Oregon's State Innovation Model Project
Progress Report
October 1, 2013–December 31, 2013

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Overview

State Innovation Model (SIM) funding moved transformation efforts forward during this first quarter of the demonstration period. The funding allowed Oregon to accelerate health system transformation, fueling the spread of the coordinated care model from the Medicaid population to other payers and populations more quickly and effectively. During this first quarter of the demonstration period, Oregon achieved all the key goals and objectives as outlined in our operations plan. We produced some notable accomplishments in this period and have built a foundation for exciting work going forward.

Some accomplishments from the first quarter that were possible thanks to this funding include:

- The release of the Public Employees' Benefit Board (PEBB) request for proposals for health insurance reflecting elements of the coordinated care model for the 2015 benefit year. OHA received 11 proposals in response to the RFP. Proposal evaluation is underway with final selection completed in early 2014. The board is hoping to see innovative models of care reflecting elements of the coordinated care model, as implemented in Oregon's Medicaid coordinated care organizations (CCOs).
- A multi-payer consensus was finalized among almost all of Oregon's major public and private payers with a signed agreement to support alternative payment strategies for patient-centered primary care homes across the state. Engagement of the technical work necessary to apply the recommendations is underway.
- Oregon's Quarterly Health System Transformation report was published in November. The report highlights key metrics, indicating performance of Oregon's CCOs as the coordinated care model is implemented in the Medicaid population. Preliminary data indicated a decline in hospital and emergency department visits and costs. Additionally, the report indicated an increase in primary care visits. These promising results signal that the state is on the right track with the model. Oregon's transformation progress reports are online at www.Oregon.gov/OHA/metrics.
- OHA's Transformation Center and the Northwest Health Foundation sponsored a one-day summit, bringing together all of the CCOs and representatives from the CCOs' Community Advisory Councils to share accomplishments, innovations and lessons learned from the first year of the model. A total of more than 600 participants attended the morning and afternoon sessions. The summit was a ringing success, with stakeholders clamoring for more opportunities to learn from each other and share best practices. The summit information is viewable at http://transformationcenter.org/#cco-summit.

In addition to these accomplishments, SIM funding is accelerating health system transformation across Oregon by spreading best practices among CCOs and other health plans. Specifically, SIM dollars supported the following key activities this period:

Creating Learning Communities

- During this period, at the request of CCO medical directors and other clinician partners, the Transformation Center launched a statewide learning collaborative to support innovation in the care of complex patients. More than a hundred providers participated in

the initial meeting with ongoing sharing of best practices planned for 2014. Please see the *Transformation Center* section of this report for more details.

- The Transformation Center initiated a learning collaborative to build the organizational capacity of the Community Advisory Councils (CACs) that each CCO works with. Initial focus is assistance for the community needs assessments and community health improvement plans that are required by statute and are due to be submitted in June 2014.
- The Transformation Center started planning for a learning collaborative for the CCOs in partnership with the Institute for Healthcare Improvement. The collaborative will focus on principles and tools of science of improvement, and CCOs will use those tools to support implementation of their new Oregon Legislature-funded transformation projects to fuel innovation. This learning opportunity is planned for spring 2014.
- Planning for a learning collaborative to expand Oregon's health care interpreting capacity is underway with discussion between the SIM project officer and state SIM leadership to finalize our approach.

Tools and Resources to Support Innovation

- SIM resources support a robust analytical capacity that improves our ability to provide timely, accurate, actionable data to CCOs. For example, Oregon has acquired and implemented the Milliman Grouper software to provide additional in-depth analysis of data sets.
- Working with the Centers for Medicare & Medicaid Services to acquire Oregon's Medicare data set to be included in our All Payers/All Claims database.so we can have a full picture of the health care delivery system in Oregon and assist our evaluation of the coordinated care model and its impacts.
- Oregon's Patient-Centered Primary Care Institute (PCPCI) conducted two well-attended, week-long trainings focused on integrating behavioral health in primary care clinics. The institute also held two live webinars focused on care transitions and measuring patient experience of care, and developed a strategic plan and scope of work for its technical assistance activities for the coming year.

Integrating Systems and Developing Partnerships:

- Patient engagement is a key aspect of transformation and some new efforts are being incorporated into the Transformation Center's work plan with stakeholders. Initial focus is on the Medicaid population, based on the recommendations presented to the Legislature on best approaches for patient engagement from the recently concluded Individual Responsibility and Health Engagement task force. For example, the task force recommended development of a resource guide for adoption, implementation and measurement of evidence-based member engagement strategies that target the use of appropriate and high value health services, prevention, self-management and individual empowerment; another recommendation is to promote the use of the Choosing Wisely campaign as a shared decision-making tool to facilitate engagement among consumers, providers and CCOs. The report is available at: http://library.state.or.us/repository/2013/201312301434381/.

- The Oregon Health Authority launched a SIM-supported funding opportunity for collaborative partnerships between CCOs and local public health authorities to tackle population health and clinical care challenges. Four grants have been made that integrate public health and clinical system approaches in the areas of: maternal child health; tobacco reduction; obesity prevention; and alternative opiate management strategies.
- Due to SIM support, three additional Regional Health Equity Coalitions have been established. These coalitions will expand a successful model instituted in other parts of the state to build regional cross-jurisdictional capacity to advance health equity practices for communities experiencing health inequities within health system transformation. The three new coalitions will serve Hood River, Jackson and Klamath counties, where, according to ACS 5-year estimates (2008– 2012), people of color make up approximately 18.3 percent of the total population, but may be disproportionately represented in the Medicaid population at 25 percent.
- With leadership from the state's Early Learning Council, early learning hubs are being developed across the state to pull together resources focused on children and families in defined service areas. With support from the Transformation Center, the Child Health director and Early Learning Division staff are working toward implementation of cross-sector learning collaboratives once the hubs are in place. The first year of Oregon's unified Kindergarten Assessment is complete and data will continue to drive shared work across the Early Learning Council and the Oregon Health Policy Board.

Oregon's SIM Context: The Coordinated Care Model

Coordinated Care Model Implementation and Spread

Oregon Health Policy Board's (OHPB) newest recommendations completed

Now with one year of operation of coordinated care organizations in Medicaid, Governor John Kitzhaber directed the Oregon Health Policy Board, the body setting Oregon's health policy, to identify possible statutory and regulatory changes necessary to ensure that the state capitalizes on the opportunity to extend the coordinated care model into the commercial marketplace. The OHPB was asked to identify recommendations for the Legislature and the Governor by the end of 2013, including, but not limited to:

- Strategies to mitigate cost shifting, decrease health insurance premiums, and increase transparency and accountability;
- Opportunities to enhance the Oregon Insurance Division's rate review process;
- Alignment of care model attributes within Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB) contracts; and
- Alignment of care model attributes within Cover Oregon's qualified health plans.

This work explicitly supports Oregon's SIM goals of spreading the coordinated care model and accelerating health system transformation.

OHPB completed its charge in this quarter, delivering its recommendations in December 2013. Three principal strategies were identified to meet the Governor's charge, and the board endorsed recommendations made by a Coordinated Care Model Alignment Workgroup and the Oregon Insurance Division (OID). Those strategies and recommendations are:

1. To create system-wide transparency and accountability through a robust measurement framework, including a public-facing health system dashboard, to track the effect of the Affordable Care Act implementation and Oregon's health system reforms;
2. To measure the total cost of care and move the health care marketplace toward a fixed and sustainable rate of growth;
3. To improve quality and contain costs by expanding an innovative and outcome-focused primary, preventive and chronic care infrastructure;
4. To spread the foundation of Oregon's health system transformation, the coordinated care model, to the broader market by aligning coordinated model principles across payers and implementing organization alignment around those principles; and
5. To implement administrative simplification and improve consumer outreach strategies in OID's rate review process.

This work sets the stage for spreading the coordinated care model beyond Medicaid as Oregon enters its first SIM demonstration year. Efforts to spread the coordinated care model are actively underway in Oregon. The PEBB RFP for the 2015 benefit year was released during this quarter, with multiple bids received from a variety of bidders for both statewide and regional plan options. The RFP included the need to respond to how PEBB could address key elements of the coordinated care model that will further the triple aim of better health, better care and reduced costs. Review is still underway, with selection to be completed in spring 2014.

Under the SIM grant, OHA and its partners will focus on particular goals to spread the model, such as establishing PEBB contracts that incorporate the coordinated care model and increasing adoption of patient-centered primary care homes statewide. Ongoing work under the auspices of the Oregon Health Policy Board supports SIM spread activities by engaging partners across market segments to set clear expectations and share responsibility and accountability for outcomes. The final recommendations of the policy board to the Governor are included as Appendix A to this report and are also are available online.

Specific Accomplishments This Quarter

Accelerating Innovation

Transformation Center

In this period, the Transformation Center worked to assist the implementation and spread of the coordinated care model. SIM investments have provided necessary resources to establish a robust center that supports coordinated care organizations, Community Advisory Councils and clinical innovation efforts across the state. The center convenes internal and external partners toward fostering clear communications and reducing or eliminating barriers and administrative burden. Supporting the success of CCOs is critical to spreading the coordinated care model. An estimated 80 percent of Oregon's health care providers see Medicaid enrollees, and more than 92 percent of all Medicaid clients are enrolled in CCOs. The success of CCOs with their provider networks will set the stage for the changes needed across the health care delivery system. The Transformation Center undertook an ambitious agenda between October and December 2013 and achieved great success. Details on the center's activities this quarter are outlined below:

Transformation in Action summit

During this reporting period, the Transformation Center, in partnership with the Northwest Health Foundation, planned and sponsored Transformation in Action, a one-day coordinated care organization summit held on Dec. 5. For the first time, CCOs and members of their Community Advisory Councils came together to hear about innovation and lessons learned from the first year of CCO operations. Governor Kitzhaber provided opening remarks and participated in a panel discussion with the leaders from all 16 CCOs. Acting OHA Director Tina Edlund highlighted the findings of Oregon's Health Systems Transformation Quarterly Progress Report published in November. Dr. Adewale Troutman gave the keynote address, Health Equity: From Theory to Practice. Sessions that featured compelling opportunities for CCOs to learn from each other included:

- Applying alternative payment models to manage costs and promote high quality care;
- Promising telehealth approaches to support health care in our community;
- Achieving local coordination: health and early learning systems;
- Integrating primary and behavioral health care initiatives;
- Bridging the gap: improving care transitions from hospital to community care;
- Integrating population health within a health care delivery system to achieve the triple aim;
- A taste of CHIPS: the development of community health improvement plans in multiple CCOs;
- Health literacy training: achieving CCO objectives through advanced patient-centered communication; and
- The patient-centered primary care home: building a community primary care infrastructure.

The summit's open plenary session was recorded to enhance statewide viewing opportunities. The video of the opening plenary session is online at www.youtube.com/watch?v=DVFsd9Kl4EA.

Building on the momentum of the summit, the Transformation Center is developing a "Transformation Bank" to collect and disseminate the innovations developed by CCOs or others into a searchable database accessible to CCOs, partners and other interested parties. The bank initially will include innovations that CCOs, providers and other delivery system partners have attempted — successfully or not — as a means of sharing lessons learned and strategies for success and growth with contributions from other sources over time.

Initially, ideas will be organized around CCO transformation plan areas: integration of behavioral, physical and oral health care; increased recognition of PCPCH clinical settings; implementation of alternative payment methodologies that align payments with outcomes; producing community-led health assessments and community health improvement plans; increasing adoption of electronic health records, health information exchanges and their meaningful use; facilitation of outreach and member engagement; providing health services tailored to the cultural, health literacy and linguistic needs of consumers; and meeting the culturally diverse needs of communities and reducing health disparities.

These areas are of vital concern across the entire delivery system and will set the groundwork for further engagement as PEBB completes its RFP selection process. The PEBB board will fold in the work across those selected vendor plans, which may include some of the CCOs, as Oregon goes forward with the spread the coordinated care model. This work is now underway and it is anticipated the bank will be part of the Transformation Center website in the first quarter of 2014.

Transformation fund grants
The center has coordinated efforts to distribute new, non-competitive transformation funds to the CCOs provided by the Oregon Legislature in July 2013. The $30 million in state General Fund money is intended to support CCO-proposed projects that are innovative, scalable, transferable and related to CCO transformation plans. The funding is spread across projects related to:

- Development of health information exchange and associated technology (leveraged with Designated State Health Program matched resources) to achieve HIT/HIE Phase 1.5 strategic goals;
- Population health, case and disease management and achieving quality metrics;
- Provider panel and clinic enhancements to provide extended primary care services to high-risk Oregon Health Plan members; and
- Projects designed to improve patient engagement and patient accountability.

Examples that reflect innovation within, and spread of, the coordinated care model include:

- Building on AllCare Health Plan's innovative payment model for patient-centered primary care homes, they will adapt that model to achieve similar financial and clinical integration among their partners. Innovative payment methodologies and delivery models will support integrating physical, mental and dental health and addiction recovery into nonhospital-based systems and into lower-cost, preventive settings.
- Columbia Pacific is developing and delivering wraparound services that engage partners, such as a community-wide Resilience Trumps ACES training that addresses the adverse effects that prolonged childhood trauma can have on brain development, and which offers hopeful behavioral health interventions for community members.
- Expansion of patient-centered primary care projects across multiple CCOs that will help fuel spread of the coordinated care model beyond CCOs.

Summaries of the transformation fund projects are available at http://transformationcenter.org/transformation-funds/.

SIM resources will support a learning collaborative beginning in spring 2014 to promote the application of the science of improvement tools and resources. This will assist CCOs in their implementation of these transformation projects through our collaboration with the Institute for Healthcare Improvement.

Overcoming institutional barriers
The Transformation Center continues to focus on improving OHA internal processes and opportunities for innovation, as well as supporting and providing technical assistance to the CCOs and their health care delivery systems. The innovator agents have developed a learning

community to share best practices and coordinate communications and operational solutions with OHA's Division of Medical Assistance Programs; Addictions and Mental Health Division; and the Public Health Division. An "Issue Tracker" has been developed and is in beta testing. This is a secure, online database that tracks issues identified by CCOs and the steps taken toward resolution. Data are shared with innovator agents, CCO account representatives and quality assurance coordinators. This will be valuable not only for improvement of our own agency internal operations, but also future learning for other states' agencies to overcome institutional barriers that slow innovation and transformation of the delivery system.

Learning collaboratives

As part of the rapid cycle learning supported by the SIM grant, the Transformation Center continues to offer a learning collaborative to support the Community Advisory Councils (CAC). Each CCO is required to have an advisory council composed of 51 percent of CCO consumers. The CAC collaborative is designed to support leadership and organizational development needs so that councils are best-positioned to meet their statutory obligation to deliver a community health assessment and community health improvement plan for each CCO by June 2014, and actively participate in efforts to spread the coordinated care model in their communities. The Transformation Center facilitated bringing CAC members from across the state to the recent CCO summit, Transformation in Action, thanks to funding support from Oregon's local Northwest Health Foundation, to share in lessons learned and discussions among CCOs , Oregon's Governor, Oregon Health Authority leadership, innovator agents, and other stakeholders. The Transformation Center is planning a CAC summit in May 2014 to bring together CAC members as they finalize the community health assessment and community health improvement plans for submission in June 2014.

The learning collaborative for medical directors and quality improvement coordinators continues meeting monthly with participants reporting it as a high value experience and requesting additional time for more in-depth sharing. Early 2014 sessions focus on prioritizing performance measure subjects and sequencing for ongoing work.

Please see the *Clinical Innovation* section below for details on the complex care learning collaborative that was initiated in this reporting period.

Patient engagement

As the Transformation Center works with CCOs and their delivery system providers, issues about how best to engage patients and their families is a common topic that is especially challenging within low-income and vulnerable Medicaid populations. The Transformation Center's director of Systems Innovation staffed a legislatively-appointed Individual Responsibility and Health Engagement Task Force (HB 2859, 2013). The task force made recommendations to the Oregon Legislature for establishing mechanisms to meaningfully engage Oregon Health Plan (OHP) members in their own health, disease prevention and wellness activities. An executive summary of the recommendations is included as Appendix B and is viewable at www.oregon.gov/oha/OHPR/irheDocs/HB%202859%20Task%20Force%20Report%20to%20Legislature.pdf. The Transformation Center will help implement many of the final recommendations.

Clinical innovation
More than 100 people attended the initial gathering of both public and private medical directors to share best practices on complex patient care in November. A key clinical leader, David Labby, M.D., Ph.D., chief medical officer for Health Share, a Portland-area CCO, assisted with planning this initial gathering of providers. He also acts as principal investigator on a CMMI Community Innovation "Health Commons" grant (via Providence Health & Services). Dr. Labby presented an overview of the Health Commons project that will integrate care delivery for Medicaid and dually-eligible Medicare/Medicaid beneficiaries through cooperation among traditional health care competitors in the tri-county/Portland metropolitan area.

Providers participated in additional sessions that included: patient identification strategies; expanded care clinics; and community-based workforce projects. Also, 12 participants submitted posters that illustrated successes and lessons learned based on their work with complex patients. Materials from this kick-off event, including the poster sessions, are viewable at http://transformationcenter.org/complexcare/. In response to positive feedback and requests to continue to convene this group, the Transformation Center has developed a learning collaborative to further share on-the-ground best practices for providing complex care that will include a variety of providers, including community health workers, and care coordinators from many of the CCO networks and some of the partnering health plans. For example, in February the Transformation Center will present a webinar on "trauma-informed care" to all complex care meeting participants and invite the 67 primary care practices that are participating in Oregon's Comprehensive Primary Care Initiative. Future complex care meetings will include practices, projects and participants doing this work outside of the CCO environment.

The director of Clinical Innovation and the OHA chief medical officer have been planning the structure and the recruiting of the Council of Clinical Innovators. This SIM-supported project will recruit a cadre of 10 to 12 providers who will serve as champions of change and support implementation of the coordinated care model through provider-to-provider conversations. The "Transformation Academy" will provide extensive sharing of best practices and leadership skills to the clinical innovators who will carry these tools back to their local communities to foster the spread and adoption of coordinated care model principles across many practice areas. The Transformation Center engaged Dan Reece, a network of care manager for PeaceHealth, as a consultant to develop the business plan for this project, which has been completed. The next step in launching the council is to develop an advisory committee. Recruitment for the advisory committee is underway. Further input from CCOs, health plans, and health system leaders will be sought with the recruitment of champions of clinical change expected to be conducted in May and June 2014.

Developing partnerships
The Transformation Center's executive director and director of Systems Innovation have had discussions with a variety of organizations including: Oregon Health & Science University; Oregon Health Care Quality Corporation (QCorp) and its Patient-Centered Primary Care Institute; a number of social service organizations focused on areas such as housing, early childhood, and economic stability; and health and consumer advocates. These conversations will

enable the Transformation Center to link CCOs with organizations that can help them achieve their innovation goals. It also will forge additional linkages for spreading innovation.

In addition, the Transformation Center has acted as a conduit between the Federal Reserve Bank of San Francisco and CCOs to support local conversations on how to promote health care in their communities and seek ways to leverage resources to improve population health. Working with community development experts is a potential avenue to fully integrate population health and health care delivery systems.

Communications
Supported by SIM investments, the Transformation Center website aggregates information in a central, easy-to-navigate website, which includes OHA resources; contacts; links to funding and grant opportunities; learning collaborative schedules and resources; metrics resources, and more. The website has been refreshed to support its growth as a one-stop platform for relevant, actionable information related to health transformation. The website will continue to evolve in support of CCOs and other partners to achieve success through the coordinated care model, and to support the spread of the model beyond Medicaid. The website is viewable at http://transformationcenter.org/. The website also aims to further information about the value of the coordinated care model to other payers, and to the Oregonians the model serves. Stories about Oregonians being served by the coordinated care model can be found at www.oregonhealthstories.com.

Delivery Innovation

With SIM support, Oregon has several initiatives underway to improve health care delivery systems to achieve the improved care component of the triple aim. The Patient-Centered Primary Care Home Program continues to grow, encompassing more practices and shaping new care models experienced by consumers. Planning for robust health information technology and exchange made significant progress in this period. Oregon continues to lead in the area of adopting and promoting evidence-based best practices for clinicians. Health equity is a key component in health transformation, with three major strategies to improve care, access and outcomes for historically underserved populations. Exciting work among CCOs, local public health departments and community-based partners is underway as they launch the new community prevention projects. The details are outlined below.

Patient-Centered Primary Care Home (PCPCH) Program
The state's PCPCH Program is preparing to launch the 2014 PCPCH recognition criteria. The new criteria are based on the most recent evidence in the literature; provider experience with the 2011 PCPCH criteria, and broad stakeholder input. They will be in effect for clinics seeking recognition or renewing their recognition status starting in January 2014. Currently the state's program has 465 clinical practice sites recognized as primary care homes based on current (2011) criteria. The new standards for recognition provide a comprehensive roadmap for primary care transformation, further enhancing the adoption of evidence-based practices as a core element of Oregon's coordinated care model.

Technical assistance
Due to SIM grant support, continued technical assistance to clinics is being provided through the Patient-Centered Primary Care Institute, housed within our multi-stakeholder partner, the Oregon Health Care Quality Corporation. Planning and contract execution are nearly complete for the next phase of technical assistance through the institute for primary care practices across Oregon. The scope of work has been developed and is awaiting internal approval. We anticipate executing the contract in late January/early February 2014.

Technical assistance provided by the institute during this period has included:

- Behavioral Health Integration — two week-long, in-person training sessions were conducted. More than 140 physicians, behavioral health professionals and administrative staff received comprehensive training by a national expert on the Primary Care Behavioral Health (PCBH) model. PCBH is a brief, evidenced-based model for behavioral health intervention designed for health care team members in primary care settings;
- Care Transitions and the Primary Care Home;
- Care Setting Transitions and the Primary Care Home (webinar);
- Measuring and Improving the Patient Experience of Care: Surveys, Tools & Approaches (webinar).

Slides and audio recordings are available at www.pcpci.org/resources.

Please see the *Payment Reform section* below for details about how Oregon is moving toward implementing the recommendations of the Multi-Payer Primary Care Payment Strategy Workgroup that was convened and facilitated by Oregon Health & Science University's Evidence-based Practice Center.

Certification site visits
During this reporting period, 11 site visits were conducted to recognized primary care homes. Thanks to the SIM support, the PCPCH Program is working to expand and improve this process and provide additional technical assistance to clinics. The PCPCH Program is conducting an innovative pilot project to include a community-based clinical consultant at all site visits. The consultant clinicians all have experience in moving their own practices to the new model of care. Contracts have been executed with four consultants and each has conducted an initial "training" site visit. The program has received positive feedback from clinics about inclusion of a local mentor as part of this process, and provides peer-to-peer learning at the site visit. A more comprehensive evaluation will be available in fall/winter 2014 and will be reflected in the subsequent quarterly report.

Communications
The program continues to work on its communications strategy to ensure alignment with other health system transformation activities. This is an area in which technical assistance from CMMI consultants may be useful to support Oregon's communication efforts on working with providers and their staffs on moving to this new model of care. The program has increased efforts to focus on practices that encounter challenges in meeting the PCPCH standards, including independent practices and those in rural and frontier Oregon. Efforts are underway to increase engagement

with rural providers, and the program conducted two community forums in Eastern Oregon in October 2013.

Oregon Health Information Technology

In the previous quarter, OHA leveraged its SIM-funded HIT consultant (Patricia MacTaggart of George Washington University) to help develop consensus on HIT/HIE Phase 1.5 services. To begin developing the planned services, OHA submitted a State Medicaid HIT Plan Update and an HIT I-APD-U to CMS in December to request funding for one of the Phase 1.5 services: expanded technical assistance to providers who are eligible or potentially eligible for the Medicaid EHR Incentive Program.

The SIM-supported stakeholder work continued with the OHA HIT Task Force. The task force completed a draft of the business plan framework, which providers recommendations for Phase 2.0 efforts, planned for 2015 and beyond. The framework is expected to be finalized in January 2014.

OHA has partnered with the Oregon Health Leadership Council (OHLC, please see Appendix C for a roster of members) to support the availability of Emergency Department Information Exchange (EDIE) in hospitals across Oregon. EDIE is a solution developed by Collective Medical Technologies (CMT) to exchange information among EDs to identify frequent users and share care plans with ED teams to help those frequent ED utilizers to determine if there is another care setting that is more appropriate. SIM funds are being used for a grant that will be combined with funding from OHLC, its members and the state's hospitals to procure and implement the EDIE solution. In this quarter, all 59 hospitals in Oregon agreed to implement EDIE by November 2014. Oregon hospitals and health systems (including Kaiser, Legacy, OHSU, PeaceHealth, Providence, and St. Charles) have signed attestations committing their organizations to implement the EDIE system within the next 12 months.

Health Evidence Review Commission (HERC)

A key component of Oregon's transformation is translating evidence to ensure the right care is being delivered at the right time in order to help achieve the triple aim. SIM funding continues to support the OHSU Evidence-based Policy Center work toward making recommendations for improving the Health Evidence Review Commission's clinical evidence synthesis and translation work to aid the spread of the coordinated care model. Work during this period included a series of 18 interviews of HERC staff and members of both HERC and its two subcommittees that develop evidence-based reports. Questions focused on areas in which participants in the process felt things were working well and others where improvements could be made. This will help develop a broader survey of the over 400 stakeholders who track the work of the HERC, based on their listserv, and to other key stakeholders that can identify the key areas of process improvement and needs of the delivery system for the HERC's work. The center also developed process maps for 15 different topics on which reports have been completed to identify potential common bottlenecks to be addressed in the future. This collaboration with the Center will address best practices for dissemination and translation of HERC guidelines through the efforts of the Transformation Center, in alignment with national efforts such as "Choosing Wisely" to guide providers and their patients to evidence-based care.

Long-term Care Integration

Long-term care innovator agents

Another example of how Oregon is accelerating innovation is the development of long-term care innovator agents focused on linking medical care with the systems that coordinate and deliver long-term services and supports. Inspired by the innovator agent model in the Transformation Center, Oregon has leveraged SIM funds and state General Fund dollars provided in the 2013 legislative session to support a total of seven long-term care (LTC) innovator agent positions. Working in conjunction with Transformation Center innovator agents, the LTC innovator agents will address consumer and systems issues to facilitate better outcomes, lower costs, and avoid cost shift between social and medical systems. The positions are designed to address areas of shared accountability between CCOs and the LTC system and focus on improving coordination between the long-term care system and CCOs. High-cost, heavy utilizers who are dually eligible (Medicare/Medicaid) or triply eligible (eligible for Medicare, Medicaid and long-term services) will be a priority for intervention.

SIM funding supports three of those positions as state employees, and the state General Fund supports an additional four positions, which will be contracted out to four of Oregon's larger Area Agencies on Aging that administer the Medicaid program and services for older adults and people with disabilities in their geographic regions. These four agencies serve the bulk of the Medicaid-enrolled older adults and people with disabilities in Oregon and are the most rational method of establishing the positions given the absence of Adults and People with Disabilities state offices in those regions. Hiring and onboarding activities will be completed in early 2014.

Efforts to align with social services and long-term care

While Oregon's CCOs don't administer long-term care and services, there is intent to align efforts in the various regions across the state. First-year Memoranda of Understanding (MOU) between local Aging and People with Disabilities field offices or Area Agency on Aging offices are contractual obligations in the CCO contracts with OHA. The MOUs have five required and eight optional domains in which the parties state how they will work together in each domain and how they will hold each other accountable. There are 33 MOUs between CCOs and local offices because CCO and local office service areas do not coincide. Information about, and copies of, MOUs may be found at www.oregon.gov/DHS/Pages/hst/apd-cco-info.aspx. The initial MOUs were scheduled to sunset in fall 2013. Renewal of the MOUs will be a focus in 2014, including some evaluation of 2013 activities to help guide the next generation of agreements. The LTC innovator agents are responsible for leading the MOU process. Due to the delay in hiring, the renewal work is in its initial stages or has not yet commenced in some regions. Other areas have taken the initiative to begin discussing their agreements and will use the innovator agents to complete the work as the agents begin working.

LTC/CMS Study Group

Because long-term care services and supports were excluded in the legislation that authorized the development of Medicaid CCOs and their related global budgets, CMS asked Oregon to study the problem and outline strategies for system coordination and integration.

A group of 20 stakeholders was selected by Oregon Department of Human Services and Oregon Health Authority leadership to address this question (LTC/CCO Study Group); the group

completed its work and submitted a report to CMS in this quarter. The report includes an Oregon model framework with outcome statements that will support better coordination between long-term services and health systems. The model framework includes these seven domains:

- Care team/Care plan and coordination across providers;
- Financing/contracting;
- Performance, quality measurement and monitoring;
- Data and information sharing;
- Public and stakeholder engagement;
- Consumer engagement; and
- Medicare.

This model framework represents Oregon's definition of integration. The final report (Appendix D) is viewable on line at: www.oregon.gov/dhs/cms/Meeting%20files/LTC_CCO%20Study%20Group%20Report%2012_20_13%20FINAL%20to%20CMS.pdf. More information about the study group and its meetings, materials and work is also available at www.oregon.gov/DHS/cms/pages/index.aspx.

A subcommittee of the study group focused on shared accountability between health systems and long-term care made recommendations for performance measurement including long-term supports and services (LTSS) metrics and reporting the CCO incentive measures separately for the subpopulation of older adults and people with disabilities. The subcommittee agreed to continue working on shared accountability measures and financial mechanisms to support shared accountability work upon greater stakeholder feedback of work to date. A plan for gathering further stakeholder input was recommended. More information about the subcommittee, its work products, and timeline for further action is available at: www.oregon.gov/DHS/cms/pages/SharedAccountability.aspx.

SIM resources supported this work through funding a contact with the Center for Health Care Strategies to provide overall facilitation of the study group and the shared accountability subcommittee described below as well as assisting in the preparation of the final report.

Housing with Services

Oregon's SIM project supports a community-oriented congregate housing with services pilot project based on a similar model developed in Vermont. In this model, partnerships between health plans, housing providers, and long-term supports and services providers are used to achieve positive health outcomes, address social determinants of health, increase member engagement, reduce health disparities, and save costs in housing that serves mostly low-income, older adults and people with disabilities. During this reporting period, a comprehensive project service plan including project assumptions, proposed staffing, a service package and rate structure based on projected enrollment, and a budget and financing model was developed and is undergoing final review and revisions by project partners.

Health Equity
SIM funding supports expanding Oregon's network of Regional Health Equity Coalitions (RHECs). RHECs operate as advisors to CCOs' Community Advisory Councils and community partners on culturally relevant and specific strategies to reduce health disparities. They also provide technical assistance and support to a range of agencies and community leaders to act as change agents to improve equity and the representation of the interests of marginalized communities in health transformation efforts.

Regional Health Equity Coalitions
During this reporting period, the RHEC RFP for the new SIM-funded coalitions was developed and posted. A review panel was convened consisting of OHA program representatives, the evaluation consultant for the original RHECs, and members of the existing RHECs. Five proposals were submitted, and in December notices of intent to award were issued to:

- Nuestra Comunidad Sana (Hood River County) — a community-based health services organization with a 26-year history serving the Latino community and close ties to PacificSource CCO;
- Health Care Coalition of Southern Oregon (Jackson County) — a collaboration entity with established partnerships in three counties and existing partnerships with three CCOs;
- Klamath County Health Department — local health authority leading a "Healthy Klamath" collaborative that seeks to eliminate health disparities in partnership with health system partners and tribal and community-based partners.

Priority activities for the next quarter include finalizing the contracting process, and establishing tools to implement the evaluation and reporting of contract deliverables.

Developing equity leadership in communities through the DELTA project
In order to reduce health disparities, a key aspect of our success in transforming the health care delivery system, further progress was achieved this quarter to continue to expand learning opportunities that build leadership in the communities of Oregon in health equity. The initial Developing Equity Leadership through Training and Action (DELTA) Cohort completed the pilot series in August 2013. Armed with rich evaluative data, the DELTA Advisory Committee met twice during the reporting period to refine the goals and activities of future cohorts, finalize the application process for the next round of participants, and provide guidance on application review methodology for the learning collaborative.

With the support of SIM funding, the application process was established for DELTA Cohort 2 and included the development of the application document, scoring criteria and review form and a profile grid of applicants to ensure diverse representation. Applications were released on Oct. 1, 2013 and due on Nov. 1. A review committee, consisting of a subcommittee of advisory committee members, reviewed and scored 42 applications and identified 25 individuals for Cohort 2, including representatives of five coordinated care organizations.

During the reporting period, OHA contracted with a consultant, Ignatius Bau, a national leader in health equity data collection and analysis, and who is well-connected with national-level experts was recruited to provide expertise to the learning collaborative. Mr. Bau provided consultation

on refining cohort goals, provided input on the staging and development of discussion topics, and identified resources and tools to share with the cohort members. His ongoing work will be to provide support on the analysis of cohort feedback to identify quality improvement strategies for years 2 and 3.

Health care interpreter project
OHA is working closely with our CMMI project officer to identify a new approach to supporting development and expansion of the Health Care Interpreter (HCI) workforce. Accurate and appropriate interpretation services are critical to supporting high-quality care and to ensuring that all Oregonians can benefit from transformation activities that are strengthening the delivery system. In addition, CCO contract language requires the use of qualified or certified health care interpreters in health care delivery, so establishing strong relationships between this emerging workforce and the health systems and patients they serve is imperative. To that end, OHA has been in discussions with Oregon Workforce Partnerships to consider a learning collaborative strategy that brings HCIs and health systems together to identify and address language access barriers to health and develop relationships. OHA looks forward to working on solutions to address the restriction of SIM funds so that OHA can continue to support federal mandates on language access and fully support transformation for all Oregonians.

Community Health/Population Health Integration
Oregon is striving to integrate population health and the health care delivery systems. SIM resources support several strategies that capitalize on the principles, practices and community relationships that are the leading edge of the public health system to build and strengthen relationships and systems coordination with the health care delivery system.

Community Prevention Grants
In December 2013, the Public Health Division received 10 applications from local public health and CCO consortia for the SIM Community Prevention Program. A review panel scored and ranked all 10 applications and determined awards for the top four applicants, ranging from $130,000–$180,000 per year. In total, the four funded applications serve six of Oregon's 16 CCOs and 20 of Oregon's 36 local health departments. Successful applicants serve both the most urban area of the state as well as rural and frontier jurisdictions. The selected Community Prevention Program projects are:

- Center for Human Development, in partnership with Eastern Oregon CCO and all 12 local public health authorities in the Eastern Oregon region, will implement strategies to increase developmental screening in early childhood and health care settings, and will expand evidence-based nurse home visiting programs.
- Intercommunity Health Network CCO, in partnership with Benton, Lincoln and Linn county health departments, will drive down tobacco use through interventions targeting the tobacco retail environment as well as provider-level interventions to assess patients' tobacco use status and provide referrals to cessation resources.
- Jackson County Public Health, in partnership with AllCare CCO, Jackson Care Connect CCO, Josephine County Health Department and PrimaryHealth of Josephine County CCO, will improve the health of women and families through a comprehensive preconception health program consisting of social marketing and outreach campaigns

targeting young women and Latinas and provider-level interventions to ensure routine screening for pregnancy intent.

- Multnomah County, along with Clackamas County and Washington County health departments and Health Share of Oregon CCO, will address the growing issue of opioid dependence through a community naloxone recovery program targeting clients of the region's syringe exchange program and social service providers, and through standardized opioid prescribing guidelines for providers.

Health indicators by race and ethnicity

Staff from Program Design and Evaluation Services (an OHA/Multnomah County joint program), working under a SIM-funded subcontract, have been continuing work on the analysis of 31 public health indicators by race/ethnicity and by CCO region. The intent is that this information will assist CCOs in the development of their required Community Health Assessments and Community Health Improvement Plans and will give CCOs a better understanding of the health risk behaviors of their service areas. Multiple health indicators will be included.[1] Once complete in March 2014, the public health indicators analyzed by CCO region will be shared with CCOs; consultants are working with OHA to determine the most appropriate data display and publication method. This information goes beyond what is available for CCOs in their claims data and can assist CCOs with identifying areas for further population-level quality improvement, particularly around the prevention of disease and disability. This will also be useful for evaluation and monitoring of transformation efforts across the state.

An advisory committee is continuing work on the design and protocol development of a Medicaid Behavioral Risk Factor Surveillance System (BRFSS) survey to be fielded in mid-2014. OHA expects the survey to be fielded in March or April of 2014. The survey will include risk factors for chronic disease and injury and will also assess social determinants of health. The survey will yield CCO-specific estimates and will oversample on race and ethnicity to provide state-level estimates of these risks among specific populations. Information will also be collected on the Medicaid expansion population. OHA began methodological and logistical planning for a race/ethnicity oversample of the ongoing annual Behavioral Risk Factor Surveillance System survey as well.

Oregon Public Health Assessment Tool

With support from SIM funding, a mortality data module was added to the Oregon Public Health Assessment Tool (OPHAT) in August 2013 and released with version 1.1. In September 2013, the following OPHAT datasets were updated to include 2012 data: birth risk factors, fertility, population estimates, communicable disease and pregnancy/abortion. Work continues on updating the mortality data, redesigning the user interface and other functional enhancements that will be released with version 2.2 at the end of February 2014. The OPHAT tool will serve as

[1] Indicators to be included: leading causes of death, years of potential life lost, suicide deaths, opioid-related overdose deaths, motor vehicle crash deaths, health status, poor physical or mental health limiting daily activities, positive youth development, lung cancer incidence, heart attack hospitalizations, diabetes, hypertension, breast cancer by stage, pertussis, salmonella, chlamydia, HIV diagnosis, fall hospitalizations, overweight/obesity prevalence in adults and eighth-graders, alcohol-related deaths, binge drinking in teens and adults, cigarette smoking in adults and eighth-graders, low birth weight births, prenatal care in first trimester, teen pregnancy, teen births, and adequate immunization

a resource to local public health authorities, CCOs, hospitals and other local organizations, particularly as they develop Community Health Assessments and Community Health Improvement Plans. OPHAT will allow local communities to monitor the change in health status indicators over time and create simple queries of population health data with convenience.

Linking Health to Education: Early Learning Council Work
The Joint Early Learning Council and Health Policy Board Subcommittee completed its straw proposal and recommendations for aligning health and early learning system transformation based on a collective impact approach. Both policy bodies endorsed the straw proposal and implementation is now underway. The Early Learning Council and the Oregon Health Policy Board have agreed upon kindergarten readiness as the priority, shared agenda for their work together (as measured via the state's kindergarten assessment).

OHA's director of Child Health has continued to serve as the liaison between the OHA and Oregon's Early Learning Council, which has just approved the first six regional early learning hubs that will oversee local coordination of early learning services. Up to 16 hubs will be certified by July 2014, after which cross-system learning collaboratives are expected to begin. The Transformation Center will serve as the backbone agency supporting these joint early learning collaboratives; staffing, content and scheduling for the learning collaboratives are underway.

The state's first year of a unified, kindergarten assessment was completed in October. The Department of Education convened a three-day interpretive panel to advise on how to message and report on the first year data. In keeping with the straw proposal, a presentation on kindergarten readiness and assessment data will be presented to the Metrics & Scoring Committee in spring 2014 for consideration as a potential CCO incentive metric.

Finally, OHA continues to explore how Oregon's HIT/HIE services can be used to share child information across health and early learning systems, such as developmental screening results. Implementation is expected in the next year for data sharing, and further updates on the progress of the hubs will be included in future quarterly reports.

Payment Reform
Oregon continues to strive to move payments away from fee-for-services to outcomes-based alternative payment structures. Exciting work to advance payment reform took place in this reporting period.

Primary care multi-payer strategy workgroup
With the support of the SIM grant, a Multi-Payer Primary Care Payment Strategy Workgroup was convened and facilitated by Oregon Health & Science University's Evidence-based Practice Center. This workgroup met four times, and included all the major commercial insurers in the state, representatives of the new Medicaid CCOs, primary care provider organizations and the state. Through a consensus process, they produced recommendations for strategies for public and private payers to support primary care homes in Oregon. The end result is that nearly all commercial and public payers in Oregon (excluding Medicare FFS) will offer structured

payments, using Oregon's patient-centered primary care home recognition standards, to support patient-centered primary care homes. Payers will establish the amount, the type of payment and timeline for implementation with the providers in their networks. As purchasers, PEBB, OEBB and Medicaid are also aligning with this agreement through their contracting processes.

The agreement was formalized by organization participants' signatures at the November Oregon Health Leadership Council meeting. As described previously, OHLC is a collaborative organization working to develop approaches to reduce the rate of increase in health care costs and premiums so health care and insurance are more affordable. Formed in 2008 at the request of the Oregon business community, the council brings together health plans, hospitals, the Oregon Health Authority and physicians to identify and act on cost-saving solutions that maximize efficiencies and quality. The signed consensus document is in Appendix E and more details about Oregon's PCPCH program are available at www.oregon.gov/oha/OHPR/Pages/healthreform/pcpch/index.aspx.

As part of this process, the state's PCPCH program agreed to work with payers and practices to identify and agree on a common set of meaningful outcome metrics, consistent with those already in place for Oregon providers, in order to track program success and build in practice accountability for progress toward transformation. The program and payers also agreed to discuss reporting formats and administrative processes that simplify the administrative burden on practices and to convene to review progress toward outcome metrics on at least an annual basis. To meet this purpose, PCPCH program staff convened a group tasked with developing recommendations for a PCPCH scorecard and reporting strategy. Program staff plan to track the measures in the draft report (see Appendix F) and provide updated data to the multi-payer group in fall 2014. Based on findings over the course of the next year, adjustments to the payer collaboration or individual payer contributions may need to occur depending on:

- Whether cost savings and other outcome measures expected from this effort are realized;
- Whether practices are progressing according to the structure of the PCPCH program;
- Whether there is a need to convert some practices (e.g., established and high achieving practices or underperforming practices) to a different kind of reimbursement model;
- Whether new research reveals opportunities for improved practice transformation and cost containment;
- Whether shared savings or other payment models provide opportunities for reinvestment.

Other multi-payer payment reform

OHA plans to continue to work with the OHLC and has asked the Evidence-based Practice Center to facilitate discussions on payment reform beyond primary care in the demonstration period. Those discussions are being planned in partnership with the OHLC and are anticipated to start in early 2014.

Additional work in this area included:

- Ongoing consultation with payment reform experts to inform and advise the state and stakeholders on payment approaches;
- Continued monitoring of the new federally qualified health center (FQHC) Alternative Payment Pilots in four clinics for potential spread more widely across Oregon;

- Continued work with the Oregon Association of Hospitals and Health Systems (OAHHS) Small and Rural Health Committee to prepare Oregon's smaller (Type A & B) hospitals for transformational changes brought on by health reforms and market changes. Working in collaboration with federal and state leaders, the goal of this work is to develop solutions not only to support the financial sustainability of small rural hospitals but also to spread the coordinated care model.

CCO incentive payments
OHA is finalizing plans to disburse quality bonus pool dollars to Medicaid CCOs based on their performance on the 17 CCO incentive metrics. This is a key factor driving Medicaid system delivery transformation efforts, with the CCOs focused on meeting their targets. One CCO has dramatically improved their network's number of PCPCH certifications, and all have partnered with other payers and the Transformation Center to spread best practices around each of the metrics, as discussed earlier. Initial quarterly reports show a decline in hospital and ED visits and costs, and more investment in primary care. This is the first step in moving from traditional per member, per month (PMPM) rate payment to outcomes-based performance payments, a key aspect of Oregon's coordinated care model.

Analysis and Evaluation

Performance measurement
SIM resources support Oregon's efforts to create a powerful analytical toolbox to drive performance and enable data-driven decision making. A key component of the coordinated care model is a commitment to transparency. Initial implementation of the model in Medicaid has featured published performance metrics data to guide CCO operations and inform the public and stakeholders about success and opportunities for ongoing improvement. As transparent performance data become available for other public and private lines of business, this will help spread the coordinated care model across Oregon.

To provide status updates on the state's progress toward Medicaid goals, OHA has now published three quarterly reports showing quality and access data, financial data, and progress toward reaching benchmarks. The state is tracking 17 CCO incentive metrics and 16 additional state performance metrics. It is also tracking financial data, displayed both by cost and by utilization. By using quality, access and financial metrics together, the state can monitor the extent to which CCOs are effectively and adequately improving care, making quality care accessible, eliminating health disparities, and controlling costs for the populations that they serve.

The November 2013 quarterly report (see Appendix G, or view at www.oregon.gov/oha/Metrics/Pages/index.aspx) compiles nine months of utilization and cost data based on claims made for payments from the coordinated care organizations in 2013. This report also shows six months' worth of several statewide performance metrics. In the months to come, analysis on more metrics will be completed and published. Also, for the first time, this report showed baseline race and ethnicity data for performance measures. This critical information will help highlight areas of greatest disparity and potential improvement.

Preliminary data show emergency department use declining, for example, while primary care is increasing. While progress will not be linear — in the months and years to come there will be movement in the right direction and there will be setbacks — this report is both promising and encouraging. It signals that the state is on the right track with the coordinated care model.

A similar statewide but multi-payer quarterly dashboard is planned for first release in March 2014. Recent Oregon Health Policy Board meetings have included public discussion of potential data elements for this dashboard and board members provided input on priority information for monitoring health system transformation and ACA implementation statewide. See this presentation from the November 2013 board meeting for proposed data elements: www.oregon.gov/oha/OHPB/2013MeetingMaterials/Draft%20measurement%20framwork%20presentation.pdf. In addition to providing regular data on the progress of health system transformation, the dashboard will act as a foundation for the transparency and cost containment work proposed by the Oregon Health Policy Board in their recommendations to Governor Kitzhaber delivered this quarter (see Oregon SIM context for more information).

Supported by SIM resources, the state has partnered with Oregon Health Care Quality Corporation (QCorp), an Agency Healthcare Research and Quality (AHRQ) chartered value exchange and a Robert Woods Johnson Aligning Forces grantee. QCorp is working to provide an objective check on the initial CCO metrics. QCorp has also partnered with Oregon's health insurance exchange, Cover Oregon, for its initial qualified health plan metrics, and will be working with the OHA Office of Health Analytics on PEBB and OEBB metrics.

Cover Oregon has launched a workgroup to make recommendations for appropriate health outcomes and quality measures to be used across Cover Oregon plans, Public Employees' Benefit Board (PEBB), Oregon Educators Benefit Board (OEBB) and OHA, as required by HB 2118 (2013). Recommendations are anticipated by June 2014.

Analytic tools and capacity

SIM resources have made it possible to have key information systems and project management staff in place to enhance our ability to systematically produce performance metrics in a transparent process. The Oregon Health Authority Office of Health Analytics filled several key positions (not all positions are supported by SIM funding) including a data development and integration manager to expand OHA capacity for data analytics to support transformation. An initiative is underway to build a technology and analytic infrastructure that produces reliable, timely data to meet the needs for CCO metrics initially, while developing tools and processes that are expandable to other data needs including Oregon's All-Payer All-Claims (APAC) database. Specific tools and capacity building completed include:

- The Milliman Health Care Cost Guideline Grouper software was purchased to allow use of a common grouping tool between our All-Payer All-Claims database and our internal Medicaid data.
- A contract with AUS Marketing Research Systems Inc., d.b.a. Social Science Research Solutions, has been executed to support data collection and analysis for the Oregon Health Insurance Survey. This survey will allow Oregon to monitor ACA implementation

with the 2014 Medicaid expansion and the new health insurance exchange, as well as the spread of the coordinated care model.
- The contract to select the vendor to conduct the Consumer Assessment of Health Care Providers and Services (CAHPS) survey and data analysis has been executed and work begins in January 2014.

Self-evaluation
Oregon's final operational plan outlines three primary objectives for SIM evaluation and lists a number of self-evaluation measures under each. The following updates are organized by objective.

Objective 1: Assess the success of the overall model (CCM) in Medicaid
The CCO quarterly performance report described above under the performance measure heading provides timely data on the effects of CCM implementation in Medicaid. As noted, the latest reports contain promising trends about increased primary care utilization and decreased hospital and emergency department visits.

A SIM-funded contract for "midpoint" evaluation of how the coordinated care model (CCM) is being implemented in Medicaid and how it is impacting quality and experience of care was awarded to Mathematica Policy Research in December. (The RFP for the contract was developed with input from CMMI and contracted SIM technical assistance staff.) Assessing the success of the CCM is the first of Oregon's three evaluation objectives for the SIM grant and results from this evaluation will inform efforts to spread the model to other payers and populations. Mathematica's final plan for the midpoint evaluation is due in mid-January.

However, the Mathematica scope of work covers the Medicaid "midpoint" evaluation only and does not include other aspects of the SIM self-evaluation. As described in the final Operational Plan, Oregon does not anticipate contracting with just one entity for evaluation of SIM efforts. Instead, the state will let contracts for particular elements of data collection, analysis and evaluation (e.g., analysis of whether utilization or expenditure changes observed in Medicaid spread to other payers) as needed. A January meeting is planned to scope some of this work.

Objective 2: Assess the spread of CCM to other payers and populations
As described elsewhere in this report, an RFP for PEBB services incorporating CCM elements was released in the fall and plan selection will occur early in 2014. Oregon will report on covered lives receiving coordinated care model care in future reports as PEBB, OEBB and exchange-based plans adopt elements of the model. Information regarding the spread of specific features of the CCM (alternative payments, patient-centered primary care, etc.) is highlighted throughout this report and includes:
- As of December 2013, there were more than 465 recognized patient-centered primary care homes statewide.
- Nearly all the commercial and public payers in Oregon (excluding Medicare FFS) have agreed to offer structured payments to support patient-centered primary care homes.

- Four collaborative projects between CCOs and local public health departments are expected to launch early in 2014, focusing on population health and addressing the leading causes of death and disability.
- The Transformation Center engaged more than 100 providers, plan representatives and payers in a complex care learning collaborative that launched in November 2013.

Objective 3: Assess how individual elements of the CCM contribute to transformation
The Medicaid waiver midpoint evaluation referenced above will provide some preliminary information on this question in the Medicaid context. The analysis necessary to address this question in other contexts is likely to take place in years 2 and 3 of the grant.

National evaluation
Oregon is also working closely with CMMI contractors from the Urban Institute and National Academy of State Health Policy (NASHP) on their plans for national-level evaluation of the SIM test states. The contractors are planning a site visit to Oregon in early March and will conduct several focus groups and interviews as part of that visit. They are also planning surveys of providers and the PEBB population and Oregon staff are consulting with the contractors on the most effective methods.

Planned Activities for Next Quarter

January 1, 2013, through March 31, 2014

Below is a summary of our key activities scheduled for the next quarter, Jan. 1 through March 31, 2014, by subject area within the Oregon SIM project. We are on target with expected activities that are detailed in our operational plan and appendices. The SIM Operations Team meets regularly to check in on progress, identify barriers and resolve problems. At this time, we do not perceive any barriers to accomplishing the work described below.

Accelerate Innovation

Transformation Center

- Launch ongoing complex care learning collaborative;
- Launch ongoing science of improvement learning collaborative supporting CCO transformation projects;
- Maintain CAC learning collaborative and plan CAC summit and CAC leadership development program;
- Initiate planning for the 2014 CCO summit;
- Expand content and time for the CCO medical directors learning collaborative;
- Plan for Council of Clinical Innovators, steering committee and recruitment strategies;
- Develop and launch the “Transformation Bank”;
- Incorporate recommendations from Individual Responsibility and Health Engagement Workgroup into Transformation Center’s work plan;
- In partnership with the Office of Equity and Inclusion, promote health equity strategies within CCOs;
- Launch second wave Transformation Center website;

- Complete development of the Transformation Center master communications plan and implement.

Delivery Innovation

Patient-centered Primary Care Homes

- Continue technical assistance offerings through the PCPCH Institute to primary care clinics, including ongoing resources to first cohort of clinics, and start another set of clinics for hands-on technical assistance.
- Engage CMMI technical assistance to update and align PCPCH communications plan and stakeholder engagement strategy.
- Develop technical specifications and guidance documents for updated recognition criteria.
- Design and execute contract for online application system changes needed for updated recognition criteria.
- Develop and launch relational PCPCH database for program administration.
- Expand site visit teams and train verification site visit clinical consultants.
- Schedule, coordinate and conduct PCPCH verification site visits.
- Conduct ongoing PCPCH program evaluation and analysis.
- Develop annual PCPCH program report.

Health Information Technology

- Continue working with the Health Information Technical Advisory Group (HITAG) to help define the scope of work (including major technology requirements) and applying for federal funding for Medicaid's share of HIT/HIE Phase 1.5 development.
- Work with the OHA HIT Task Force to finalize the business plan framework for Phase 2.0.
- Develop materials and provide training on HIT.
- Develop proposals for telehealth/mobile device pilots.
- Continue to prioritize development of provider directory and notifications and alerting.
- Submit HIT I-APD-funding request to support implementation of additional Phase 1.5 services: clinical quality metrics registry, provider information repository services, statewide Direct secure messaging expansion, notifications, and patient/provider attribution.
- Spread awareness about HIT and how it can be used in various settings to advance the triple aim.
- Participate in the steering committee for the EDIE solution, and proceed with implementation of the exchange of information between Oregon hospital emergency rooms.

Health Evidence Review Commission (HERC)

- Continue work with Oregon Health & Science University Evidence-based Practice Center to review evidence for clinical decision making.
- Continue process improvement assessment to increase the efficiency of HERC's process, deliverables and translation to evidence-based clinical decision tools.

Community Health/Population Health Integration

- Monitor community prevention grants and provide technical assistance to support implementation and integration with their local CCO and health care delivery system efforts. Collect best and promising practices to disseminate.

Long-term Care Integration

Innovator agents

- Complete hiring of long-term care innovator agents. Commence monthly long-term care innovator agent meetings that will include education on the aims of the coordinated care model, and the critical liaison role they will be playing.
- Continue work with the CMS/LTC/CCO Study Group and Shared Accountability Subcommittee to develop a plan for implementation of the group's recommendations approved by leadership, including shared accountability follow up.
- Continue work with OHA health analytics unit on CCO and long-term care services and supports metrics.
- Develop quarterly report on LTC/CCO Memoranda of Understanding activities.
- Preparing metrics recommendations for submission to the Metrics and Scoring Committee.
- Shared accountability work will continue both through an internal workgroup following up on CMS/LTC/CCO Study Group recommendations (as mentioned above) and through the Long-Term Care 3.0 Initiative carrying out the health care transformation work referenced in Senate Bill 21 from the Oregon 2013 legislative session.
- Quarterly summary report of housing with services project management activities.

Housing with Services

- Evaluation plan will be finalized.
- IT consultant's draft recommendations including system needs and specifications will be submitted.
- Accounting consultant will be hired or contracted.
- Training for system users will be provided.
- Program core agreement (including service package and rate) will be refined, possibly finalized.
- Project will seek final approval for the LLC agreement and project plan from the boards of directors of prospective partner agencies.
- Marketing/outreach plan will be developed and implemented in conjunction with resident council.
- Marketing/outreach materials will be distributed in program buildings.
- Materials and meetings related to services and service delivery will be translated/interpreted to increase access for all building residents.
- Intra-organizational policies and procedures will be completed.
- IT software and hardware will be purchased and installed to support program operations and track services.

- Accounting system will be purchased or developed, installed and documentation provided to show it is working.

Health Equity

- Begin conducting regional health equity coalition site visits.
- Convene statewide meeting for coalition trainings.
- Provide technical assistance to CCOs and facilitate stronger relationships between local health system and community partners serving populations with disproportionately poor health outcomes.
- Develop and provide tools and resources for meaningful community engagement, health equity leadership, health equity planning, development of health equity metrics, and support for policy development that increase and advance health for all of Oregon's communities.
- Implement the equity leadership learning collaborative with DELTA Cohort 2.
- Complete negotiations with CMMI to develop health care interpreter learning collaborative and begin operational work to implement.

Early Learning Councils

- Develop learning collaborations between CCOs and the Early Learning Council to achieve kindergarten readiness.
- Continue coordination of screening, services and data across CCOs and early learning hubs.

Payment Reform and Spreading the Model

- Continue meetings and develop common agreement for action steps for next phase of multi-payer collaboration on payment reform beyond recent primary care strategies.
- Continue to monitor primary care consensus efforts across payers, with the PCPCH program assessing metrics and coordinating alignment with the Comprehensive Primary Care Initiative efforts in Oregon.
- Continue assessment of FQHC alternative payment pilots for potential spread more widely.
- PEBB Board will evaluate proposals, aiming to select vendor(s) by spring 2014. Selected vendors contracts will contain the key elements of the coordinated care model as expectations with associated accountabilities, including partnership with the state on reduction of cost trends.
- Monitor 2014 PEBB benefits to further PCPCH use and wellness efforts for state employees.
- Prepare for next round of PEBB member engagement meetings for spring 2014 to further discuss coordinated care model efforts with state employees.
- Continue discussions with the Oregon Educators Benefit Board on their next benefit RFPs and inclusion of coordinated care elements, based on work to date in PEBB.

Analytics and Evaluation

- With input from the Oregon Health Policy Board, the Governor's Office, and a technical advisory group, continue work to initiate a multi-payer dashboard, including measures of coverage trends and access to care, quality of care, utilization and expenditures.
- Continued development of the initial metric database and testing the grouper software will occur.
- Continue to refine plans and develop measurement capacity for SIM self-evaluation.
- Collaborate with CMMI contractors for national SIM evaluation; host contractors for site visit in March 2013.
- Work with contractors on midpoint evaluation of the coordinated care model in Medicaid; prepare report due to CMS in February that reflects progress and outcomes to date.

Likelihood of Achieving Next Quarter's Objectives

OHA does not perceive any barriers to achieving our next quarter's objectives, with the caveat that those requiring further discussion with our federal partners may be delayed. We continue to work internally and with our SIM project officer to identify strategies to build and expand Oregon's health care interpreting capacity to achieve our health transformation goals related to health equity. We also want to continue to work with our federal partners regarding the challenges of maximizing the use of data related to substance abuse (42CFR) to further coordination of care across both our public and private markets, and how to facilitate an efficient process to start to incorporate Medicaid FFS data with the state's All-Payer All-Claims database.

Substantive Findings

Initial progress to date has been outlined in this report, summarizing the three months of SIM funding for the first demonstration period. Some key areas to highlight:

Early results of first six months of coordinated care model in Medicaid now available
We noted above some very early initial findings on lower hospital and emergency room use and increased primary care visits in our first months of CCOs operating in Medicaid (see Appendix H). As we continue into the demonstration period, we will continue to update CMMI with our progress to fully implement the coordinated care model in Medicaid and spread of the model across other markets and populations in Oregon.

Initial evaluation findings for spread of the patient-centered primary care model in Oregon
Although not directly funded using SIM resources, the PCPCH program conducted an evaluation to identify modifications to improve the PCPCH model, assess the OHA's implementation efforts, and provide evidence for continued support of the program. The evaluation was divided into four sections, and results are available for two of the four pieces. See Appendix H and I for executive summaries of the work.

Key findings from surveys and site visits to date include:

- The average number of primary providers in PCPCHs is 5.1, and practices indicate they consist of one to 39 FTE providers.
- Size as measured by number of other full-time equivalent clinical staff ranged from zero to 70, with an average size of 9.4.
- More than 80 percent of PCPCHs needed to add at least one new service in order to achieve recognition.
- Eighty-two percent of PCPCHs feel that implementation of the PCPCH model is helping them achieve the aim of improving the individual experience of care and improve population health management.
- Seventy-eight percent of PCPCHs feel that model implementation is helping practices increase the quality of care for patients and 75 percent feel that it is increasing access to services.
- The two most important factors influencing the decision of a practice to become recognized as a PCPCH are the opportunity to improve patient care, and the eligibility for enhanced payment.
- The most important barriers to PCPCH implementation are cost and lack of resources; staffing and training; time; and the administrative burden and reporting.
- Standard 4.E.0, a written agreement with local hospitals focused on communication around hospital care transitions, is the most common deficiency leading to an "improvement plan" on site visits.
- Clinics feel the technical assistance (TA) provided at the site visits is valuable to better understand the intent of various PCPCH standards/measures — particularly when the "clinical advisor" was included to provide a more thorough assessment, consultation, and connection to TA resources.
- During site visits, a desire for mentorship connections ("someone like us who has done this") and other specific TA needs have been identified as priorities.

Need for technical assistance to further community and health delivery system engagement in reducing health disparities

Evaluation results from the initial DELTA cohort, as well as ongoing requests from CCOs, indicate that health systems are hungry for more technical assistance and support to meet diverse communities' needs and to make stronger connections with community partners. Additionally, opportunities for joint and collaborative learning are valuable for relationship building, while specific tools and templates are needed to apply the learning directly.

Lessons Learned

The CCO Transformation in Action summit held in December brought together individuals and organizations to share experiences from the first year of CCO operations. The excitement of summit participants was palpable and provides lift and direction for continued collaboration and shared innovation. It also sent important signals to OHA about the type of assistance most needed in Oregon's communities as we fully implement Medicaid CCOs and spread the coordinated care model into other markets in Oregon. We have learned that communications and stakeholder engagement are critical, with a definite need to bring groups together face-to-face to

successfully negotiate consensus, share implementation experiences and build learning community networks. CMMI's investment in travel and tools to share learning are invaluable to achieve this. We look forward to a continued strong performance in health transformation as we move forward into the next SIM demonstration period.

Suggestions/Recommendations for Current/Future SIM States

None to report at this time.

Suggestions/Recommendations for CMMI SIM Team

- OHA looks forward to finalizing a technical assistance plan that supports the needs of the Oregon SIM project areas. CMMI consultants provide a rich resource to support our innovative work in Oregon.
- Information about topics and dates for SIM-sponsored webinars lags and it becomes challenging for getting the members of Oregon's teams to be able to participate, and have interactive opportunities to ask questions. It would be good to understand what is planned going forward during our demonstration year so we can share the schedule with our project leads and their multiple teams across Oregon.
- We would like to work with CMMI to review the expectations for required detailed narrative reporting with specific due dates for the entirety of Demonstration Year 1, including expected format and any necessary supporting documentation. This would be for any expected quarterly reports, and also detailed descriptions of what narrative will be expected at the end of the demonstration year as well. This will allow the grants management team and the operational teams to anticipate needs far in advance and to collect any needed "artifacts" as the year progresses, rather than having to scramble to collect at the end of the year. We want to ensure we provide CMMI with needed information but also allow our multiple projects leads maximum time to focus on implementing and working with stakeholders for all of Oregon's activities necessary to spread the coordinated care model.
- We want to work closely with CMMI regarding the federal evaluation plans as they are finalized and resultant expectations for the state. Initial discussions with the evaluators directly have been helpful and are proceeding, and Oregon wants to be sure the evaluators, the state and CMMI review any updates or refinements in a timely manner to ensure we can to respond to data, information sharing or other requests that will support the federal effort.

Findings from Self-Evaluation

See the *Substantive Findings section* above, but to summarize: As reported earlier, preliminary data about the impact of the coordinated care model in Medicaid are promising. These data indicate a decline in hospital and emergency department visits and costs, as well as an increase in primary care visits. It is too early to report on the performance of the model in other contexts but some self-evaluation measures of model spread are included in the *Analytics and Evaluation section* earlier in this document. Information about related (but not SIM-funded) Patient-Centered Primary Care Home Program evaluation is provided above.

Problems Encountered/Anticipated and Implemented or Planned Solutions

Disallowed costs issue
Oregon and the CMMI project officer continue to work toward a resolution in the near future that will work for CMMI and OHA on disallowed costs. Discussions are ongoing.

Multiple, complex and/or unanticipated requests for documents or meetings with extremely short turnaround times
With clear and prompt guidance from CMMI, expectations and specific requirements could be better met and also prevent delays in getting initiative-related work started. We appreciate the flurry of requests CMMI may get from others about the SIM states, and know that those requests are unavoidable. However, requests CMMI does have some lead time on, or can anticipate that can be shared as soon as possible would be greatly appreciated to avoid delays in getting complete information back, or ensure Oregon's participation at potential meetings or webinars going forward.

Some challenges Oregon is monitoring
Delays due to implementation of the ACA

- Due to the launch of Oregon's Health Insurance Exchange in October and planning for Medicaid expansion in January 2014, OHA has deferred establishing a Transformation Center Multi-Payer Steering Committee until later in 2014 to ensure our partners are able to fully engage with the Transformation Center.
- With now almost 200,000 new Oregonians signing up for coverage either through our Medicaid program or for a Qualified Health Plan on the exchange, OHA and its sister agencies, the Department of Human Services, the Oregon Insurance Division and CoverOregon are working full time 24-7 to ensure those enrolled are getting access to coverage. This is a major focus of this next upcoming quarter as it has been this last quarter. While implementation and spread of the coordinated care model remain the state's focus, leadership and staff are stretched as we enter into the second quarter of the Demonstration Period.
- The execution of a contract for an OHA master website plan, development of the website and data portal is delayed. The website, which will support communication about the coordinated care model to external audiences and multiple payers, was delayed due to the priorities and staffing levels in the Office of Information Services, largely due to staffing needed to prioritize system activation for the Health Insurance Exchange and planning for Medicaid expansion. The Transformation Center plans to move forward in the next quarter with this project.

Work Breakdown Structure

Please see Appendix J.

Points of Contact

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Appendix A
Recommendations for aligning Affordable Care Act implementation with Oregon's health system reform

http://www.oregon.gov/oha/OHPB/2013MeetingMaterials/OHPB%20final%20recommendations%20to%20Governor%20Kitzhaber.pdf

Appendix B
Recommendations from the Task Force on Individual Responsibility and Patient Engagement

http:www.oregon.gov/oha/OHPR/SIM/docs/Appendix%20B%20Rec%20from%20the%20Taskforce%20on%20Individual%20Responsiblity%20and%20Patient%20Engagement.pdf

Appendix C
Oregon Health Leadership Council members

George Brown, M.D., Legacy Health, *Co-Chair*
Don Antonucci, Regence Blue Cross Blue Shield of Oregon, *Co-Chair*
Pat Curran, CareOregon
Andy Davidson, Oregon Association of Hospitals and Health Systems
Jim Diegel, St. Charles Health System
Majd El-Azma, LifeWise Health Plan of Oregon
Chris Ellertson, Health Net
Craig Fausel, M.D., The Oregon Clinic
Jim Fitzpatrick, CIGNA
Robert Gluckman, M.D., Providence Health & Services
Bruce Goldberg, M.D., Oregon Health Authority
Howard Graman, M.D., PeaceHealth
Norm Gruber, Salem Health
Ken Hamm, First Choice Health
John Hill, PeaceHealth

William Johnson, M.D., Moda Health
Chuck Kilo, M.D., OHSU
Doug Koekkoek, M.D., Providence Health & Services
Andrew McCulloch, Kaiser Permanente
Melinda Muller, M.D., Legacy Health
Roger Muller, M.D., United Healthcare
Larry Mullins, Samaritan Health Services
Ken Provencher, PacificSource Health Plans
Joe Robertson, M.D., OHSU
Tom Russell, Adventist Health
Micah Thorp, D.O., Northwest Permanente
David Underriner, Providence Health & Services
Roy Vinyard, Asante Health System
John Wagner, Aetna

Appendix D
Study Group Report on the Integration of Long Term Care Services into the Global Budgets of Oregon's Coordinated Care Organizations

http:www.oregon.gov/oha/OHPR/SIM/docs/Appendix D LTC_CCO Study Group Report 12_20_13 FINAL to CMS.pdf

Multipayer Strategy to Support Primary Care Homes

November 5, 2013

Background

Strong, effective primary care health homes are foundational to transforming and sustaining high quality healthcare for Oregonians. Evidence shows that team-based primary care will lead to better outcomes and drive down costs. The more quickly Oregon can drive adoption of primary care health homes statewide, the more quickly we will drive achievement of the Triple Aim (improving care, improving health, and reducing cost).

Oregon's statewide primary care health home program is known as PCPCH (Patient Centered Primary Care Home). PCPCH is a tiered approach representing increasing levels of primary care home attributes for a given practice. A broad-based, multi-payer strategy is needed to support primary care homes statewide. Multi-payer support will ensure that practices are compensated for the work they are doing to provide coordinated care, and supported in achieving outcomes through a robust and shared primary care home approach.

The Oregon Health Authority (OHA) and the Oregon Health Leadership Council (OHLC) convened a series of meetings from July to September 2013 that brought together payers and other key partners from around the state to develop consensus-based strategies to support primary care homes in Oregon, facilitated and supported by the Center for Evidence-based Policy. Through the process, the organizations listed below agreed to the shared goals, objectives and initial key actions listed in this document.

Goal

Mutual investment and commitment to accountable, sustainable, patient-centered primary care that results in achievement of the triple aim.

Objectives

1. Simple, straightforward, and explainable payment models
2. Payment policies will align
    - Metrics
    - Standards
    - Quality
    - Accountability audits
    - Other support
3. Meaningfully raise the bar in the delivery of quality care and outcomes for patients
4. Allow for innovation, continuous improvement and movement to the triple aim
5. Build on existing efforts and align with them where possible
6. Facilitate and/or further provider transformation

Actions

To reach the goals and objectives, payers agreed to the following initial joint actions:

1. All Oregon payers will use a common definition of primary care home based on OHA's PCPCH Program. (see attachment)
2. Payers will provide variable payments, or other payment models, to those primary care practices in their network participating in OHA's PCPCH program, based on each practice's PCPCH points total and their progress toward achieving outcomes which lead to the Triple Aim. Some payers may also require that practices meet specific thresholds or other conditions prior to qualifying for payments. The structure, qualifications, and amount of these payments will be the responsibility of each payer to determine or negotiate with practices in their network.
3. OHA's PCPCH program will build in practice accountability for progress toward transformation. They will work with payers and practices to identify and agree on a common set of meaningful outcome metrics, consistent with those already in place for Oregon providers, as well as reporting formats and administrative processes that simplify the administrative burden on practices.
4. The Oregon Health Authority, through its state health transformation efforts, has efforts underway to assist providers in achieving the standards of PCPCH, including the Transformation Center, site visits, and the Patient-Centered Primary Care Institute. Payers will work with providers, purchasers, and other stakeholders to identify meaningful ways for further collaboration in order to support the long-term sustainability of primary care homes. This group will specifically discuss efforts to engage self-insured employers in primary care home efforts.
5. Payers will convene to review the progress toward outcome metrics, and impact on total cost of care on at least an annual basis and determine whether adjustments need to be made to this payer collaboration or individual payer contributions based on the following:
    - Whether cost savings and other outcome measures expected from this effort are realized.
    - Whether practices are progressing according to the structure of the PCPCH program.
    - Whether there is a need to convert some practices (e.g. established and high achieving practices or underperforming practices) to a different kind of reimbursement model.
    - Whether new research reveals opportunities for improved practice transformation and cost containment.
    - Whether shared savings or other payment models provide opportunities for reinvestment.

    Payers will also work with providers to review implementation strategies.

6. Participating organizations agree that strong primary care homes are a necessary foundation for achieving the Triple Aim, and that the ability to adequately and sustainably invest in primary care will be the result of changes across the entire medical neighborhood. For this reason, participating organizations in this effort support OHA's commitment to convene broad payment reform discussions no later than January 31, 2014.

Participating Organizations Agreeing to these Goals, Objectives and Actions

John Wagner
Aetna

Pat Curran
CareOregon

Suzanne Dinsmore
Childhood Health Associates of Salem

John Sobeck
CIGNA

Paul Barner
First Choice Health

Christi Siedlecki
Grants Pass Clinic

Chris Ellertson
Health Net of Oregon

Janet Meyer
Health Share of Oregon

Bess Jacobo
Kaiser Permanente

Majd El-Azma
LifeWise Health Plan of Oregon

Shikha Gupta
Moda Health

Evan Saulino
Oregon Academy of Family Physicians

Robin Moody
OR Association of Hospitals and Health Systems

Bruce Goldberg
Oregon Health Authority

Don Antonucci
Oregon Health Leadership Council

Jo Bryson
Oregon Medical Association

Susan King
Oregon Nurses Association

Ken Carlson
Oregon Pediatric Society

Ken Provencher
PacificSource Health Plans

Dave Underriner
Providence Health & Services

Don Antonucci
Regence Blue Cross Blue Shield of Oregon

Chris Senz
Tuality Health Alliance

Valerie Gordon
Umpqua Health Alliance

Patient-Centered Primary Care Home 2014 Recognition Criteria
Quick Reference Guide

Oregon Health Authority
Last Updated August 19, 2013

This guide is intended to provide a brief overview of Oregon's Patient-Centered Primary Care Home (PCPCH) Program criteria for recognition that will be effective January 1, 2014. The technical specifications will be available mid-September 2013.

Please refer to the following definitions when using this document:

Unchanged: The measure was part of the 2011 criteria.
New: This optional measure was added to the 2014 criteria.
(D): Data submission required.

The scoring system for the 2014 PCPCH recognition criteria remains the same. There are 10 must-pass standards that every recognized clinic must meet. The other standards are optional, allowing clinics to accumulate points towards a total that determines their overall tier of PCPCH recognition. A clinic's overall tier of recognition is determined by the following:

Tier 1:	30 – 60 points and all 10 must-pass measures
Tier 2:	65 - 125 points and all 10 must-pass measures
Tier 3:	130 or more points and all 10 must-pass measures

Important Note:
Any clinic applying for PCPCH recognition must review the technical specifications prior to submitting an application. The technical specifications describe each measure in more detail, including what documentation the clinic must have to support their attestation. Clinics must have all services, processes, and policies they attest to in place at the time the PCPCH application is submitted.
The technical specifications for the 2014 criteria will be available mid-September 2013.

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged or New?	Must Pass?	Points Available
CORE ATTRIBUTE 1: ACCESS TO CARE - *"Health care team, be there when we need you."*			
Standard 1.A) In-Person Access			
1.A.1 PCPCH surveys a sample of its population on satisfaction with in-person access to care.	Unchanged	No	5
1.A.2 PCPCH surveys a sample of its population using one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools on patient satisfaction with access to care.	Unchanged	No	10
1.A.3 PCPCH surveys a sample of its population using one of the CAHPS survey tools, and meets a benchmark on patient satisfaction with access to care.	Unchanged	No	15
Standard 1.B) After Hours Access			
1.B.1 PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours.	Unchanged	No	5
Standard 1.C) Telephone and Electronic Access			
1.C.0 PCPCH provides continuous access to clinical advice by telephone.	Unchanged	Yes	0
1.C.1 When patients receive clinical advice via telephone, these telephone encounters (including after-hours encounters) are documented in the patient's medical record.	New	No	5
Standard 1.D) Same Day Access			
1.D.1 PCPCH provides same day appointments.	New	No	5
Standard 1.E) Electronic Access			
1.E.3 Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH provides patients with an electronic copy of their health information upon request.	New	No	15
Standard 1.F) Prescription Refills			
1.F.1 PCPCH tracks the time to completion for prescription refills.	New	No	5
CORE ATTRIBUTE 2: ACCOUNTABILITY - *"Take responsibility for making sure we receive the best possible health care."*			
Standard 2.A) Performance & Clinical Quality			
2.A.0 PCPCH tracks one quality metric from the core or menu set of PCPCH Quality Measures.	Unchanged	Yes	0

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged or New?	Must Pass?	Points Available
2.A.2 PCPCH tracks and reports to the OHA two measures from the core set and one measure from the menu set of PCPCH Quality Measures. (D)	Unchanged	No	10
2.A.3 PCPCH tracks, reports to the OHA and meets benchmarks on two measures from the core set and one measure from the menu set of PCPCH Quality Measures. (D)	Unchanged	No	15
Standard 2.B) Public Reporting			
2.B.1 PCPCH participates in a public reporting program for performance indicators.	New	No	5
2.B.2 Data collected for public reporting programs is shared within the PCPCH (with providers and staff) for improvement purposes.	New	No	10
Standard 2.C) Patient and Family Involvement in Quality Improvement			
2.C.1 PCPCH involves patients, caregivers, and patient-defined families as advisors on at least one quality or safety initiative per year.	New	No	5
2.C.2 PCPCH has established a formal mechanism to integrate patient, caregiver, and patient-defined family advisors as key members of quality, safety, program development and/or educational improvement activities.	New	No	10
2.C.3 Patient, caregiver, and patient-defined family advisors are integrated into the PCPCH and function in peer support or in training roles.	New	No	15
Standard 2.D) Quality Improvement			
2.D.1 PCPCH uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.	New	No	5
2.D.2 PCPCH utilizes improvement teams that are multi-disciplinary and meet regularly to review timely, actionable, team-level data related to their chosen improvement project and documents their progress.	New	No	10
2.D.3 PCPCH has a documented clinic-wide improvement strategy with performance goals derived from community, patient, family, caregiver, and other team feedback, publicly reported measures, and areas for clinical and operational improvement identified by the practice. The strategy includes a quality improvement methodology, multiple improvement related projects, and feedback loops for spread of best practice.	New	No	15

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged or New?	Must Pass?	Points Available
Standard 2.E) Ambulatory Sensitive Utilization			
2.E.1 PCPCH obtains information necessary to track selected utilization measures most relevant to their overall or an at-risk patient population.	New	No	5
2.E.2 PCPCH reports to the OHA selected utilization measures, and sets goals and works to optimize utilization through: monitoring selected measures on a regular basis, and enacting evidence-based strategies to promote appropriate utilization. (D)	New	No	10
2.E.3 PCPCH reports to the OHA selected utilization measures, and shows improvement or meets a benchmark on selected utilization measures. (D)	New	No	15
CORE ATTRIBUTE 3: COMPREHENSIVE WHOLE-PERSON CARE - *"Provide or help us get the health care, information, and services we need."*			
Standard 3.A) Preventive Services			
3.A.1 PCPCH routinely offers or coordinates recommended age and gender appropriate preventive services based on best available evidence.	Unchanged[1]	No	5
3.A.2 PCPCH routinely offers or coordinates recommended age and gender appropriate preventive services, and has an improvement strategy in effect to address gaps in preventive services offerings as appropriate for the PCPCH patient population.	New	No	10
3.A.3 PCPCH routinely offers or coordinates 90% of all recommended age and gender appropriate preventive services.	New	No	15
Standard 3.B) Medical Services			
3.B.0 PCPCH reports that it routinely offers all of the following categories of services: Acute care for minor illnesses and injuries; Ongoing management of chronic diseases including coordination of care; Office-based procedures and diagnostic tests; Patient education and self-management support.	Unchanged	Yes	0
Standard 3.C) Mental Health, Substance Abuse, & Developmental Services (check all that apply)			
3.C.0 PCPCH has a screening strategy for mental health, substance use, or developmental conditions and documents on-site and local referral resources.	Unchanged	Yes	0

[1] The intent of this measure has not changed, but the language has been clarified.

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged or New?	Must Pass?	Points Available
3.C.2 PCPCH has a cooperative referral process with specialty mental health, substance abuse, or developmental providers including a mechanism for co-management as needed.	Unchanged[2]	No	10
3.C.3 PCPCH is co-located either actually or virtually with specialty mental health, substance abuse, or developmental providers.	Unchanged	No	15
Standard 3.D) Comprehensive Health Assessment & Intervention			
3.D.1 PCPCH provides comprehensive health assessment and interventions, when appropriate, for at least three health risk or developmental promotion behaviors.	Unchanged	No	5
Standard 3.E) Preventive Services Reminders			
3.E.1 PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders and to proactively advise patients/families/caregivers and clinicians of needed services.	New	No	5
3.E.2 PCPCH tracks the number of unique patients who were sent appropriate reminders.	New	No	10
3.E.3 Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH sends reminders to patients for preventative/follow-up care.	New	No	15
CORE ATTRIBUTE 4: CONTINUITY - *"Be our partner over time in caring for us."*			
Standard 4.A) Personal Clinician Assigned			
4.A.0 PCPCH reports the percentage of active patients assigned to a personal clinician or team. (D)	Unchanged	Yes	0
4.A.3 PCPCH meets a benchmark in the percentage of active patients assigned to a personal clinician or team. (D)	Unchanged	No	15
Standard 4.B) Personal Clinician Continuity			
4.B.0 PCPCH reports the percent of patient visits with assigned clinician or team. (D)	Unchanged	Yes	0
4.B.2 PCPCH tracks and improves the percent of patient visits with assigned clinician or team. (D)	New	No	10

[2] The intent of this measure has not changed, but the language has been clarified.

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged or New?	Must Pass?	Points Available
4.B.3 PCPCH meets a benchmark in the percent of patient visits with assigned clinician or team. (D)	Unchanged	No	15
Standard 4.C) Organization of Clinical Information			
4.C.0 PCPCH maintains a health record for each patient that contains at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record; and updates this record as needed at each visit.	Unchanged	Yes	0
Standard 4.D) Clinical Information Exchange			
4.D.3 PCPCH shares clinical information electronically in real time with other providers and care entities (electronic health information exchange).	Unchanged	No	15
Standard 4.E) Specialized Care Setting Transitions			
4.E.0 PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care.	Unchanged	Yes	0
Standard 4.F) Planning for Continuity			
4.F.1 PCPCH demonstrates a mechanism to reassign administrative requests, prescription refills, and clinical questions when a provider is not available.	New	No	5
Standard 4.G) Medication Reconciliation			
4.G.1 Upon receipt of a patient from another setting of care or provider of care (transitions of care) the PCPCH performs medication reconciliation.	New	No	5
4.G.2 PCPCH tracks the percentage of patients whose medication regimen is reconciled.	New	No	10
4.G.3 Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH performs medication reconciliation for patients in transition of care.	New	No	15
CORE ATTRIBUTE 5: COORDINATION AND INTEGRATION - *"Help us navigate the health care system to get the care we need in a safe and timely way."*			
Standard 5.A) Population Data Management (check all that apply)			
5.A.1a PCPCH demonstrates the ability to identify, aggregate, and display up-to-date data regarding its patient population.	Unchanged	No	5

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged or New?	Must Pass?	Points Available
5.A.1b PCPCH demonstrates the ability to identify, track and proactively manage the care needs of a sub-population of its patients using up-to-date information.	Unchanged	No	5
Standard 5.B) Electronic Health Record			
5.B.3 PCPCH has a certified electronic health record and the PCPCH practitioners must meet the standards to be "meaningful users" of certified electronic health record technology established by the Centers for Medicare and Medicaid Services.	Unchanged[3]	No	15
Standard 5.C) Complex Care Coordination (check all that apply)			
5.C.1 PCPCH assigns individual responsibility for care coordination and tells each patient or family the name of the team member responsible for coordinating his or her care.	Unchanged	No	5
5.C.2 PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs.	Unchanged	No	10
5.C.3 PCPCH develops an individualized written care plan for patients and families with complex medical or social concerns. This care plan should include at least the following: self management goals; goals of preventive and chronic illness care; and action plan for exacerbations of chronic illness.	Unchanged[4]	No	15
Standard 5.D) Test & Result Tracking			
5.D.1 PCPCH tracks tests ordered by its clinicians and ensures timely and confidential notification or availability of results to patients and families with interpretation, as well as to ordering clinicians.	Unchanged	No	5
Standard 5.E) Referral & Specialty Care Coordination (check all that apply)			
5.E.1 PCPCH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians.	Unchanged[5]	No	5

[3] The intent of this measure has not changed, but the language has been clarified.

[4] This measure was included in the 2011 criteria under Standard 5F; the intent has not changed, but language is clarified and reorganized under 2014 Standard 5.C.

[5] The intent of this measure has not changed, but the language has been clarified.

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged or New?	Must Pass?	Points Available
5.E.2 PCPCH demonstrates active involvement and coordination of care when its patients receive care in specialized settings (hospital, SNF, long term care facility).	Unchanged[6]	No	10
5.E.3 PCPCH tracks referrals and cooperates with community service providers outside the PCPCH, such as dental, educational, social service, foster care, public health, non-traditional health workers and pharmacy services.	Unchanged[7]	No	15
Standard 5.F) End of Life Planning			
5.F.O PCPCH has a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services.	Unchanged	Yes	0
5.F.1 PCPCH has a process to engage patients in end-of-life planning conversations and completes advance directive and other forms such as POLST that reflect patients' wishes for end-of-life care; forms are submitted to available registries (unless patients' opt out).	New	No	5
CORE ATTRIBUTE 6: PERSON AND FAMILY CENTERED CARE - *"Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness."*			
Standard 6.A) Language / Cultural Interpretation			
6.A.0 PCPCH offers and/or uses either providers who speak a patient and family's language at time of service in-person or telephonic trained interpreters to communicate with patients and families in their language of choice.	Unchanged	Yes	0
6.A.1 PCPCH translates written patient materials into all languages spoken by more than 30 households or 5% of the practice's patient population.	New	No	5
Standard 6.B) Education & Self-Management Support			
6.B.1 PCPCH has a process for identifying patient-specific educational resources and providing those resources to patients when appropriate.	Unchanged[8]	No	5
6.B.2 More than 10% of unique patients are provided patient-specific education resources.	New	No	10

[6] This measure was included in the 2011 criteria as measure 5.E.1.b; the intent has not changed, but language is clarified and reorganized as measure 5.E.2.

[7] The intent of this measure has not changed, but the language has been clarified.

[8] The intent of this measure has not changed, but the language has been clarified.

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged or New?	Must Pass?	Points Available
6.B.3 More than 10% of unique patients are provided patient-specific education resources and self-management services.	New	No	15
Standard 6.C) Experience of Care			
6.C.1 PCPCH surveys a sample of its patients and families at least annually on their experience of care. The patient survey must include questions on access to care, provider or health team communication, coordination of care, and staff helpfulness. The recommended patient experience of care survey is one of the CAHPS survey tools.	Unchanged	No	5
6.C.2 PCPCH surveys a sample of its population at least annually on their experience of care using one of the CAHPS survey tools. The patient survey must at least include questions on provider communication, coordination of care, and practice staff helpfulness.	Unchanged[9]	No	10
6.C.3 PCPCH surveys a sample of its population at least annually on their experience of care using one of the CAHPS survey tools and meets benchmarks on the majority of the domains regarding provider communication, coordination of care, and practice staff helpfulness.	Unchanged[10]	No	15
Standard 6.D) Communication of Rights, Roles, and Responsibilities			
6.D.1 PCPCH has a written document or other educational materials that outlines PCPCH and patient/family rights, complaint, and grievance procedures; roles and responsibilities; and has a system to ensure that each patient or family receives this information at the onset of the care relationship.	New	No	5

[9] The intent of this measure has not changed, but the language has been clarified.

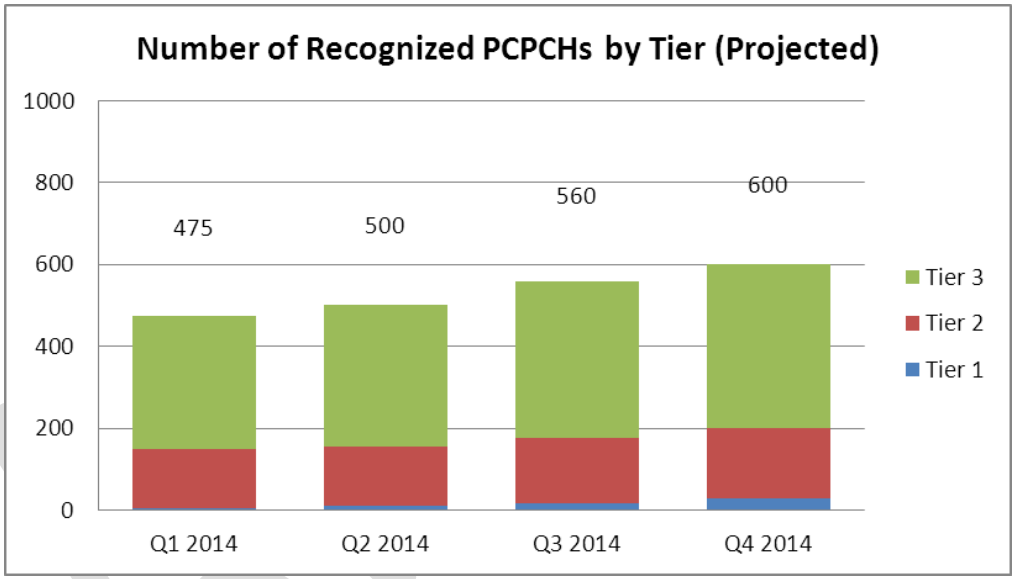
[10] The intent of this measure has not changed, but the language has been clarified.

Oregon Health Authority | PATIENT CENTERED PRIMARY CARE HOME PROGRAM

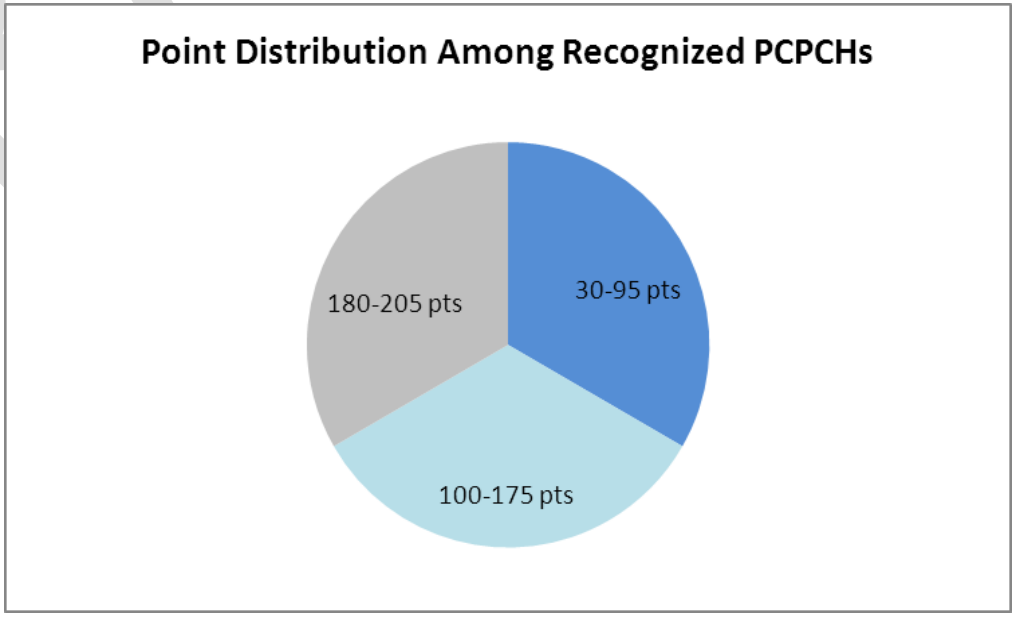
Progress Report – 2014

Characteristics of PCPCHs

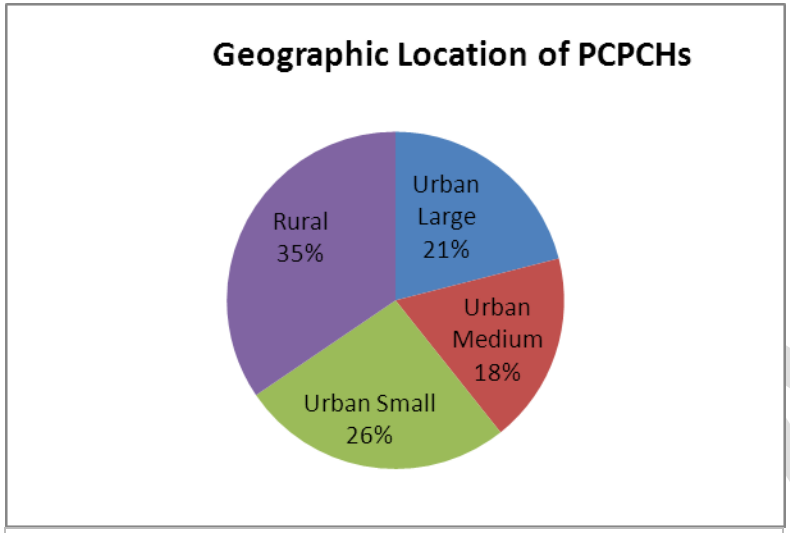
At the end of 2014, there were 600 recognized patient-centered primary care homes (PCPCHs) . Approximately two-thirds of all recognized PCPCHs are recognized at a Tier 3 (the highest) level.



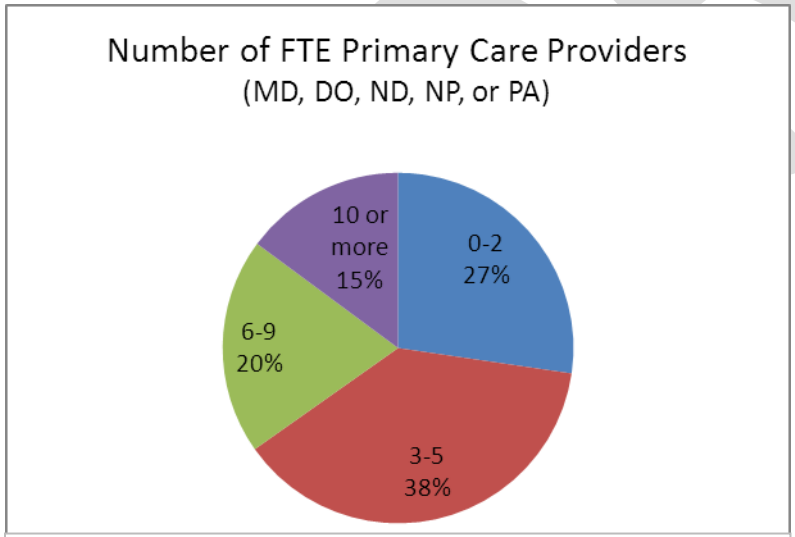
Practices accumulate points toward their overall tier of PCPCH recognition based on standards that they attest to doing at the time of their PCPCH application. In the current PCPCH model, a total of 205 points are possible. Approximately one-third of PCPCHs received between 30 and 95 points; one-third received between 100 and 175 points; one-third received between 180 and 205 points.



PCPCHs are located in a variety of geographic areas.



Source: Report on the Results of the 2012-2013 Supplemental Surveys, August 2013. Sherril B. Gelmon, DrPH and Rachel Trotta, MPH, Portland State University



Source: Report on the Results of the 2012-2013 Supplemental Surveys, August 2013. Sherril B. Gelmon, DrPH and Rachel Trotta, MPH, Portland State University

Urban Large- urbanized areas with a population of greater than 200k

Urban Medium- urbanized areas with a population of 100k to 200k

Urban Small- urbanized areas with a population of 40k to 100k

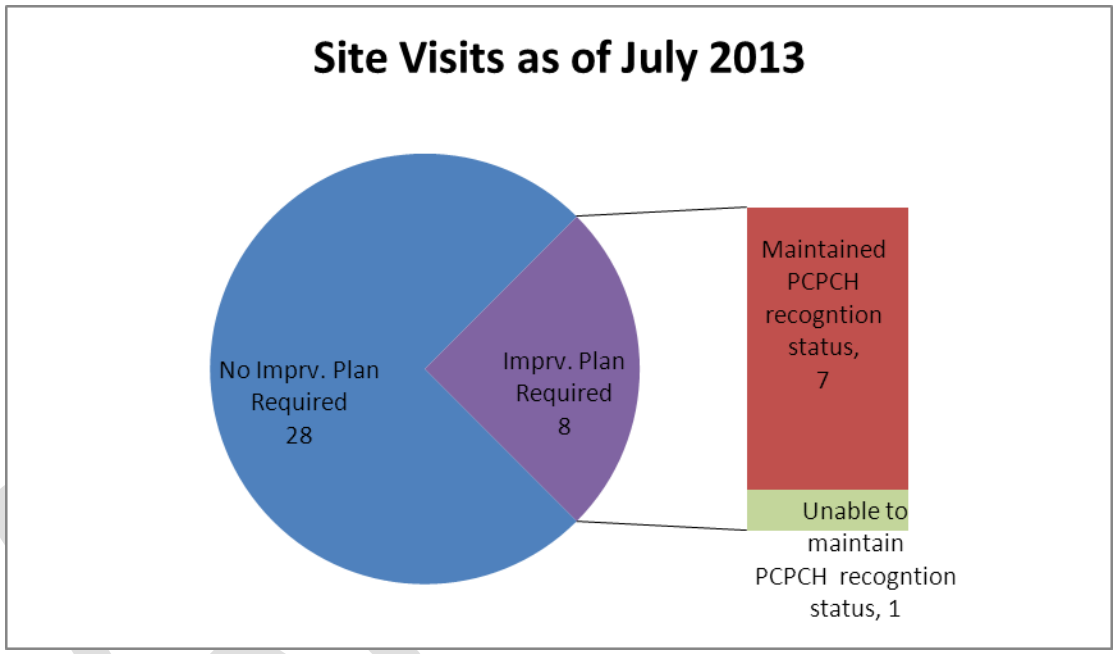
Rural- communities located 10 or more miles from a population center of at least 40k

Frontier- counties with less than 6 people per square mile (No PCPCHs fall into this category)

PCPCHs also varied in size and number of full-time equivalent primary care providers at the practice. The average number of FTE primary care providers in PCPCHs is 5.1 providers with a range of 1 provider to 39 providers.

Site Visit Findings

The PCPCH program uses a self-attestation model for recogntion. This model has the advantage of having a comparatively low administrative burden for clinics applying for recognition. In this model, however, a strong verification program is important. On-site verification visit were designed with three stated goals to align with overal PCPCH program strategies:



1. **Verification** that the clinic practice and patient experience in the practice accurately reflects the Standards and Measures attested to when the clinic was recognized as a PCPCH.

2. **Assessment** of the care delivery and team transformation process in the clinic to understand how integrated the qualities and intent of the PCPCH with regards to teamwork and service are in the practice.

3. **Collaboration** to identify needs/barriers/areas of improvement to help clinics establish improvement plans, and to connect clinics with technical/colleague assistance through the PCPCH Clinical Advisor and the statewide Patient-Centered Primary Care Institute to overcome improvement barriers.

A total of 36 clinics received a site visit by July 2013. These clinics are representative of recognized PCPCHs overall. Out of these 36 clinics, 8 clinics (22%) received improvement plans because they had attested to meeting a must-pass standard that could not be verified or because there were enough PCPCH Standards/Measures that could not be verified to potentially cause them to drop a PCPCH tier level. The improvement plan outlines what the clinic needs to do to meet the measure within 90 days. Out of these 8 clinics with improvement plans in place, 7 provided evidence of improvement that allowed them to maintain their recognition status as a PCPCH.

Positive Findings:

- Site visit tools/protocols were sufficient to verify that clinics were meeting the intent of the standards/measures they attested to but also sufficient to uncover instances where clinics were not meeting standards/measures they attested to. In some instances, site visits found clinics that were meeting standards/measures that they did not attest to.
- A considerable number of clinics reported the PCPCH Standards/Measures provided a framework for improvement that they felt guided their improvement strategies.
- A majority of the clinics had implemented specific access improvements (ie expanded hours, open access scheduling, etc), added new team roles (ie RN Care coordinator, behavioral health provider) and services within the last 2 years.

Areas for Improvement:

- The must-pass standard of having a written agreement with hospitals (Standard 4.E.0) was the most common deficiency leading to an improvement plan.
- Site visits findings demonstrative considerable variability in the robustness of implementation for some standards/measures (listed below) even within a single tier level. These findings reflect that PCPCH clinics can likely be separated into more than three tiers of capability under the current PCPCH Standards/Measures.

  Standards with greatest variability:
  - 1.A – In-Person Access
  - 2.A – Performance and Clinical Quality
  - 3.A – Preventive Services
  - 3.C – Mental Health, Substance Abuse and Developmental Services
  - 4.D – Clinical Information Exchange
  - 5.A – Population Data Management
  - 5.C – Complex Care Coordination
  - 5.E – Referral and Specialty Care Coordination
  - 5.F – End of Life Planning

Utilization and Expenditure Data

In order to better understand the effects of PCPCH recognition on utilization of services and expenditures, the PCPCH program contracted with Portland State University to do an evaluation of the effects. The PSU evaluation team conducted a population level comparison of service utilization and expenditures for individuals attributable to PCPCHs one year prior and one year following PCPCH recognition in relation to individuals attributable to non-PCPCHs over the same time period. The PCPCH group includes individuals attributable to recognized PCPCH practice sites while the control group includes individuals attributable to non-PCPCH recognized sites. The data for the comparison study is APAC medical and pharmacy claims data for calendar years 2010-12. The results are in the tables below. The same two tables will be shown with expenditure data.

Table 1. Utilization - PCPCH group- Change from Pre to Post Years

	Amount		Rate of Change	
	Visits			
Service Type	% Use	Per Individual	% Use	Per Individual
Office Visit (E&M)				
PCP				
BH Specialist				
Other Specialist				
Home Visit				
Immunization				
Amb. Surgery				
Lab				
Radiology				
DME				
Transportation				
Pharmacy				
ED				
Inpatient				
Other Institutional				
Other/Unknown				

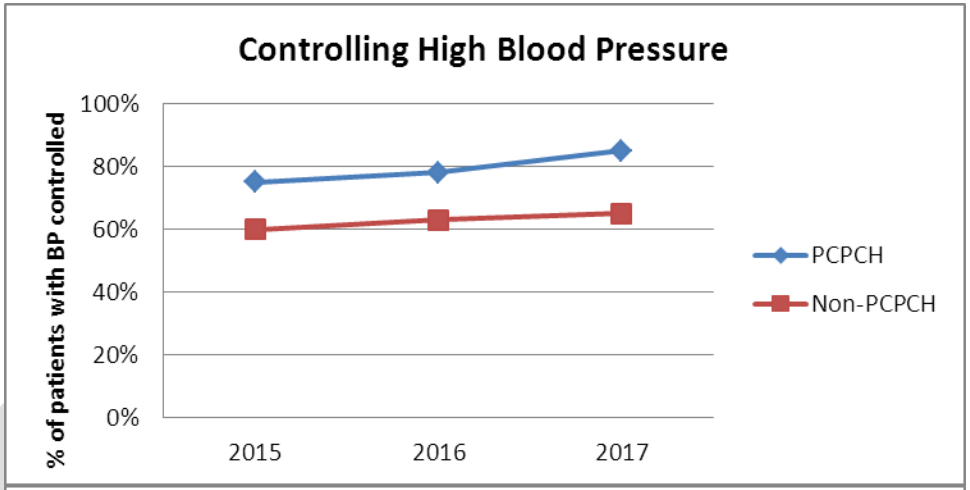
Table 2. Utilization - Difference btwn PCPCH and Control Group

	Amount		Rate of Change	
	Visits			
Service Type	% Use	Per Individual	% Use	Per Individual
Office Visit (E&M)				
PCP				
BH Specialist				
Other Specialist				
Home Visit				
Immunization				
Amb. Surgery				
Lab				
Radiology				
DME				
Transportation				
Pharmacy				
ED				
Inpatient				
Other Institutional				
Other/Unknown				

Clinical Quality Data

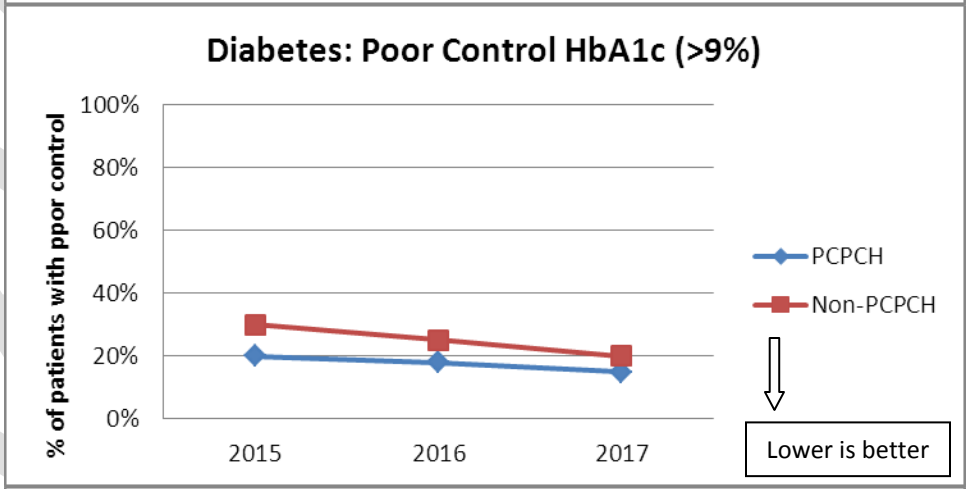
Controlling High Blood Pressure (NQF 0018)

The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.



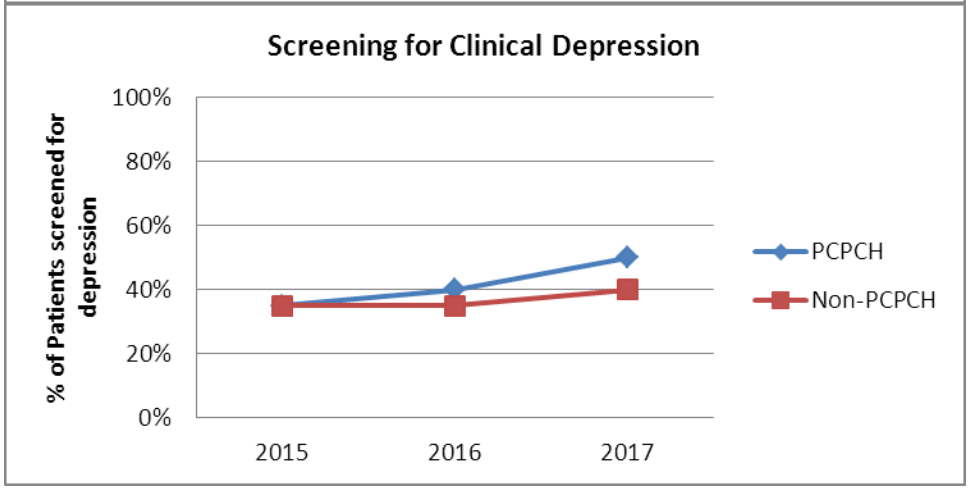
Diabetes: HbA1c Poor Control (>9.0%) (NQF 0059)

The percentage of members 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.



Screening for Clinical Depression (NQF 0418)

Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool and follow up plan documented.



Appendix G
Oregon's Health System Transformation Quarterly Report
November 2013

http://www.oregon.gov/oha/Metrics/Documents/report-november-2013.pdf

Part IV - PCPCH Evaluation Report August 2013
Executive Summary

The Oregon PCPCH recognition is a "self-attestation" model with comparatively low administrative burden for clinics applying, compared to other industry "medical home" recognition standards, such as NCQA. This methodology has likely helped ensure extraordinary participation - over 400 clinics are recognized as Oregon PCPCHs less than 2 years into the life of the program. However, the fidelity of a "self-attestation" model relies upon a strong verification program.

On-site verification visits were designed with 3 stated goals to align with overall PCPCH program strategies:

1. **Verification** that the clinic practice and patient experience in the practice accurately reflects the Standards and Measures attested to when the clinic was recognized as a PCPCH. Additionally, for those clinics that are participating in the Medicaid PCPCH payments for "ACA-qualified" patients, verifying that clinics have evidence of required documentation, care planning, and service performance for the "ACA-qualified" patients.
2. **Assessment** of the care delivery and team transformation process in the clinic to understand how integrated the qualities and intent of the PCPCH with regards to teamwork and service are in the practice.
3. **Collaboration** to identify needs/barriers/areas of improvement to help clinics establish improvement plans, and to connect clinics with technical/colleague assistance through the PCPCH Clinical Advisor and the statewide Patient-Centered Primary Care Institute to overcome improvement barriers.

Summary of Results

Implementation/Fidelity: A total of 36 PCPCH site visits were completed by the end of July, 2013. Eight (8) clinics received "improvement plans" because they had attested to meeting a "must pass" that could not be verified OR because there were enough PCPCH Standards/Measures that could not be verified to potentially cause them to drop a PCPCH Tier level.

Standard 4.E.0 – the "written agreement with hospital" focused on communication around hospital care transitions was the most common deficiency leading to an "improvement plan". The "improvement plan" outlines what the clinic needs to do to meet the measure within 90 days, and by July 31, 2013 four (4) clinics had met their "improvement plans" and implemented this "hospital agreement".

Overall, site visit tools/protocols were found to be sufficient to verify that clinics were meeting the intent of the standards/measures they attested to, but also were sufficient to uncover instances where clinics were not meeting standards/measures they attested to as well as instances where some clinics were actually meeting some standards/measures they did not attest to.

Quality/Cost and Efficiency: A significant number of clinics reported the PCPCH Standards/Measures provided a "framework for improvement" that they felt guided

their improvement strategies. Most PCPCHs were able to demonstrate data improvements for quality measures. A majority of clinics had implemented specific access improvement efforts (ie expanded hours, "open access scheduling"). A majority of clinics had added new team roles (ie RN Care coordinator, Behavioral Health provider) and services within the last 2 years.

Site visit findings also demonstrated significant variability in robustness of implementation for various individual PCPCH Standards/Measures, as well as generally variable team-based care functionality. Although the 3 tier PCPCH structure often did reflect a true measure of robustness of the PCPCH model in practice, there was significant variability in performance capability for the individual PCPCH Standards/Measures in clinics even within a single tier level. The PCPCH Standards demonstrating significant variability included Standards 1A/6C – the "assessment of patient experience" standards, 2A – the "accountability" standard, 3A – the "preventive care" standard, 3C1 and 2 – the measures regarding mental/behavioral/substance abuse/developmental screening and co-management, and several of the Core Attribute 5 "care coordination" measures.

These findings reflect that PCPCH clinics can likely be separated into more than three tiers of capability under the current PCPCH Standards/Measures. The intent and robustness of the individual Standards/Measures could be altered, or TA strengthened to help achieve more robust implementation - as this variability in implementation of the model is likely to reflect in PCPCH cost, quality, and outcome effects overall.

Commonly identified areas of need for concrete technical assistance include:

- Mental/Behavioral Health integration
- Complex/routine care management and care planning
- Data management and utilization in the clinic
- Team-based care/team roles/cultivating a culture of improvement

Patient Experience: Patient interviews were routinely incorporated into the site visit day. Modified CAHPS patient experience questions with additional open-ended questions formed the backbone of the patient "focus group" interviews. Patients were often unfamiliar with the PCPCH concept, though they were overwhelmingly positive about their care and the concepts represented in the PCPCH model. Patients were solicited to identify areas for improvement, but approximately 1/3 of the time no areas for improvement were identified. This suggests that more robust facilitation or probing questions to better assess patient experience and prevent a tendency for patients to provide "positive" answers for Site Visitors may be important for future site visits. Patient participation was variable – from 2-8 patients at each site visit. Some clinics suggested the PCPCH program should provide "material recognition" of patient time and input to minimize patient burden and encourage participation.

Provider Experience: Clinics were provided an opportunity to offer feedback and suggestions about how to make the site visit process better during the site visit "wrap up" meeting, and via post-visit survey. By the end of July 2013, 26 surveys

had been sent and 10 returned. 90% of responding clinics felt the information in the site visit reports was "helpful/good" (6) or "very helpful/great (3). Two-thirds of the respondents felt the OHA site visitors were "very courteous, knowledgeable, and professional". The turnaround time for site visit reports was noted to be slow. Some clinics complained it was a burden to remove clinicians from patient care for the site visit interview timeslots.

Other key findings regarding provider experience with the PCPCH model and program include:

1. Lack of resources (financial/staff/time) under current payment/reimbursement models was unanimously identified by clinics as a primary barrier to continued transformation and sustainability.
2. Difficulty with communication between sub-specialists/hospitals and the PCPCH and difficulty with EHR data management were recurrently identified as key barriers to improving patient care, coordination, and outcomes.
3. Clinics had significant difficulty understanding and implementing the required documentation, service, and reporting requirements for the Medicaid ACA-Qualified payment program for PCPCHs. TA was provided during site visits to aid the understanding and accurate implementation of documentation and processes necessary. Some clinics that had submitted "ACA-qualified" lists for payment expressed concern about the timeliness and accuracy of payments.
4. Some clinics felt communication from the OHA regarding PCPCH, particularly in relation to other health reform efforts (CCOs, Medicaid payments for primary care), was insufficient and at times confusing.
5. Clinics felt the TA provided at the site visits was valuable to better understand the intent of various PCPCH Standards/Measures – particularly when the "Clinical Advisor" was included to provide a more thorough assessment, consultation, and connection to TA resources.
6. Desire for mentorship connections ("someone like us who has done this") and other specific TA needs was high. Most clinics did not feel they had adequate access to or knowledge of these resources. Some clinics requested TA be included in follow up plans after the site visits.

Summary of Key Recommendations

1. Expand site visit capacity to allow visits to each Oregon PCPCH every 3 years.
2. Take steps to complete site visit reports and send them to clinics in a more timely manner.
3. Implement strategies to use the insight gained at site visits as a springboard for improvement at those clinics.
4. Incorporate PCPCH-experienced clinicians as "consultants" at each site visit – to provide a robust assessment and "mentorship" collaboration with clinics, and foster meeting goals identified during site visits

5. Consider strategy modification for patient interview and assessment of patient experience - including materially valuing patient time and input, and incorporating a trained “peer” patient interviewer at each site visit.
6. Use all methods available to ensure sustainable financing of nascent PCPCH innovation by fostering administratively simple, sustainable levels of funding across the OHA and other payers to support provision of a robust PCPCH model of care for all Oregonians.

Appendix I
Patient-Centered Primary Care Home 2012–2013 Survey, Executive Summary

http:www.oregon.gov/oha/OHPR/SIM/docs/Appendix I PCPCHSurvey2013ExecSummary.pdf

State of Oregon
Quarterly Report Work Breakdown Structure
October 1, 2013 -December 31, 2013

Work Breakdown Structure			
Category	**Time**	**Description**	**Expenditure**
Salary	October-December	Transformation Center	$ 172,051.79
Salary	October-December	Analytics and Evaluation	$ 47,549.50
Salary	October-December	Equity and Inclusion	$ 31,044.64
Salary	October-December	Long Term Care	$ 38,527.61
Salary	October-December	PCPCH	$ 4,996.29
Salary	October-December	Duals	$ 12,395.00
Salary	October-December	Public Health	$ 66,859.00
Salary	October-December	Early Learning Council	$ 9,391.41
Salary	October-December	Grant Management	$ 90,876.44
Total Salary	October-December	All above	$ 473,691.68
Fringe	October-December	All above	$ 183,469.03
Travel	October-December	Transformation Center, Grants Management, Analytics and Evaluation, Equity and Inclusion, PCPCH, Public Health	$ 16,566.56
Equipment	October-December	NA	$ -
Supplies	October-December	Grants Management, Long Term Care, Transformation Center, OHIT	$ 19,667.54
Contractual	October-December	Transformation Center, Health Analytics, Long Term Care, HERC, OHIT, PCPCH	$ 963,270.74
Other	October-December	Grants Management, Transformation Center, Duals, Equity and Inclusion, OHIT, PCPCH, Public Health	$ 289,388.88
Total Direct	October-December	NA	$ 1,946,054.43
Cost Allocation	October-December	NA	$ 266,400.94
Total	October-December	NA	**$ 2,212,455.37**