborative and participatory process, the Office of Equity and Inclusion and the Regional Health Equity Coalitions have identified three evaluation questions, five main outcomes resulting from RHEC activities, and eight indicators for monitoring progress. The Office of Equity and Inclusion (OEI) has identified successes associated with each indicator across the six RHECs, and some key milestones to highlight during this funding cycle include the following:

- Regional Health Equity Coalitions include members across sectors representing healthcare, transportation, housing, education, law enforcement, and juvenile justice. Health-related member organizations include oral health, behavioral health, physical health, and Coordinated Care Organization (CCO) administration.

- A RHEC engaged the newly-elected Mayor of the largest city in their region on health equity issues disproportionately affecting Latino residents. The Mayor has now created a Latino Advisory Council and continues to meet with RHEC members.

- A RHEC sponsored a forum with the U.S. Representative in their region to discuss health equity issues facing their community members.

- One of the RHECs partnered with the Regional Health Equity Task Force to interview community members about their experiences accessing health services across three counties and produced a 35-minute video and 25-page report. These materials were presented to the CCO, resulting in an assessment of healthcare interpreter services in the region. Findings from the assessment led the CCO to contract with the RHEC to provide their providers with additional training on how to use healthcare interpreters appropriately.

Demographic data collection instruments are being finalized to capture data on all RHEC leaders and members. RHEC Coordinators will begin administration of the instrument in summer of 2015. To ensure optimal inclusion of participants in demographic data collection, instruments will be available in English, Spanish, Russian, Vietnamese, and Braille; and will target steering/leadership committee members, coalition members, and meeting/event participants. These surveys will ask respondents about race, ethnicity, disability, zip code, age, gender, sexual orientation, language, and coalition role.

Each of the coalitions are in the process of completing needs assessment reports which will guide development of five-year strategic plans to address the social determinants of health and improve health outcomes regionally. The Southern Oregon Health Equity (So Health-E) Coalition has made their needs assessment reports available to the public here: http://www.oregon.gov/oha/oei/Pages/sohea.aspx

The annual Regional Health Equity Coalition Spring Gathering was held in southern Oregon, on May 12-13, 2015. There were 34 attendees including representation from all coalitions, the Governor's Office, the Office of the Chief Medical Officer, CCOs, public health, and community based organizations. Meeting topics included training on a framework for policy change to promote equity, legislative process 101, state data resources, equity and inclusion bill analysis and program development tool training.

Twenty members of the first Developing Equity Leadership through Training and Action (DELTA) cohort presented their project work, completed their training and graduated in September 2014 which provided OEI staff and community with the opportunity to acknowledge the 2014 cohort and their accomplishments. DELTA builds the capacity and commitment of health leaders to eliminate health disparities; creates opportunities to share strategies and challenges across organizations and programs; builds camaraderie and relationships with interdisciplinary organizational partners; provides concrete, applicable health equity tools; stimulates leaders to act individually and collectively to address significant challenges and barriers in all populations accessing optimal health.

In January 2015, twenty-five new members began a second DELTA cohort. Between January and July 2015, seven DELTA training sessions were held that focused on the following topics:

- Social Determinants of Health/Health Disparities in Oregon
- Metrics for Collecting Race, Ethnicity, and Language Data
- Unconscious Bias in Workforce Recruitment, Hiring and Retention
- Literacy and Language that Supports Communication and Health Equity
- Empowerment and Equity Strategic Planning
- Effective Community Engagement, and
- Addressing Impacts of Power and Privilege

Each training session was facilitated by trainers from OEI's Qualified Training Registry for Diversity, Inclusion and Health Equity, as well as outside subject matter experts. The 2015 cohort is scheduled to present their individual project work, complete their training, and graduate in September 2015. Projects address a range of health equity issues within organizations and are

individually and collectively addressing 13 of the 15 national Culturally and Linguistically Appropriate Services in Health and Health Care Standards (CLAS).

After each training session, cohort participants are expected to complete individual training evaluations. These evaluations have assessed attainment of training objective knowledge, opportunities for learning application and served to inform the DELTA curriculum development for future cohorts. Key outcomes include developing community partnership engagement plans, recommendations for improving language communication, messaging strategies to communicate effectively across literacy levels, and generating plans to reduce implicit bias. Currently, OEI is working with evaluators as they conduct key informant interviews for post-program impact evaluation.

Current and former DELTA participants receive an electronic quarterly newsletter entitled, "*DELTA in 3D*" published in November 2014, February 2015, May 2015, and August 2015 focused on individual cohort member updates, related diversity and disparity articles, local and national health equity events, and funding announcements. Current and former DELTA cohort members have also increased utilizing a shared Groupsite for training materials, discussion forums, and training calendar logistics and connect with OEI staff for technical assistance in continuing to implement their DELTA project work.

The Public Health Division continued funding for four community health improvement projects jointly implemented by CCOs, local public health departments and other partners. The projects have used evidence-based strategies to address the leading causes of death and disability in alignment with local community health improvement plans. The Transformation Center and the Public Health Division hosted a joint meeting between CCO and local public health authority leaders in December 2014, which provided an opportunity for shared learning and discussions about opportunities to work together, specifically as it relates to chronic disease and maternal and child health initiatives. The Public Health Division completed fielding of the Medicaid Behavioral Risk Factor Surveillance System Survey (MBRFSS) and provided preliminary data and an informational webinar to CCOs in April 2015. A full MBRFSS report will be produced and disseminated in fall 2015.

Health information technology and health information exchange supports for transformation

As noted in Sections A and E, OHA collaborated with the Oregon Health Leadership Council, Oregon hospitals and health systems and others to implement the Emergency Department Information Exchange: a real-time alert system for emergency department clinicians. OHA used SIM funding to subsidize the first year's costs, on the condition that the vast majority of Oregon hospitals agree to participate. With this leverage, 95 percent of Oregon hospitals have live feeds as of May 2015, sending data and receiving notifications. Section E notes several other significant steps forward for health information technology and exchange infrastructure to support transformation.

Analytic supports for transformation

With support from SIM resources, OHA has launched a [multi-payer dashboard](#) to provide data on health care cost and utilization, health insurance coverage and quality of and access to care across markets including commercial insurance carriers, Medicare and Medicaid. (The dashboard is described also in Sections D and I.) Trends will be tracked over time and new data sources and lines of business will be added as they become available. The most recent multi-payer dashboard published in April 2015 is available online here: http://www.oregon.gov/oha/OHPR/RSCH/DashboardDocs/April%2030,%202015%20Leading%20Indicators%20Report.pdf.

Thanks to SIM support, all of the data sets in the Oregon Public Health Assessment Tool (OPHAT) were updated on schedule in October and November 2014 and in February 2015. Also in February 2015, OPHAT version 3.0 was released with the addition of new indicators in the Birth Risk Factor module. Over the last year, the Public Health Division has offered OPHAT training for CCOs, the Metrics Technical Advisory Group and local public health authorities.

Using cooperative levers to implement and spread the model

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

Patient-centered primary care

As of May 2015, 550 clinics in Oregon had achieved Patient-Centered Primary Care Home recognition. The Patient-Centered Primary Care Home model can function as a critical starting point for further delivery system and payment reform, so increasing adoption of the standards around the state supports spread of the coordinated care model. OHA has taken an engagement model approach to encourage practices at various stages on the transformation spectrum to pursue this voluntary recognition and to continue to make incremental improvements once recognized.

A 2013 survey of recognized PCPCHs 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. 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. Please see Appendix 12 for PCPCH annual report.

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

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

Cooperation for health information exchange

The establishment of Oregon's Emergency Department Information Exchange (EDIE) is another example of advancing transformation through cooperation. As described under structural levers, OHA and the Oregon Health Leadership Council (OHLC)—representing the leadership of health care purchasers across the state—were able to secure an agreement from all 59 Oregon hospitals to participate and financially support EDIE. OHA anticipates expanding on EDIE by adding inpatient and discharge data and making hospital event notifications available to CCOs, plans, providers and HIEs through the PreManage program (see also Section E).

Year 3

Financial levers

Under the coordinated care model, OHA held back 3 percent of payments to CCOs to create an incentive "pool" for 2014. This was an increase from 2 percent for 2013. To earn their full payment, CCOs had to meet benchmarks on at least 12 of the 17 incentive measures and have at least 60% of their members enrolled in a patient-centered primary care home. Overall, the model continues to show improvements, even with the inclusion of the more than 434,000 additional Oregonians who have enrolled in the Oregon Health Plan (OHP) since January 1, 2014. Today, approximately 1.1 million Oregonians are enrolled in OHP.

All CCOs showed improvements in some number of measures and 13 out of 16 CCOs earned 100 percent of their quality pool payments in 2014.The full report is available at: http://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx

In May of this year, the PEBB board approved health-plan premium rates for all core benefit plans, at a composite rate of 2.6% increase per employee, per month (PEPM). This is well below the legislatively-directed budgetary cap of 3.4% annual growth limiting PEBB's budget.

PEBB attributes the lower rate of increase to five factors:
- Members are choosing plans that better fit their and their family's needs
- Our contracted health plans are gaining efficiencies through:
  - o Care management for members with ongoing conditions

- o Prescription drug management, including use of generic drugs and patient compliance
- o Member selection of state-recognized Patient Centered Primary Care Homes
- o Members receiving the right care, at the right time, and in the right place through their patient-centered primary care home and primary care provider
- Increased shared responsibility for health. Members are focusing on wellness, including using fully covered preventive services
- A decrease in the consultant fee
- Lowering the PEBB administrative fee

Additionally, the state will continue to encourage the adoption of alternative payment methods in Medicaid and others markets at the plan to provider network level as well. HB 231 recently passed and will require major insurers and CCOs to report the percentage of their total health care expenditures that are directed toward primary care, similar to Rhode Island's model. The specific services to be counted as primary care would be defined in rule by OHA and the Oregon Insurance Division. Further, the OHA would convene a voluntary learning collaborative, protected from anti-trust laws that are only applicable to conversations occurring in state-supervised public meetings, where insurers and providers could share best practices in primary care alternative payment methodologies and develop strategies for coordinated technical assistance. The importance of multi-payer engagement in payment reform was originally noted in Oregon's October 2013 Operational Plan.

OHA will continue to use its purchasing power to spread the coordinated care model. With PEBB contracts executed, OEBB 2017 plan year contracts are the next opportunity to incorporate key elements of the CCM (the request for proposals will go out in 2016 with the benefit year beginning October 2017). Work will also continue on establishing and fully implementing a hospital payment incentive program in Medicaid, complementing the CCO incentive payments. See page 62 in this report for more details on the Hospital Transformation Performance Program.

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

A Sustainable Health Expenditure Work Group (SHEW) (see also Section A) was formed in July 2014 to develop a methodology for establishing a statewide health care cost growth benchmark for health entities and health plan premiums. The long-term goal was to consider ways to share statewide accountability for a sustainable, predictable rate of growth in health care spending. The group has representatives from multiple payers and health care sectors, as well as economic and actuarial expertise. The SHEW met five times in 2014 in order to develop a methodology for determining a sustainable rate of growth. Using SIM funds, OHA contracted with Dr. John McConnell, a health economist at the Center for Health Systems Effectiveness to help guide this work. The SHEW provided an update on their work in November 2014 before producing a final

report and presentation in December 2014. These reports and more information is available online here: http://www.oregon.gov/oha/Pages/srg.aspx

The SHEW concluded its initial work as outlined by OHPB in December 2014. The OHPB has decided to incorporate a second phase of the SHEW into the Coordinated Care Model Alignment Workgroup as a time-limited subcommittee focused on refining and recommending adjustments to the methodology, clearly defining the purpose and determining appropriate uses for the total health care expenditure calculations, and developing recommendations for accountability mechanisms and policies to ensure steady progress in cost containment. The group will continue to work collaboratively with Dr. John McConnell and Oregon Health & Science University Center for Health Systems Effectiveness to complete and further refine the measurement framework. As additional data is available, the calculations will need to be adjusted to account for any fluctuations in health care spending. Brian DeVore, OHPB member, will serve as the group's liaison to the Board.

Legal and regulatory levers

As with the financial levers, Oregon has not made substantive changes to plans for using legal and regulatory levers to advance the coordinated care model in Year 3. Working with the OEBB to incorporate CCM elements into their request for proposal and contract language remains a key strategy. The OHPB's Coordinated Care Model Alignment work group is operational and is focused on supporting spread of the coordinated care model beyond Medicaid to the PEBB, the OEBB and to the commercial market, including employers and qualified health plans on Oregon's Marketplace. The Coordinated Care Model Alignment work group is described in more detail under cooperative levers, since it will focus on developing tools and templates to support *voluntary* alignment across markets.

Structural levers

In November 2015, the Transformation Center will sponsor the third CCM Summit in Portland, Oregon. The new OHA Director, Lynne Saxton will provide opening remarks. The focus of the summit will be *Highlighting Outcomes and Promoting Excellence in Implementation of the CCM*. The summit will bring together providers and clinicians, public and private health care purchasers, coordinated care organizations, community stakeholders, health leaders, lawmakers, policymakers and funders to 1) share outcomes and lessons learned, 2) support excellence in coordinated care model implementation across sectors and 3) inspire future innovation in Oregon and beyond.

Technical assistance and other structural supports for transformation will continue to be a significant part of the state's strategy for implementing and spreading the coordinated care model in Year 3. Some specific future activities that were not described in Oregon's 2013 Operational Plan or the 2014 update include:

Additional technical assistance

- A Technical Assistance Bank developed by the Transformation Center, offers a menu of custom technical assistance on a broad range of topics that CCOs may access upon request. Initial areas of assistance included community health improvement plan implementation and evaluation; community advisory council development; health equity; patient engagement; oral health integration; public health integration and tools for measuring improvement. Available topics have been expanded to include: alternative payment methods; behavioral health integration; early learning systems and strategies; health information technology; health program evaluation; health systems leadership; primary care transformation, including patient-centered primary care homes; and project management.

- The Transformation Center continues to communicate with the Office of Equity and Inclusion, Office of Health Information Technology, Patient-Centered Primary Care Program, Public Health Division, Office of Health Policy and Research, and Child Well-being Team to ensure coordination of OHA technical assistance for the topics listed above. To date: 13 of the 16 CCOs have submitted at least one TA Bank request, for a total of nearly 260 technical assistance hours.

- The learning collaborative series, hosted by the Patient-Centered Primary Care Institute, continues into Year 3 to help clinics be successful at transitioning to the new model of care.

The review of the Health Evidence Review Commission's process in the development and spread of clinical guidelines by the Center for Evidence-Based Policy (CEbP) using stakeholder outreach was completed in September 2014. CEbP's report included recommendations on how the process can be improved to better translate evidence to support the provider networks of the CCOs and other providers as the coordinated care model is spread to improve care and lower costs.

A Commission retreat was held in October 2014 to discuss the recommendations, which resulted in a work plan to be completed in Year 3, including developing a website where CCOs and their providers can search HERC guidelines and other Prioritized List-related information by keyword and a patient decision support resource kit, developed with the CEbP, to provide CCOs assistance with the translation and dissemination of HERC evidence-based products.

Increasing the number of qualified and certified health care interpreters

In June 2014, OHA received CMMI approval to move forward with developing learning collaboratives to support the use of qualified and certified interpreters in health system transformation. The activity has ramped up in Year 2 with the contracts to deliver the learning collaborative in place and students being enrolled in courses towards certification.

The Office of Equity and Inclusion (OEI) recruited thirty-five candidates to participate in the first health care interpreter (HCI) learning collaborative beginning June 8, 2015. Subsequent

collaboratives will be delivered in 4 additional locations around the state through the remainder of the grant period. Outreach materials, FAQs and posters have been created to market the opportunity. Additionally, CCOs and various HCI stakeholders, including a statewide advocacy group, training centers and language service providers are actively recruiting local individuals with bilingual proficiency to participate.

In addition to the learning collaboratives, OEI has convened two stakeholder meetings, designed to meet quarterly throughout the grant period, to build awareness of the need of interpreters and share best practices in working with interpreters and supporting Limited English Proficient clients and resolve challenges as they arise. The stakeholder meetings have consistent participation from CCOs, language service providers, hospitals, clinics, providers, active HCIs, for an average of 31 participants per session. The stakeholder meetings will continue to meet quarterly throughout the grant period.

OEI is working with the HCI Learning Collaborative evaluator to implement the evaluation activities. The evaluation includes both process and formative evaluations using a mixed-methods approach. Qualitative data will be collected through semi-structured interviews, facilitated discussions (e.g., focus groups) with stakeholders and HCIs, and document review. Quantitative data will be collected through data base reviews and surveys. Data collection will occur at appropriate points throughout the project.

The learning collaborative contract requires the provider to conduct process evaluation and assess participant satisfaction with the learning collaborative. At the end of each training, learning collaborative participants will complete an OHA-approved survey. An example of survey questions includes: satisfaction with training; applicability to interpreter's profession; and recommendations for improvement. A copy of the survey results shall be submitted to OHA.

Learning collaborative participants will be surveyed 3 months after the completion of learning collaborative to measure training effectiveness.

Continued development of health information technology and exchange functionality

Telehealth pilot projects that were described in the 2013 Operational Plans began in Year 2. Five proposals were selected and the grants have been executed for the activities to commence.

Oregon will continue to develop Phase 1.5 health information technology and exchange services. Please see Section E for more details.

Support for behavioral health integration

In February 2015, the OHA Transformation Center, in collaboration with OHSU researchers, completed an environmental scan to determine the extent of behavioral and physical health integration activity across the state and how integration efforts could be further supported. Transformation Center representatives visited communities, interviewed integration leaders and provider teams, and participated in stakeholder meetings. The OHSU research team conducted semi-structured interviews with 4-10 key stakeholders in 5 CCOs that were selected on the basis

of variation in size, organizational structure, geographic location, and experience delivering integrated care. Interviewees included CCO leaders, behavioral health and primary care providers. The findings were used to develop a technical assistance strategic plan.

The scan found some degree of behavioral health integration occurring in most communities, but there is significant variation in the manner, breadth and depth of integration. Although it is too early for significant outcome data to emerge, providers often cited examples for how care is improving and patients' lives are being positively impacted. Similar concerns and challenges were raised across communities. These fell into three general categories - reimbursement and financial sustainability, information sharing, and workforce development. Providers are interested in learning how integration is being implemented in other communities and they are willing to share their experiences. See Appendix 13 for a summary of the scan.

Based on the above, the Behavioral Health Technical Assistance Plan has nine components. Some strategies are underway, e.g. the Behavioral Health Information Sharing Advisory Group and the PCPCH Standards Advisory Committee. Some strategies are being further developed, e.g., podcast interviews with integration leaders and virtual site visits. The most impactful strategy for many smaller clinics will be the availability of onsite integration practice consultation and coaching.

Population health

In Year 3, OHA will continue to integrate population health in its overall approach to spreading the CCM. OHA's Public Health Division has revised its statewide health improvement plan in order to address the SIM Population Health Plan requirements. In the process of updating the statewide health improvement plan, seven priority areas were selected based on Oregon's epidemiology, alignment with community health, CCO, hospital and local public health community health improvement plans and stakeholder feedback: tobacco, obesity, oral health, substance use, suicide, immunizations and communicable disease control. Each of the seven priority areas includes community strategies, health system strategies, and strategies that promote health equity by specifically targeting efforts to reduce health disparities. The plan will be implemented through a shared governance structure with oversight for the plan provided by the Public Health Advisory Board. The State Health Improvement Plan, which serves as Oregon's SIM Public Health Roadmap component has been included as a stand-alone document in Oregon's year three continuation application. This document has been approved for submission to CMMI, however, it has not been approved for further dissemination until additional formatting is complete and presentation graphics are developed.

Housing with Services has successfully solicited a number of grants to provide funding for operations and to provide culturally responsive services in Year 3. Negotiations with partners in the Health Share CCO and with Family Care CCO, the two CCOs serving the Portland Metro area, are progressing to provide additional health supports and sustainable funding in Year 3 and beyond. Year 3 SIM funding for Housing with Services is solely for evaluation purposes. A final program evaluation will be completed in Year 3.

Cooperative levers

As in Year 2, stakeholder consultation and collaboration will feature significantly in Oregon's Year 3 SIM activities.

As mentioned earlier, the Sustainable Health Expenditure Work Group (SHEW) was formed in July 2014 to share best practices and ensuring CCM alignment across organizations and their respective health plan contracts over the course of the next few years. Oregon has embedded the care model principles in PEBB purchasing starting this year, and continues to press forward to do the same for OEBB purchasing and incorporated in individual and small group commercial plans sold in Oregon.

In Year 3, Oregon will also take steps to improve alignment between Medicare and Medicaid materials and policies to improve the experience and coordination of care for individuals who are eligible for both programs. Efforts will include:

- Improving technology systems to provide Medicare effective dates 90 days in advance rather than the current window of 30 days or less. This will assist CCOs and their Medicare Advantage partners with CMS's "seamless conversion" alignment process. Staff will work with the Federal Coordinated Health Care Office to identify the CMS application information needed for CCOs to request "seamless conversion."

- Producing and providing monthly enrollment reports through OHA's Office of Health Analytics. These reports are now available at : http://www.oregon.gov/oha/healthplan/Pages/reports.aspx

- Updating Dual Special Needs Plans (DSNP) Coordination of Benefits Agreements (COBA contracts) for the five plans in Oregon that offer this type of Medicare plan. Technical assistance from the Center for Health Care Strategies was used to propose additional administrative alignment language in the contract. Draft contract language is being reviewed by plans.

Section H	**Participant Retention Process**

Not applicable.

Section I	**Quality, Financial and Health Goals and Performance Measurement Plan**

Overview

Oregon's SIM-specific goals, targets and monitoring activities (including accountability measures and self-evaluation plans) are described primarily in Section R – Evaluation. This section provides updates and outlines future plans for general health system performance

monitoring in Oregon. Because measuring performance is a foundational element of the coordinated care model, there is a good deal to report in this section.

<div align="center">**Year 2 accomplishments**</div>

CCO metrics and Medicaid measurement strategy

As described in the state's original operational plan, Oregon has committed to a rigorous performance measurement program in Medicaid and pledged to reduce the growth trend in Medicaid costs while maintaining or improving access and quality. In the second year of the SIM grant, Oregon has produced regular public reports on CCO incentive (pay-for-performance) measures and state performance measures, as well as Medicaid cost and utilization. Measures are reported in aggregate and by CCO, against a baseline period (usually 2011). Final 2014 data were released in June 2015 and include expanded information on the new Oregon Health Plan members. The reports are viewable at: http://www.oregon.gov/oha/metrics/pages/index.aspx

As reported earlier, the final data show large improvements:

- Emergency department visits by people served by CCOs have decreased 22 percent since 2011 baseline data.
- The rate of adult patients (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.
- The rate of adults (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.
- Patient-centered primary care home enrollment has increased 56 percent since 2011. Primary care costs continue to increase, indicating more services are happening within primary care rather than emergency departments.
- Two CCOs exceeded the Screening, Brief Intervention, and Referral to Treatment (SBIRT) benchmark. Initiation of alcohol and drug treatment has also increased. However, engagement of treatment has held steady, indicating room for improvement.

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

Performance measurement in other markets

Consistent with the spread of the CCM, Oregon is working to expand and align performance measurement across markets (see Appendix 14 for a crosswalk of measures associated with different payers or initiatives). Much of this work is ongoing and described under "Year 3" portion of this section. Accomplishments in the second year of SIM have already been noted in preceding sections. Additional details provided below.

First multi-payer dashboard

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

Metrics alignment

Senate Bill 440 is Oregon's next step on aligning metrics and improving the availability of health plan performance data. The bill requires the OHPB to develop a strategic plan for the collection and use of health care data by September 2016 and, beginning in 2017, creates a new Health Plan Quality Metrics Committee under the OHPB to adopt and report on quality measure for CCOs, OEBB, PEBB and state-regulated commercial plans.

Paying hospitals for care improvements

In 2013, Oregon House Bill (HB) 2216 created a hospital incentive measure program for the 2013-2015 biennium (the Hospital Transformation Performance Program, or HTPP). HB 2216 also established the nine-member Hospital Performance Metrics Advisory Committee, which is tasked with recommending a set of performance measures for hospitals. The HTPP baseline report was published in April 2015, and the report for the second year of the program will be published in summer 2016. Subject to CMS approval, in March 2015, the program and the work of the committee were extended by four additional years when the Governor signed HB 2395. Information on the program, including the program design for the first two years of the program and measure specifications, can be found here: http://www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx. Information on the Committee, including agendas and meeting minutes, can be found here: http://www.oregon.gov/oha/analytics/Pages/Hospital-Performance-Metrics.aspx.

Incorporating quality information into rate review

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

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

New accountability and quality metrics, aligned with Oregon's CCO incentive metrics, have been built in to Public Employees' Benefit Board health plan contracts to ensure plans are improving care in key areas. OHA will be further refining the process and implementing incentive payments for health plans in the future. This alignment was strengthened by the recent passage of SB 440, Oregon's next step on aligning metrics and improving the availability of health plan performance data. The bill requires the Oregon Health Policy Board (OHPB) to develop a strategic plan for the collection and use of health care data by September 2016 and, beginning in 2017, creates a new Health Plan Quality Metrics Committee under the OHPB to adopt and report on quality measure for CCOs, PEBB, OEBB and state-regulated commercial plans.

Population health measurement

Population health initiatives under SIM are discussed in Sections D and G of this operational plan update and in the "Oregon State Health Improvement Plan" submitted with our continuation application. However, two Year 2 accomplishments regarding population health measurement should be noted here:

- OHA completed data collection and analysis on a Medicaid-specific Behavioral Risk Factor Surveillance System (MBRFSS) survey. CCO-specific MBRFSS results were shared in April 2015 and an informational webinar was provided to CCOs at that time. In partnership with CDC, Oregon and many other states use the general population BRFSS survey to monitor trends in health status and health behavior at a population level. This Medicaid-specific fielding of the questionnaire provides CCOs and the state with a snapshot of the health status and needs of the Medicaid population and will be used to help prioritize health improvement work with Medicaid beneficiaries. A full MBRFSS study report will be released in fall 2015.

- All of the data sets in the Oregon Public Health Assessment Tool (OPHAT) were updated on schedule in October and November 2014 and in February 2015. Also in February 2015, OPHAT version 3.0 was released with the addition of new indicators in the Birth Risk Factor module. Over the last year, the Public Health Division has offered training on using OPHAT for CCOs, the Metrics Technical Advisory Group and local public health authorities.

- The OHA Transformation Center and Public Health Division jointly hosted a meeting of CCO and local public health authority leaders in December 2014 with representatives from nearly all CCOs and local public health agencies in attendance. The meeting allowed for shared learning and facilitated discussions; participants left the meeting with action steps each partner committed to taking over the next three months to build on opportunities to work together on population health.

- The four SIM supported Community Prevention grantees have continued to implement successful population health initiatives.

Capacity

In addition to these substantive accomplishments, SIM funding has allowed OHA to strengthen and stabilize its capacity for performance measurement, analysis and reporting transparency. Establishing expertise and capacity in these areas is a strategy for Oregon's SIM project, as OHA believes that measurement and accountability will help drive change across the health care system. In Year 2, Oregon:

- Brought on 8.0 FTE positions in Health Analytics. Individuals in these positions are directly involved in creating CCO metrics, the dashboards and analytic products described above, in improving and validating key data sources such as the All-Payer, All-Claims data system, and in evaluating Oregon's health system transformation efforts. Efforts are underway to assess future sustainability after SIM ends for these key functions, as the OHA looks to do its own internal transformation across its programs.

- Executed a contract with the Center for Outcomes, Research and Education to build an Accountable Care Data System. This interactive data and dashboard system that tracks cost and quality measures over time, compares CCO performance and allows for dynamic exploration of outcomes by key subgroups.

- Executed a contract with a data layout consultant to help present dashboards and other products for external audiences, including the general public. The benefits of this contract can be seen in the clear and engaging presentations of data on the CCO and multi-payer dashboards on OHA's website.

- Continued to collect data and improve operations of the All-Payer, All-Claims data system, working with contractor Milliman.

- Executed a contract with Bailit Health Purchasing to provide consulting services to OHA for health system performance measurement and metrics development; development and implementation of health care alternative payment methods; and tools and strategies to help purchasers adopt elements of Oregon's health system transformation initiatives.

<div align="center">

Year 3

</div>

A great deal of the performance measurement work described above will continue through Year 3 of the SIM grant, as outlined in our original Operational Plan. For example, the CCO and multi-payer performance reports will continue to be produced regularly and improved over time, the Consumer Assessment of Healthcare Providers and Systems survey will be fielded annually for the Medicaid population, and alignment of metrics across payers will increase as work on SB 440 gets underway. The PEBB contracts successfully incorporated many of the CCM principles including data collection and reporting on aligned metrics, which will be tied to incentive payments in future contracts.

Please refer to Section D for details on performance measurement and analytic activities anticipated in Year 3.

Section J	**Appropriate Consideration for Privacy and Confidentiality**

The October 2013 Operational Plan outlined the considerations Oregon is implementing, in alignment with federal law, for privacy and confidentiality. The state will continue those efforts going forward through the SIM project period. One challenge to be noted continues to be the sharing of behavioral health information to maximize care coordination.

Year 2 accomplishments

Oregon has engaged in technical assistance provided through CMMI related to 42 CFR, Part 2, including several conference calls. Oregon participated in developing the SIM testing state's written response to HHS rule changes related to 42 CFR, Part 2 and joined the letter as a signatory. This was valuable to the OHA's Behavioral Health Information Sharing Advisory Group developed to help CCOs, their partners and providers better understand existing law parameters and to coordinate care across physical and behavioral health at the delivery system level.

Year 3

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

Section K	**Staff/Contractor Recruitment and Training**

Year 2 accomplishments

The October 2013 Operational Plan and the 2014 update described our continued efforts to ensure the SIM investment in Oregon is supported with well-trained staff and that there is ongoing support. Staff recruitment and training continues to be vital to the success of the implementation and spread of the coordinated care model.

Year 3

No significant changes from the originally approved operational plan are expected for project strategies or timelines in this section. Oregon will be examining the current staffing pattern and the use of contractors and consultants in more depth over Year 3 as we refine our ongoing sustainability planning to support the implementation and spread of the coordinated care model.

Overview

A strong healthcare workforce is essential if Oregon is to achieve transformation's triple aim of better health and better care at lower cost. The state has a number of workforce capacity development and monitoring initiatives under way that will help ensure that Oregon has the health care workforce needed to support transformation. SIM funding provides support for a few specific workforce development projects but much of the work described below is funded with other resources.

Year 2 accomplishments

Practice supports and workforce supply

With direct support from SIM, Oregon's Transformation Center is supporting the healthcare workforce by providing resources and technical assistance. Among many other accomplishments in Year 2 (described in detail in Section G), the Transformation Center made progress in the Clinical Innovators program, the Quality Improvement Community of Practice and in completing the assessment of traditional health workers utilization. Expansion of the professional health care interpreter pool across the state is made possible by SIM funding.

Clinical Innovators

As mentioned above, the Transformation Center supported workforce development by hosting learning opportunities for the pilot cohort of thirteen Clinical Innovators, including five physicians, three social workers, two dieticians, one nurse, one expanded practice dental hygienist and one social scientist. Their local innovation projects address behavioral health integration, care transitions, tele-dermatology, health literacy, care coordination, oral health care access in rural communities, obesity prevention in Latino communities, trauma informed care, and payment reform for behavioral health. In January 2015, the Clinical Innovators submitted six-month progress reports describing the status of their projects and feedback on their experience to date. All 13 Innovators indicated that their experience was very valuable or valuable for supporting their work. The second cohort was selected in May 2015 and will begin the learning program in July 2015.

Quality Improvement Community of Practice

The Transformation Center convened a Quality Improvement Community of Practice to expand CCO quality improvement capacity. During the fall of 2014 Transformation Center staff visited all 16 CCOs to provide technical assistance on measurement plans for their Transformation Fund projects (supported by state general funds). Since December 2014, the Transformation Center has convened the Transformation Fund portfolio managers every other month to informally discuss lessons learned from project implementation. In June 2015, the Transformation Center hosted the Oregon Innovation Café, which allowed the CCOs' health system transformation champions and other stakeholders to present innovative projects and discuss lessons learned.

Topics included behavioral health integration and complex care and the event highlighted successful Transformation Fund projects.

Integrative Medicine Advisory Group

The Integrative Medicine Advisory Group was established in the fall of 2013 to advise the director of OHA on ways to promote the use of integrative medicine disciplines within Oregon's health care delivery system, including CCOs. The advisory group consists of the five integrative medicine professions in Oregon that have a federally-recognized accrediting agency and a state-level health care regulatory board. These include acupuncture and Oriental medicine, chiropractic, direct-entry midwifery, massage therapy and naturopathic medicine. Advisory group participants also include CCO medical directors and a commercial health plan medical director.

In the fall of 2014, the IMAG finalized a tool to facilitate information sharing by the integrative medicine professionals with CCOs and other health plans on key credentialing issues. The tool demonstrated the ability of the disciplines to meet core credentialing standards, and includes information on the education, training and professional qualifications required by their state health care regulatory boards. The tool has been reviewed by the state licensing boards and has been shared with the CCOs through their medical directors and also will be available to other health plans to encourage them to consider including these types of providers in their networks. The tool is available at http://www.oregon.gov/oha/Transformation-Center/Resources/IMAG-Credentialing-Tool_FINAL_012015.pdf

The IMAG is also finalizing a resource guide to inform, educate and demonstrate the value of the disciplines' ability to support and enhance health system transformation. The resource guide summarizes best practices and the role of the disciplines in successful care delivery models, with emphasis on CCO Incentive Measures and key health cost drivers. It will also be shared with the CCOs, and made available to other health plans. The IMAG plans to have this completed in the summer of 2015.

Health care interpreters

In Year 2, and with the support of CMMI, OHA launched a learning collaborative to increase the number of health care interpreters across the state and released a request for proposal for training services. The Immigrant and Refugee Community Organization (IRCO) received the contract to provide training services. The first learning collaborative cohort of 35 interpreters began June 8th in Portland. As of July 22, a total of 49 interpreters have completed the training. Subsequent cohorts will be held throughout the state in Bend, Pendleton, Medford and Wilsonville. Going forward, OHA expects 150 health care interpreters to successfully complete the 64 hour training, thereby increasing access and improving the quality of services for people with language barriers to health care.

Traditional Health Workers

As a means of supporting the coordinated care model and whole-person care, Oregon is promoting the engagement and utilization of the traditional health workforce, which includes community health workers, peer support and peer wellness specialists, personal health navigators and doulas. These development activities are not funded by SIM but there are several accomplishments to report. In the last year, OHA established a Traditional Health Worker Commission to support and foster the use of the traditional health workforce; the commission has sub-groups working on scope of practice, systems integration and training evaluation/program scoring.

Training and certification of Traditional Health Workers

In Year 2, OHA reached and exceeded its Medicaid waiver goal of training and certifying 300 traditional health workers (THW). By March 2015, OHA had certified 354 THWs and approved 24 THW training programs.

In 2015, the training focus will shift to ensuring the incumbent workforce has access to an Incumbent Worker Assessment as a pathway to certification. A key partner organization, Multnomah County Community Capacitation Center, is in the process of developing an assessment tool for community health workers. The THW Commission will complete its 2014/15 work plan with the development of an Incumbent Worker assessment tool to be used for all THWs worker types seeking certification.

Diversity of the workforce

Our date indicates reveal that 100% of THW training program participants had at least an HS/GED and 54% of those individuals had some college level course work with additional data showing that 33 (26%) of participants have bachelor's degrees and above.

Systems integration

OHA continues to coordinate THW system level activities within OHA and the Community College Workforce Development Agency (CCWD) to support health care workforce development and employment. The THW Commission is working closely with Rogue Community College to develop and field their statewide THW needs assessment. The assessment will evaluate payment models, pay rates, utilization of THWs and employment trends. The assessment is to be completed along with a comprehensive report in the summer of 2015.

OHA Medical Assistance Program division is working to establish specialty categories for Peer Support Specialists to align with Medicaid/Addictions and Mental Health peer provider categories and develop billing codes for services rendered by THWs in order to support adoption of Traditional Health Workers services by providers.

House Bill 2024, introduced during the 2015 legislative session, will authorize THWs to play a lead role in, and receive reimbursement for, providing oral health assessments and preventative services to support oral health integration.

Traditional Health Worker Survey

In the fall of 2014, the Transformation Center initiated a formal assessment of CCOs to identify barriers to their use of traditional health workers (THWs). The use of THWs has been mostly through one-time grant funding or via direct hiring by some of the health plans, the CCOs or their predecessor, managed care plans, or through foundational support. These services have not been billable in the traditional Fee for Service claims system. The survey identified financial sustainability and access to trained THWs as top barriers to the use of THW services in CCOs. The next phase of the assessment will likely focus on identifying financial sustainability strategies CCOs could adopt to support their THW services, which will aid the sustainability of using these valued services to enhance coordination of care. For more information please see http://www.oregon.gov/oha/oei/pages/thw-commission.aspx.

Medicaid Primary Care Loan Repayment Program

As part of its 2012 Medicaid waiver, Oregon committed to providing $2 million annually in educational loan repayment to primary care providers willing to serve Medicaid clients (and others) in underserved areas of the state for the 2013–2015 biennium. Twenty-seven awards have been made to physicians, nurse practitioners, dentists and other providers who are serving Medicaid clients in underserved areas of the state. It is expected that all the awards from Oregon's $4 million commitment will be made no later than September 2015. The program accepts applications on an ongoing basis and will be targeting outreach to behavioral health providers in upcoming cycles. More information about the program is located at: http://www.ohsu.edu/xd/outreach/oregon-rural-health/providers/loan-repayment/ompclrp.cfm

Additionally, OHA worked to increase the scope of other programs to attract and retain providers in needed areas. A strong outreach campaign was conducted to increase the number of sites participating in the federal National Health Service Corps (NHSC) Program and to increase the number of individual providers benefitting. OHA worked to include CCOs, with CCO staff participating for the first time in site visits related to the National Health Services Corps. OHA staff also worked through professional associations, the state Office of Rural Health and the Primary Care Association. The results of these collaborative efforts will be seen in fall 2015.

Workforce Policy

The OHPB's Health Care Workforce Committee develops policy recommendations to support and augment Oregon's healthcare workforce. With a mix of healthcare industry and education members, the Committee provides a broad overview on both the current workforce and on developing the pipeline necessary to have the right workforce for the future. Although not funded by the SIM grant, the Committee's recommendations support Oregon's transformation efforts and have led to significant change.

The Health Care Workforce Committee efforts in Year 2 include work in the areas of primary care graduate medical education and primary care provider loan repayment; research into the emerging trends in the workforce; and monitoring of healthcare workforce licensing data. For more information, go to http://www.oregon.gov/oha/OHPR/HCW/pages/index.aspx.

Graduate Medical Education

In Year 2, based in part on the recommendations of the Healthcare Workforce Committee in a Policy Options Memo, the MODA Health Grant Committee provided a $506,000 planning grant to establish a Graduate Medical Education Primary Care Consortium. The Consortium's primary goal is to develop primary care residency programs in underserved areas of Oregon. Seventy percent of physicians completing both medical school and residency in the same state stay in the state to build a practice. Having residency programs in or near communities that need primary care physicians is an evidence-based strategy for recruiting physicians to those communities. Both of Oregon's medical schools, two health systems, OHA staff and representatives from Oregon's current primary care residency programs are participating on the Consortium planning committee. Several potential locations for residency programs have been identified and Consortium structure is under development. The Policy Options Memo and other information is located at: http://www.oregon.gov/oha/OHPR/HCW/pages/index.aspx

In addition, HB 3396, recently passed in the legislature requires the Oregon Health Policy Board to conduct a study of effectiveness of existing Oregon health care provider recruitment and retention incentives (e.g. loan repayment, tax credits, etc.) and to make recommendations about the feasibility of a broad range of other possible policy options including direct subsidies, a retirement plan for health care professionals, graduate medical education financing, and others. It also combines a range of existing incentive programs into a single fund, effective in 2018. The Legislature expects to use the OHPB's report, due in September 2016, to prioritize appropriations for the combined fund.

Provider Incentive Programs

At the request of the OHPB and the Healthcare Workforce Committee, the OHA analyzed the state's primary care provider incentives. This analysis, completed in Year 2, was used by a legislative task force and other policy makers to propose methods to streamline and maximize the effectiveness of the various incentives. More than twenty policy proposals were introduced during the 2015 Legislative session ranging from extending existing programs scheduled to sunset, to adding provider disciplines to existing programs and expanding the number and location of communities that can benefit from these programs. The analysis is located at: primary care provider incentives

Out of those twenty bills, House Bill 3396 passed and addressed many of the concerns about provider incentives. The bill established the Health Care Provider Incentive Fund, to be administered by the Oregon Health Authority. The bill streamlined provider incentives and collapsed several programs into one fund. Additionally, the bill extended the sunset on provider tax credits by four years.

As noted above, the bill also appropriated $180,000 to the OHA for a study of the effectiveness of the various provider incentives used in Oregon. The OHPB is charged with reporting back to the Legislature in September of 2016 the results of the study and recommendations on future provider incentive programs.

In Year 3, the Healthcare Workforce Committee will focus on the workforce needed to achieve true behavioral health and primary care integration. Deliverables will include an analysis of the available workforce data and recommendations on how to implement successful integration pilot projects statewide. Additionally, the Committee will investigate the training needed to produce this workforce and the barriers to entering the workforce and will develop recommendations for potential solutions

Healthcare workforce licensing data

In 2009, the Oregon State Legislature passed a law requiring seven health professional licensing boards to collect workforce data from their members during license renewals and submit data to the Oregon Health Authority. The seven boards represent 21 health professions. The Oregon boards required to report include:

- Dentistry
- Pharmacy
- Health Licensing Agency for the Oregon Board of Licensed Dieticians
- Medical Board
- Occupational Therapy Licensing
- Physical Therapist Licensing Board
- State Board of Nursing

Beginning in 2011, OHA began producing a biennial report based on health profession licensing data. The reports analyze provider demographics, supply, practice plans, employment characteristics and geographic distribution. In Year 2, the third biennial report was in production. With three data points now available, this report will include health profession trend data.

In addition, three Oregon boards voluntarily report data:

- Licensed Professional Counselors and Therapists
- Licensed Social Workers
- Psychologist Examiners

Also in Year 2, legislation was introduced to require almost all health profession licensing boards, including the three currently reporting voluntarily listed above, to collect and submit workforce data. This legislation passed and will expand the number of required boards from seven to seventeen.

<div align="center">

Overview

</div>

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

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

<div align="center">

Year 2 accomplishments

</div>

Science of improvement

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

In 2015, OHA contracted with IHI to offer Leading Quality Improvement: Essentials for Managers to CCO improvement portfolio managers. This course focused on improvement skills to achieve strategic goals. Each webinar included a case study such as measurement, modeling, innovation and engaging patients and families. Monthly webinars will continue and address topics such as team building, portfolio management, evaluation and measurement.

Transformation Center technical assistance and quality improvement

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

Patient-Centered Primary Care Institute technical assistance and quality improvement

The Patient-Centered Primary Care Institute (PCPCI) is the centralized "front door" for primary care provider-level quality improvement training and technical assistance. The institute works with various stakeholder community-based organizations to leverage existing expertise through the Expert Oversight Panel, a multitude of technical assistance subcontractors and the Technical Assistance Learning Network, all designed to bring together technical assistance experts, academic medical centers, independent physician associations and other learning networks to identify resources gaps and strategically deploy needed provider-level supports. In the second year of SIM, PCPCI offered fifteen webinars for 600 attendees, and a series of learning collaboratives for 24 practices representing over 280 providers and 115,000 patients, each facilitated by technical assistance partners from around the state. Webinar recordings and supporting materials are located at www.pcpci.org. Please see Section G for more information.

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

Quality improvement and care transformation in long-term care

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

Clinical evidence for better care

Oregon completed a detailed review of the processes used by the Health Evidence Review Commission to develop and disseminate clinical guidelines. Input from a wide variety of stakeholders was used to identify areas for potential improvements in an effort to better translate evidence as the coordinated care model spreads to support providers to improve care and lower costs. Process improvements already completed include:
- Redesigning the coverage guidance development process to include a more robust evidence search and earlier and more defined involvement of stakeholders (underway, projected completion August 2015).
- Conducting a yearly public nomination process on new topics from which HERC can select topics to develop coverage guidance on (completed January 2015).

- Reaching out to and learning from other organizations making coverage recommendations/decisions based on health technology assessments (site visit to Washington Health Technology Assessment Program conducted January 2015).

As part of the broader plans for transforming health care delivery in Oregon, the Center for Evidence-based Policy is designing a guide to assist CCOs in adopting, promoting and using shared decision making. To help inform the development of guide content the Center performed a needs assessment on behalf of CCOs and other payers. This needs assessment will be followed by a review of the evidence in support of shared decision making tools, as well the as best practices to encourage their use at the point of care. As part of the guide, the Center will also include an algorithm for selecting shared decision making tools and a resource kit for implementation.

Data infrastructure for quality improvement

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

- Oregon began regular publication of dashboard reports, both a statewide multi-payer performance report "Leading Indicators" with quality measures, utilization statistics and expenditure trends by major payer category, and a CCO performance dashboard, including quality measures and cost and utilization trends for Medicaid.

- The CCOs completed technology plans outlining how they will develop the ability to electronically report clinical quality data for three CCO incentive measures: depression screening, diabetes control and hypertension control. These technology plans are a first step towards ensuring that CCOs can leverage certified electronic health record technology to access individual-level electronic clinical quality measure data on their beneficiaries from providers.

- Oregon received Medicaid fee-for-service data to incorporate into the state's All-Payer All-Claims database as of spring 2015. Oregon will receive Medicare fee-for-service data annually moving forward.

- Current implementation of the EDIE in all of Oregon's hospitals and future plans will allow providers, health plans and CCOs, and regional health information exchanges to access this data as real-time notifications when their member or patient has a hospital or emergency department event.

- Statewide data on population health status and behaviors and on kindergarten readiness (collected under the auspices of the Early Learning Council and hubs) are being analyzed by CCO region to inform CCOs' efforts to bridge gaps between medical care, community health and education.

- The Public Health Division released a new version of the Oregon Public Health Assessment Tool with a redesigned, user-friendly interface and updated data.

Transformation Fund grants

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

Year 3

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

- Several new learning collaboratives developed in response to stakeholder requests and identified needs. Any new learning collaboratives will be designed to support continued CCO improvement as indicated by performance against established benchmarks or as identified as themes for improvement or focus in CCO transformation plans.

- Planning began for the Oregon Health System Innovation Café to promote peer-to-peer learning, information sharing and networking. The June 2015 event supported the spread of innovative health system models addressing complex care, behavioral health integration, traditional health workers, health information technology and telehealth.

- A Technical Assistance Bank developed by the Transformation Center, will continue to offer customized technical assistance on a broad range of topics that CCOs may access upon request (see Section G). Technical assistance offerings will be targeted to address CCO performance against established benchmarks or as indicated through CCO transformation plans.

- A new learning collaborative series will be hosted by the Patient-Centered Primary Care Institute for 24 primary care clinics, representing over 280 providers and 115,000 patients. The collaboratives will focus on patient evidence of care, improving access and patient-centered communication skills, behaviors and attitudes (see Section G).

- As noted above, the Health Evidence Review Commission will continue to implement process improvements based on the stakeholder input and review conducted in the first half of 2014. Improvements planned for completion in Year 3 include developing a

website where CCOs and their providers can search HERC guidelines and other Prioritized List-related information by keyword and a patient decision support resource kit, developed with the Center for Evidence-based Policy, to provide CCOs assistance with the translation and dissemination of HERC evidence-based products.

- The Patient-Centered Primary Care Home Program (see above) will begin a renewed cycle of site visits, offering practice facilitation and other technical assistance to help clinics advance along the spectrum of transformation.

CCO transformation plans

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

Population health

In Year 3, OHA will continue to integrate population health in its overall approach to spreading the coordinated care model. OHA's Public Health Division has revised the Oregon State Health Improvement Plan (SHIP) in order to meet the SIM Population Health Roadmap requirements. (Please see the SHIP document included in our continuation application). The Oregon's SHIP includes seven priority areas: tobacco, obesity, oral health, substance use, suicide, immunizations and communicable disease control. Each of the seven priority areas includes community strategies, health system strategies, and strategies that promote health equity by specifically targeting efforts to reduce disparities. The SHIP will be implemented through a shared governance structure with oversight for the plan provided by the Public Health Advisory Board. With the passage of SB 440, OHA will be leading an effort to modernize its public health system in light of health system transformation. The modernization of public health efforts would enhance the current membership and role of the Public Health Advisory Board so it acts as a governing body for Oregon's public health system and reports to the OHPB to ensure that population health is built into Oregon's ongoing health system transformation efforts.

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

<div align="center">Overview</div>

Creating a Sustainable Vision for Multi-Payer Delivery System and Payment Reform

Oregon has made a commitment to the Coordinated Care Model (CCM) and transformation of the health care delivery system as demonstrated by an intentional multi-year planning and implementation process that included extensive public discussion across and the state and active engagement by the Governor, the Legislature and the Oregon Health Authority. The State Innovation Model (SIM) grant has been an extremely valuable opportunity for Oregon to strengthen and support the CCM for Medicaid clients and spread the key elements of the model to other payers including PEBB, OEBB, Medicare-Medicaid beneficiaries and initial efforts with other stakeholders to spread further into the commercial marketplace.

Metrics are showing continued improvement in the delivery system performance in Medicaid. During this third test year, we will be doing further analysis of impact to PEBB and other parts of the delivery system. With 94% of the state's providers seeing Medicaid clients, we know that now going into our third demonstration year, providers are currently participating in the CCOs braided budgets and incentive pools. Approximately 2,200 primary care providers are practicing in a Patient-Centered Primary Care Home (PCPCH), caring for over 2 million Oregonians. All diagnosis related – group (DRG) hospitals are engaged in the hospital quality pool and efforts to support our smaller urban hospitals through the transition are progressing forward.

Ninety percent of our 1.1 million Oregonians in Medicaid are enrolled in the CCOs; 100% of 130,000 PEBB members are served with plans operating under contracts with the state that include key elements of the CCM and we anticipate 147,000 school district employees to be similarly served by 2017. All of this will continue and hopefully tip into the commercial marketplace even as the SIM investment concludes.

While the state has faced some challenges and transitions during the course of the SIM grant, there is a solid base of support and interest to carry the state forward in its efforts at the conclusion of the grant. Our new Governor, Kate Brown, has fully supported efforts to proceed and has directed the OHA to continue to implement reforms as developed under the Kitzhaber administration. The Legislature has just concluded its' most recent session resulting in legislation to further refine efforts in Medicaid, confirm and support additional spread to PEBB and OEBB, and directed the Oregon Health Policy Board to further align performance measurement and metrics. (See legislative summary in Section A for more details).

The OHA's new agency director, Lynne Saxton, describes it as "Health System Transformation 2.0 …will take all of us to continue to work together" to keep moving forward and refine and sustain the model. She has also begun extensive reorganization to align the internal OHA agency operations with the delivery system transformation to streamlined ongoing efforts. Stakeholders and advocates have worked closely with state staff and legislators to voice ongoing support of Oregon's health reform efforts to date.

The Oregon Health Policy Board will continue in its role to monitor and guide the strategic vision of health system transformation, advising the Governor, the Legislature and the OHA on any refinements or adjustments. As previously described in Section A, the Board has recently developed a strategic plan and updated their areas of focus which will provide continued support and improvement on key aspects of the coordinated care efforts. The Board is particularly focused on further integration of behavioral health and population health as the model matures, as well as ongoing assessment of overall performance of the CCM.

Since Oregon's strategy to achieve the Triple Aim through delivery system transformation was built upon existing state and local infrastructure with broad community support in its application, the state did not build a separate SIM governance structure. By using existing governance and leadership, the coordinated care model is firmly ingrained. As the State continues to move further into implementation, propelled by the initial SIM funding, the community partners and the state intend to sustain current efforts and adapt as the model continues to mature, grow and spread.

Oregon applied its SIM funding on top of an existing infrastructure and activities which led to the successful startup of our Transformation Center, increased capacity of our Office of Health Analytics, Office of Health Equity, Office of Health Information Technology and many other areas such as the state's PCPCH program to support reform efforts. The Authority's sister agency, Oregon's Department of Human Services, augmented their efforts to establish long term innovator agents with SIM funding and remains a partner in efforts with those eligible for both Medicaid and Medicare. The Division of Consumer and Business Services (DCBS) now houses Oregon's Marketplace, as CoverOregon was transitioned, alongside the Oregon Insurance Division. DCBS is working closely with the OHA and SIM efforts to consider next steps to spread to qualified health plans as the Marketplace is maturing. Oregon's state health agencies infrastructure was purposefully structured to implement and sustain the model.

Prior to SIM, Oregon built strong public and private support for the CCM through extensive stakeholder engagement for initial implementation for Oregon's Medicaid population. The model begins at the community level - with SIM activities strengthening community activities and efforts in each region. The CCOs were structured to have community participation in their governance, including county public health and behavioral health representation. Many of the new CCOs have worked across their communities with some remote frontier areas in Eastern Oregon spanning twelve counties. SIM investments have fueled expansion of efforts in communities statewide including public health grants, regional equity coalitions, and public-private partnerships to support primary care transition into the new primary care home model, and setting up housing with clinical and social services.

The OHA has increased efforts to monitor performance of our contracted partners, the CCOs and health plans, as well as using our data, especially our All Payer All Claims Database and performance metrics to monitor via dashboards and other performance measures to ensure transparency, compliance and ongoing quality improvement. The Transformation Center will continue to monitor efforts and strive to share and move best practices rapidly across delivery system networks. Future technical assistance will be targeted based on performance metrics and the in the key areas of behavioral health integration and population health.

In addition, the Legislature regularly requests and receives updates and progress assessments of CCM implementation, which will continue after the conclusion of SIM. Legislative engagement is critical for long term, sustainable transformation and is intrinsic given budget and quality impacts.

"Big Picture" Sustainability: Sustaining the Care Delivery and Payment Reform Model

Oregon has made a commitment to the CCM and transformation of the health care delivery system. This has been demonstrated by an intentional multi-year planning and implementation process that included extensive public discussion across and the state and active engagement by the Governor, the Legislature and the Oregon Health Authority as noted above. Health care transformation is "THE" direction the State is going, and that is supported broadly.

The State has supported the model and has strategically planned successful implementation even as the SIM grant was just starting. The Oregon Legislature appropriated $30 million dollars to fuel innovation and transformation among the sixteen coordinated care organizations in the previous legislative session of 2013, with some of those projects still ongoing as we move into the current budget cycle. These resources have contributed to synthesizing and spreading the CCM, supporting community-based health initiatives and health information technology investments across the state.

OHA has been planning for sustainability post-SIM funding in key areas of transformation. OHA submitted a policy option package (POP) to support continued funding of the Transformation Center as well as the Patient-Centered Primary Care Program and support for the Office of Health Analytics through the remainder of the 15-17 biennia, as the SIM grant concludes. That package was included in the recently approved state budget. Further work will help shape what will be needed as the state proceeds through this budget cycle and prepares for the 17-19 biennium in these areas and others. Year 3 of SIM allows time and resources to ensure a detailed and comprehensive analysis.

Oregon's 1115 Medicaid Waiver refinement work is underway for the rest of this five year demonstration but the state is also looking forward to the upcoming waiver renewal process. As we first initiated the model in Medicaid in 2012, we were able to secure some additional funding through our DSHRP aspect of the demonstration that was invested to support the startup of the CCOs. As we examine possible approaches to sustain key infrastructure elements long-term that have fueled the success of our model in Medicaid, we will need to have further discussions during our waiver renewal with CMS. Infrastructure like the Transformation Center's efforts or further investment in key areas such as behavioral health integration, especially in rural Oregon, are two areas under consideration that can improve the delivery of care to Oregon's vulnerable populations.

SIM funding has been critical to date and developing sustainable funding opportunities for future years, targeted to the needs we are identifying in our current evaluations and metrics, will move transformation of the delivery system even further. Work on sustainability of key infrastructure elements will be our aim as we look to the next demonstration period's focus.

Spread of the model into Oregon's payment and delivery system

It is now clear, given the data collected, that improvement continues in the delivery system as it serves the Medicaid population. With Oregon's Medicaid expansion under the Affordable Care Act, the model is touching one in four Oregonians through the CCOs. More analysis of impact to PEBB and other parts of the delivery system will provide further information on key CCM elements and inform efforts to spread the model. Oregon's providers are seeing Medicaid clients (94%) and approximately 2,200 primary care providers are practicing in a PCPCH, caring for over 2 million Oregonians. All diagnosis related – group (DRG) hospitals are engaged in the hospital quality pool and we are focusing efforts to support our smaller urban hospitals through the transition. A majority of our Medicaid CCOs or their health plan partners are also serving Medicare Advantage.

As we enter into Year 3 of SIM, ninety percent of our 1.1 million Oregonians in Medicaid are enrolled in the CCOs; 100% of our 130,000 PEBB members are served with plans operating under contracts with the state that incorporate the elements of the CCM. Over 50% of those eligible for both Medicare and Medicaid have chosen to participate in CCOs. As our eligibility and enrollment system improves, and as we adopt the Kentucky information system, that percentage will grow as it will overcome some of the current administrative barriers. We are steadily moving towards gaining 147,000 school district employees to be similarly served by 2017. All of this will continue and hopefully grow as SIM investment concludes and we sustain the model going forward.

As noted earlier, Oregon's SIM was built on existing infrastructure of both public and private efforts to date. Oregon will take the time during Year 3 to further examine the strengths and weaknesses of the model through our self-evaluation and metrics, community input, and ongoing activities. As the OHA continues its agency restructure to meet the needs of the model; as we refine and renew our 1115 Waiver; work with our new Governor and our Legislature on budget and oversight; and with our commercial payers and purchasers, Oregon's CCM will continue to evolve. Next steps to expand CCM spread to the re-stabilized Insurance Marketplace and its Qualified Health Plans can now be considered and incorporated as we move into "Health System Transformation 2.0", along with ongoing efforts toward closer engagement with Medicare. The Oregon Health Policy Board will be monitoring progress, along with the Executive and Legislative branches, to ensure the model is moving forward as it is critical to the strategic vision for health policy in Oregon and a sustainable, balanced state budget.

We are continuing to improve efforts to work within existing regulatory parameters such as behavioral health information sharing and the new managed care regulations and will continue to monitor those key levers controlled at the federal level that create barriers for fully coordinated care and innovation in the delivery system. We will also continue to examine and resolve any of our own state regulatory issues as we engage with our stakeholders and partners in order to ensure our collective ongoing success at implementing the CCM.

Population Health Efforts

Oregon's State Health Improvement Plan (SHIP) will be implemented through 2019. Implementation of the SHIP spans the entire Oregon Health Authority and is not only a result of SIM-funded efforts. The SHIP's health system strategies to reduce tobacco use and obesity, improve oral health, reduce suicide and substance use, improve immunization rates and protect the population from communicable diseases create a foundation for continued public health integration in health care. In addition, due to a legislatively mandated effort to modernize Oregon's public health system in light of health system transformation, there will be numerous opportunities for health care to identify opportunities for how governmental public health in Oregon can be better structured as a strong foundation to assist in achievement of the Triple Aim.

Hospitals, coordinated care organizations and health departments have been convening since 2012 on their common community health assessment and community health improvement plan requirements. Community health improvement plans serve as a roadmap for how population health interventions will support improved health outcomes for everyone in a given community.

At the state level, a similar approach has been taken with the SHIP. Implementation of the plan will involve ongoing work with CCOs, commercial insurers, employers, hospitals, clinics and providers so that to the extent possible, primary prevention of disease and disability is supported. Another concrete example is the use of population health metrics for CCOs and other payers (i.e., tobacco use prevalence), which will shift emphasis on clinical treatment to supporting policy interventions and leveraging Oregon's public health modernization efforts to bring public health into the fold of health system transformation.

Oregon's governmental public health system is 90% funded by federal grants which Oregon leverages to address statewide health priorities. At the local level, many CCOs are investing in population health initiatives. For example, Eastern Oregon CCO has committed to funding a regional public health coordinator position in perpetuity. This position is currently funded by the SIM Community Prevention grant. Trillium CCO invests $1.33 per member per month in prevention initiatives. Other CCOs are implementing unique methods to support public health infrastructure as they view public health as critical to their success. The Oregon Legislature has also dedicated funds to the Public Health Division through the Tobacco Master Settlement Agreement and for the modernization of public health effort. These funds will be used to convene public health, CCOs and other payers around the design and implementation of a public health system that is robust, efficient, outcomes-driven and helps each entity best meet their goals.

Oregon will utilize a process of continued measurement, reporting and evaluation of the SHIP to track the impact of public health integration with health system transformation. Oregon is required to report on the status of the SHIP and progress toward process and outcome measures annually to the Public Health Advisory Board. In addition, there may be more opportunities to look at the impact of public health integration should population health measures be selected as CCO incentive measures.

Sustaining SIM Investments beyond SIM

As noted above in this section, Oregon's health transformation activities will continue, beyond the SIM, through various strategies aimed at maintaining current achievements in cost reductions and continuing to seek additional opportunities to achieve the Triple Aim. We have started to identify the specific next steps as we look at each of the activities that SIM has funded. Many of the activities using SIM investment were vital for "start-up" or to expand existing capabilities and further funding may not be necessary. For example, the SIM investment in developing health care interpreter capacity has always been intended to be a "jumpstart" activity to create an initial pool of professional interpreters across the state and teach providers and health systems how to use this patient engagement strategy effectively. Other areas have an ongoing need to be sustained beyond the current state budget allocation. Oregon will use Year 3 to further examine in more detail all of the activities in the context of where the state agencies, or our partners in the community,, are heading and what will be necessary for continued incentivizing and monitoring of the spread of the CCM. Please, see our initial SIM Sustainability Plan, organized by Drivers, outlined in Appendix 15.

Section O	**Administrative Systems and Reporting**

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

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

A detailed SIM project management plan with milestones can be found in Appendix 16. Please also see Appendix 17 for a high-level visual timeline of Oregon's innovation and health care transformation plans and Appendix 18 for Oregon's vision of the evolution of coordinated care models.

Section Q	**Communications Management Plans**

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

Year 2 accomplishments

In the spring of 2015, OHA successfully posted and selected contractors to support transformation communications. Three contractors have been selected to provide research, analysis and recommendations on client communications, provider communications and employer communication strategies designed to spread the coordinated care model.

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

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

<div align="center">

Year 3

</div>

OHA will monitor the contractors selected to support communications through the next demonstration period and provide periodic updates on progress and products in the quarterly report. The results of the work on optimal messaging to augment current communication strategies will be invaluable to further spread of the coordinated care model efforts in Year 3 and beyond, after the conclusion of SIM support. Coupled with Oregon's increasing evidence for the performance success of the model so far, this communication work is another key component for a toolkit the state can use going forward that will enhance coordinated care alignment efforts. No other significant changes from the originally approved operational plan are expected for project strategies or timelines in this section.

Section R	Evaluation Plan

Oregon has worked closely during this year with CMMI and the national SIM consultants to develop and refine the Oregon SIM Self-Evaluation Plan, including accountability targets and our plans to incorporate the results of our rolling evaluation into our transformation work going forward.

Oregon's self-evaluation approach

Oregon has three primary evaluation objectives for its SIM evaluation. These are:

1. Assess the success of the overall CCM in Medicaid, where it was designed and launched, to inform further implementation:
   - Research question: Is the state achieving targeted per member per month (PMPM) cost trend reductions in Medicaid while at least maintaining, if not improving, quality and access?
2. Test the spread of the CCM to other payers and populations:
   - Research questions: What is the degree and pace of spread of CCM key elements (e.g., patient-centered primary care homes, care coordination and management, alternative payment methods, etc.) to non-Medicaid payers? Are other payers or populations experiencing cost trend reductions and improvements in quality?
3. Assess some of the model's key payment, delivery system and support elements individually to determine the extent to which these elements contribute to overall success:
   - Research questions: Which of the key elements, or which combination of key elements, are most strongly associated with success for Triple Aim outcomes? Is there any evidence regarding whether and how community setting, payer, or other contextual differences affect which model elements or combination of elements are most predictive of success?

These evaluation objectives and research questions were outlined in the state's original SIM application. In addition to addressing these questions, Oregon is actively monitoring the implementation, reach and impact of SIM-funded activity and the progress of broader transformation efforts. CMMI receives regular updates on these topics via quarterly reports and through the SIM core and Oregon self-evaluation metrics. Further monitoring efforts are described below.

Current status and Year 3 plans

Performance of the CCM in Medicaid
The CCM in Medicaid is spread through Oregon's CCOs which are local health entities that deliver and coordinate health care and coverage for Oregonians enrolled in Medicaid. Oregon has a robust program of CCO performance monitoring and public reporting. The state tracks 33 CCO & state performance metrics, including 16 CCO incentive measures which determine CCOs' eligibility for quality bonuses. These are reported biannually along with utilization data and per-member-per-month expenditures by category. The quality measures are also reported by race and ethnicity at the state level. The latest report, published in January 2015, contains data for July 2014-June 2014 and shows that CCOs are achieving strong results in key areas such as decreases in emergency department use, increases in primary care utilization, and reductions in avoidable hospitalizations. These reports can be found here: http://www.oregon.gov/oha/Metrics/Pages/index.aspx.

Twice-yearly CCO performance reporting will continue in Year 3 of the SIM grant. The 2014 Health Transformation Report mentioned earlier is viewable at: http://www.oregon.gov/oha/Metrics/Documents/2014%20Mid-Year%20Report%20-%20Jan%202015.pdf. The next two reports will be published in January and July of 2016. A second way in which Oregon is monitoring the success of the CCM in the Medicaid context is via an independent evaluation conducted at the midpoint of Oregon's 1115 waiver. With input from CMMI and SIM technical assistance staff, Oregon released an RFP in 2013 and awarded the contract for this work to Mathematica Policy Research, Inc. Mathematica's evaluation design included a qualitative assessment of the extent to which OHA and CCOs have supported and implemented transformation and a quantitative analysis of changes in quality since the implementation of CCOs. The report for this midpoint assessment covered the period of July 2012 through March 2014 and was recently submitted to CMS. Key findings (as of March 2014) include:

- Both CCOs and the state had made a great deal of progress in facilitating transformation of Medicaid care delivery and payment system;

- More work remained for OHA to re-align its administrative structure and to provide guidance on specific elements of reform (e.g. flexible services); more work remained for CCOs to move past the pilot testing stage for work on alternative payment methods, HIT/HIE and work to address diversity and disparities;

- There were a few promising trends in outcomes (largely primary care improvement and some narrowing of disparities) but, in general, more time is needed to track outcomes as the transformation of the delivery system matures.

These results point to the importance of providing appropriate supports under SIM for spread of the CCM—e.g. seed funding for HIE capacity, or multi-payer alignment work in primary care— and of having reasonable expectations for the timeline of system reforms.

Oregon will continue to engage independent contractors to evaluate the implementation and impact of the CCM in Medicaid (e.g. for a waiver summative evaluation due to CMS in 2018). However, this work will continue past the life of the SIM grant and no specific deliverables are anticipated during Year 3 of SIM.

Spread / Adoption of the CCM
To assess the degree and pace of adoption of the CCM's key elements to other payers and populations, Oregon has contracted with Oregon Health and Sciences University (OHSU) and Providence's Center for Outcomes Research and Education (CORE). The scope of work includes:

- Development of a typology of health system transformation that is applicable across different market segments and that can be used to track changes over time;

- Two or more periodic reports on the extent of CCM adoption in different markets, based on the typology described above; and

- A quantitative assessment of spread (or "spillover") using data from Oregon's all-payer, all-claims data system to assess whether changes in spending and utilization observed in the Medicaid context are spreading to the non-Medicare commercial population and Medicare FFS populations.

A first/baseline round of the typology was fielded in early 2015 to payers (health plans, as well as CCOs for comparison) and provider organizations (hospitals, IPAs, safety net clinics, and mental health providers). More than 100 organizations completed the survey and follow-up interviews were conducted with approximately 15 organizational respondents. Results will be available in August 2015. At least one more round of data collection is planned during the SIM period to assess whether adoption of the CCM principles in non-Medicaid markets is increasing over time. The related "spillover" analysis beginning in summer 2015 will use claims data to examine whether patterns of care in the Medicaid market are spreading to populations with other sources of coverage. Final results of that analysis are expected in late summer 2016.

In addition to contracted work, OHA is taking advantage of its All-Payer All-Claims (APAC) database to track the effects of ACA implementation and Oregon's health system reforms. The dataset enables Oregon to track utilization, expenditures, and claims-based quality measures by line of business over time. OHA recently re-designed the reporting format for these data and issued a "Leading Indicators for Health System Transformation" report, available at http://www.oregon.gov/oha/OHPR/RSCH/docs/All_Payer_all_Claims/Leading_Indicators_April

2015.pdf. Key findings for the period of 2011-2013 include a decrease in PMPM spending for Medicaid and PEBB but an increase in other markets; an increase in primary care visits in Medicaid; and a decline in inpatient admission rates across all payers. OHA intends to produce this report on a quarterly basis in the future, so further results will be available during SIM demonstration year 3.

Assessment of individual CCM elements

The question of whether some specific elements of the CCM drive transformation or performance improvements more than others is being addressed through a variety of evaluation efforts. In Mathematica's midpoint waiver evaluation, for example, researchers made a start by testing whether CCOs' overall level of transformation activity—as measured by a CCO Transformation Assessment Tool (CTAT) that Mathematica designed—was associated with improved performance on quality measures. While there were a few positive associations (as describe above), the results were not consistent and Mathematica concluded that March 2014 was likely too early to expect to see stable results. And, while the CTAT did produce sub-scores for different elements of transformation (e.g. integration of behavioral, physical, and oral health services), researchers felt that the options for model covariates were not robust enough to justify testing for an association between those sub-elements and particular quality and outcome measures (e.g. follow-up after hospitalization for mental illness).

In the spread evaluation work conducted by OHSU and CORE (see above), the results of the spread typology/survey will inform the quantitative analysis. For example, if the typology survey reveals that use of PCPCHs is spreading rapidly, researchers will explore the claims data for plausibly related changes in utilization and outcomes (e.g. primary care sensitive hospital admissions) than others. As noted above, the quantitative spread analysis results will be available in late summer 2016.

OHA is doing its own investigations of what is driving transformation by: following up with CCOs who are performing particularly well on specific incentive measures (such as developmental screening or Emergency Department use); reviewing CCOs' Transformation Plans and Progress Reports; and by learning along with CCOs and providers through convening learning collaboratives on topics like complex care and health equity. These activities will continue through Year 3 of SIM.

Additional monitoring and reporting

CMMI and Oregon have worked closely on identifying and defining measures for quarterly SIM reporting. Those details are documented in Salesforce and in accompanying metrics spreadsheets and so are not described here. Instead, this section provides information on additional monitoring of SIM activity and health system transformation in Oregon.

Several specific initiatives that are part of Oregon's SIM grant include focused evaluation activities:

- The congregate housing pilot project, which provides care coordination and health support services to residents of 11 affordable housing buildings, is being evaluated by Portland State University. A Year 1 evaluation report produced in October 2014 focused on a process evaluation of the consortium through which this project is being implemented and a baseline survey of health status and health service utilization among residents at the 11 partner buildings. Key findings regarding consortium development include the importance of providing enough lead time for board approval, addressing information sharing and privacy concerns, and requiring only modest financial investments in order to allow community-based social service organizations to participate in the consortium. The resident survey revealed that residents of the participating buildings are low-income seniors and people with disabilities who have significant rates of chronic disease, mental health conditions, and health risks (e.g. low medication adherence). Future evaluation plans include follow-up surveys of residents' experiences and satisfaction with the services; tracking of health service utilization; and a cost analysis of services delivered through the consortium.

- The Transformation Center has engaged researchers from Oregon Health & Science University to conduct formative evaluation of the Center and its operations. The team continues to analyze the data in real-time and debrief with the Transformation Center routinely to share emerging findings. As one example, researchers interviewed a handful of CCO Community Advisory Council (CAC) members. These interviews generated several suggestions for ways in which the Transformation Center could better support the CACs to advise their CCOs on how to meet their communities' health needs and move upstream to improve population health. The Transformation Center is assisting CACs with membership recruitment, orientation, and education and is providing more opportunities for networking between members of different CACs at Center events. The formative evaluation will continue to inform Transformation Center direction through July 2016.

- SIM is also funding Regional Health Equity Coalitions (RHECs), which are community groups working across CCOs, local health departments, community agencies, and other systems to increase health equity, reduce health disparities, and address the social determinants of health. An evaluation of this project is focusing on three primary questions:

  1) How effectively have the RHECs engaged their communities, specifically communities of color and other priority populations?
  2) How have the RHECs increased local capacity and leadership for addressing health disparities and equity?
  3) How have the RHECs increased coordination across health and other social support entities to collaborate on cross-cutting community wide issues?

Through a collaborative process, OHA and the RHECs have identified eight indicators to monitor progress in these areas. The first round of site visits to collect data specific to the evaluation outcomes and indicators will begin in summer of 2015. Each RHEC will produce an "Evaluation Summary" document for their region, describing their organization structure and highlighting key outcomes in their region. Evaluation activities will continue through Year 3 of SIM, with several, issue-specific evaluation briefs planned in lieu of a single, large evaluation report.

- As part of Oregon's efforts to include a population health focus in health system transformation, the state has used SIM funding to support four unique community prevention programs. These are collaborative efforts between CCOs and local public health departments, collectively supporting six of 16 CCOs and 20 of 34 local public health authorities. The collaborations have identified outcome metrics relevant to the priority health issue they identified for action (e.g. opioid deaths and opioid overdose reversals, or developmental screening rates among children under 3 years) and are reporting on those regularly.

Additional general monitoring and evaluation efforts include:

- Participant feedback on the Transformation Center's learning collaboratives, which are integral to identifying and spreading best practices throughout the state. Event attendees are asked a standard set of questions, which allows the Transformation Center to track satisfaction from session to session and across learning collaborative.

- Analysis of key CCO documents such as Transformation Plans and updates, Community Health Improvement Plans, and periodic grant reports to assess progress on health system transformation. OHA had been conducting this review and analysis internally but recently contracted with an external entity to do a comprehensive coding and content analysis of available documents. OHA will receive both the qualitatively coded data (in a database format that can be added to as more CCO documents are submitted over time) and a report about the variety, scope, and success of CCO transformation activities. This work is intended to be complete at the end of SIM Year 2.

- The CCO performance monitoring and quarterly "Leading Indicators for Health System Transformation" report and described under #1 and #2 above are also examples of Oregon's monitoring efforts.

Roles and Accountability

The Oregon Health Authority's Office of Health Analytics and Office for Oregon Health Policy & Research (OHPR) collaborate to plan and perform self-evaluation functions for the SIM grant. OHPR's Director of Health Policy Development is the agency lead accountable for SIM self-evaluation, although this may shift during SIM year 3 as a result of staff changes and OHA functional re-organization. Close alignment between policy and analytical staff will be preserved and OHA will inform CMMI of any such changes.

OHPR and Health Analytics staff ensures that contracts with external researchers adhere to agreed timelines and are within the agreed scopes of work, and that contracted researchers can access the administrative data they need to complete their analyses. These staff members consult regularly with the SIM Principal Investigator, who has been the administrator for the state's Office of Health Policy and Research and had extensive experience in health policy and services research, the Authority's Director of Health Policy and Analytics who oversees both policy and analytics and reports directly with the agency director, and the Director of Health Analytics, who oversees the performance monitoring and many of the data collection activities that feed into the SIM self-evaluation, and has many years of experience working with Oregon's Aligning Forces for Quality entity, the Oregon Quality Corporation, on performance metrics across Oregon's primary care providers. The SIM area leads are also consulted and updated on evaluation activities on a regular basis.

Strategy for Working with the Federal Evaluation Contractors
OHA is participating in the national evaluation by providing data as needed, and assisting in the coordination of focus groups, interviews, and site visits. We participate in monthly evaluation calls with CMMI and RTI and their subcontractors. We are communicating and coordinating as much as possible on both the provider and consumer surveys planned as part of the national evaluation.

How self-measurement is used for program improvement

Oregon has a number of avenues for discussing and addressing any issues highlighted by SIM monitoring and evaluation activities. Deviations from expected progress are highlighted and discussed in the following venues:

- *Monthly SIM operations team meetings* – Comprised of representatives from throughout the agency and partners representing Long Term Services and Supports from Oregon's Department of Human Services.

- *Health System Transformation Evaluation Advisory Committee* – Comprised of OHA leadership, policy, and research staff. The Committee discusses findings from evaluations of SIM and other health system transformation activities in the state, and meets on a quarterly basis. This group serves a synthesis function, ensuring that findings from specific evaluation efforts are not considered in isolation, but in relation to one another in terms of what they tell us about the success of health system transformation in Oregon overall.

- *Quality Council* – OHA has established a group comprised of senior clinical leadership and improvement personnel from across divisions to coordinate and lead the quality improvement efforts of the agency, and to assist the spread of best practices throughout the healthcare delivery system of the state. The intent of the Quality Council is to create better integration and alignment of clinical, quality improvement and compliance activities amidst the programs across the agency.

- *Oregon Health Policy Board* – regular updates provided by the Office of Analytics team and information used in broader implementation planning and monitoring

OHA's Transformation Center is the hub for transformation activities, and is represented on all three teams above. As areas of concern are triaged, and the Transformation Center is available to work with individual programs as needed to facilitate change activities and ensure SIM goals are achieved.

Furthermore, there is regular consultation with program managers and decision-makers across the agency to ensure that findings from these various evaluations are not only disseminated, but understood in the appropriate context. It is important that the findings from the external as well as internal self-evaluation activities are not viewed in isolation, but are considered in relation to one another, and in terms of what they tell us about the success of health system transformation in Oregon overall. To facilitate this, OHA began publishing quarterly evaluation update newsletters that synthesize findings from the various evaluation activities described above.

Section S	Fraud and Abuse Prevention, Detection and Correction

As outlined in our 2013 Operational Plan, we have incorporated protections and built in requirements to avoid potential fraud and abuse in our coordinated care model. We have these elements in place with our Medicaid CCOs and now these requirements have been included in the contracts that provide health insurance to state employees and will be included in the contracts supporting Oregon educators.

SIM funding is integral to the success of health system transformation in Oregon and state processes and procedures have and will continue to ensure that grant expenditures are regularly monitored and tracked to ensure appropriate use.

Year 3

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

Section T	Risk Mitigation Strategy

Oregon has updated the SIM risk mitigation plan submitted in 2014 to reflect OEBB's new RFP timeline of the 2017-2018 plan year. As mentioned earlier there are currently 900 different employee groups in OEBB, including an estimated 500 collective bargaining units, some of whom are represented by the Oregon Education Association and Oregon School Employees Association, representing 45,000 educators / 20,000 education employees. OEBB represents 247 employers, including school districts, educational service districts and community colleges. The Board has had significant turnover, with three new members, and two vacancies to be filled during the fall interim legislative session. The complexity and composition of this group, along with multiple board member transitions and vacancies, has led the Board to postpone its RFP for

one year (2017-2018 plan year). A revised timeline is currently being developed and will likely be released at the next Board meeting in October.

The Board wants to ensure the procurement will result in OEBB being able to offer plans that meet OEBB members' needs and promote and support better care, better health and lower costs for OEBB members and Oregonians overall. Executive, legislative and stakeholder commitment remain strong for the CCM.

Additional adjustments to the risk mitigation plans include updating timelines and activities, including legislative work that strengthens the spread of the model, such as SB 231 and its directive to primary care alternative payment and infrastructure investment reporting and a multi-payer learning collaborative. Please see:
https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/SB231/Enrolled

Please see Appendix 19 for the revised Risk Mitigation Plan.