Oregon's State Innovation Model Project
Progress Report
April 1, 2014–June 30, 2014

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Introduction

Great strides have been taken this quarter by Oregon Health Authority (OHA). The implementation of the Affordable Care Act and Oregon Medicaid expansion has resulted in 357,500 additional Oregonians enrolled in coordinated care organizations (CCOs) since January 1, 2014, for a total of 971,000 Medicaid enrollees (25% of the population of Oregon). Oregon has been successful in offering the coordinated care model to the dually eligible with 55% of dually eligible persons currently enrolled in a CCO. With almost 80% of Oregon providers seeing Medicaid members, coupled with increased enrollment through the exchange of another 93,698 members, the State Innovation Model support has forged new progress in Oregon's health system transformation efforts. Our first year of metrics is complete for the new CCOs in Medicaid demonstrating improvements in the delivery system as we take on broad systems change to achieve the triple aim. This quarterly report summarizes the exciting work underway made possible by State Model Innovation investments.

Highlighted Accomplishments
April - June 2014

Oregon transformation efforts supported by SIM resources gained additional momentum during this third quarter of demonstration period one, fueling the spread of the coordinated care model from the Medicaid population to other payers and populations more quickly and effectively. Significant accomplishments from the third quarter include the following:

- **Oregon Health System Transformation Performance Report**
  The fourth report on how Oregon's coordinated care organizations (CCOs) performed on quality measures was published on June 24. This is the first report to show a full year (2013) of performance data, and the results triggered the first incentive payment – payments for improvements in care, not just the quantity or types of services – to CCOs. All CCOs showed improvements on some measures and 11 out of 15 met 100 percent of their improvement targets. In aggregate, the 2013 data showed significant improvements in these areas:
    - Decreased emergency department visits and emergency department spending
    - Increased primary care utilization and spending, as well as increased enrollment of CCO members in patient-centered primary care homes
    - Increased rates of developmental screenings during the first 36 months of life
    - Decreased hospitalizations for chronic conditions
    - Increased adoption of electronic health records

  In addition, CCOs continue to hold down costs. Oregon is staying within the capped rate of growth for Medicaid spending to meet its commitment to Centers for Medicare and Medicaid Services. See Appendix 1 for the full report.

- **Public Employees' Benefit Board (PEBB)**
  As the purchaser of health care benefits for more than 130,000 Oregonians, the Public Employees' Benefit Board (PEBB) uses its buying power to get the best health care

available from health plans that serve its members. PEBB designed the 2015 benefit year RFP and resulting contracts in alignment with the coordinated care model. The contracted health plans are being held accountable for not just the way they provide care, but also to offer more ways for members to improve their health, seek new ways for members and providers to work together to achieve better health outcomes at lower costs, and to support primary care homes that can enhance care coordination for members.

PEBB recently finished negotiating and executing new contracts for health plans available beginning in 2015. The new plans include two CCOs as well as two other insurers closely involved with CCOs. Plans will report baseline data on a standard set of quality measures (developed by the HB 2118 metrics alignment work group described elsewhere in this report) in 2015 and penalties/bonuses will be attached to performance in 2016. More than 95% of PEBB members will have a choice of two or more plans.

- **Health information technology development**.
  The Emergency Department Information Exchange (EDIE), a partnership with the Oregon Health Leadership Council that is supported by SIM funds, continues to progress. As of May 1, 76 percent of Oregon emergency departments have begun the information technology integration progress, and 32 percent have live feeds. The EDIE Governance and Operations Committee has met five times through this quarter and presented a proposal to the Oregon Health Leadership Council and CCOs to support ongoing costs through a shared utility model.

SIM Accomplishments by Driver

Driver 1: Improving care coordination at all points in the system, with an emphasis on patient-centered primary care

Establishing and supporting patient-centered primary care homes

In the third quarter of SIM Demonstration Year 1, six additional clinics were recognized as patient-centered primary care homes (PCPCHs). As of this quarter, we have 501 recognized PCPCHs which exceed our 2014 target, and meet our 2015 benchmark. Which as noted above, the final 2013 data show a clear increase in the proportion of CCO members enrolled in PCPCHs over 2011.

The focus of PCPCH activity during this quarter was on expanding capacity for and providing technical assistance to practices to improve care delivery. With SIM grant support, technical assistance to clinics is being provided through the Patient-Centered Primary Care Institute (PCPCI), housed under our multi-stakeholder partner, the Oregon Health Care Quality Corporation. Technical assistance provided by the institute during this period included a webinar on using patient experience of care surveys (31 attendees) and a day-long expert learning event where more than 60 quality improvement, technical assistance and primary care home experts from over 30 organizations in Oregon convened to network, share tools and resources and brainstorm solutions to primary care transformation challenges.

Oregon has information on twenty of the practices currently participating in learning collaboratives. Those practices include over 280 providers (including MD/DO/ND, PAs, NPs and RNs) and over 115,000 patients. PCPCI did not host any learning collaboratives between April and June but did solicit and review applications for the following four new learning collaboratives that will begin in summer 2014 and last through May 2015:

- *Improving Patient Experience of Care (two collaboratives):* includes the implementation of a patient experience of care survey, patient engagement methods and design of quality improvement projects in a way that addresses multiple PCPCH standards. This collaborative includes the practice-level fielding of the clinician and group Consumer Assessment of Healthcare Providers and Systems survey.
- *Improving Access through PCPCH*: includes understanding practice supply and demand and how to move to an Open Access scheduling model. The collaborative will be tailored to support particular access needs related to absorbing many new patients, creating more same day capacity, reducing backlog and utilizing all team members in non-face-to-face visits. Please note this collaborative provides a practice coach-in-training component – this is ideal for multi-site practices who want to spread learning from this collaborative to other clinics.
- *The Patient-Centered Communication Skills, Behaviors and Attitudes Collaborative*: includes embedding the spirit of patient-centered communication in organizational culture, identifying ways to measure patient-centeredness, mastery of basic patient-centered office skills, cultural agility, health literacy and self-management support.

SIM support also enabled the PCPCH program to hire two positions this quarter; one person started in May 2014 while the other person will be starting in August 2014. Both positions will allow the program to expand capacity to conduct site visits and provide additional technical assistance to clinics.

The PCPCH program has an ongoing partnership with researchers at Portland State University (PSU) to evaluate various aspects of the program. Although the initial baseline evaluation work was not supported by SIM grant dollars in the early part of 2014, ongoing evaluation work will be supported by the SIM grant moving forward. This past quarter, PSU researchers developed a method that distills many data elements collected through the PCPCH recognition process and other means into a straightforward, easily reported score across the six core PCPCH attributes. The resulting index scores allow stakeholders to compare performance results across similar practices and across the core attributes of the PCPCH model. Recognized practices can also use the index score to track their own performance and progress with implementation of the PCPCH model and compare their progress to that of similar practices in Oregon.

HIT and HIE tools for care coordination

Oregon's significant progress in implementing the Emergency Department Information Exchange (EDIE) is described under Highlighted Accomplishments. EDIE is a technology that allows emergency department clinicians to identify patients who visit the emergency room more than five times in a 12-month period and patients with complex care needs so these patients can

be directed to the right care setting. EDIE alerts hospitals in real time when a patient is visiting the emergency room.

OHA continued to develop Oregon's HIT/HIE Phase 1.5 services, making significant progress in stakeholder engagement and planning. The Health Information Technology Advisory Group met three times during this quarter and the Health Information Technology Oversight Council held its quarterly meeting in June. OHA has also conducted three meetings with the Provider Directory Subject Matter Experts Work Group to provide guidance on scope, functions and parameters of a state-level provider directory. This input will inform the scope of work for an RFP for the state-level provider directory. Finally, OHA completed, revised and submitted its Implementation Advanced Planning Document for Phase 1.5 technology funding to CMS in June.

OHA's pilot for a statewide Flat File HIE provider directory will give Oregon organizations participating in DirectTrust access to addresses of other Direct secure messaging users. OHA is in the process of finalizing participation agreements between external pilot participants. The directory is scheduled to go live July 2014.

As reported previously, OHA is seeking a partnership with the Office of Rural Health at Oregon Health & Sciences University (OHSU) to administer telehealth pilots, leveraging OHSU's experience in rural health. OHA has met with OHSU and is currently developing a statement of work and agreement.

Coordinating medical services and long-term services and supports (LTSS)

Aligning long-term care work with social services and behavioral health is a critical component of coordinating care and achieving the triple aim. As CMMI is aware, SIM resources support three of the seven Long-Term Services and Supports (LTSS) Innovator Agents whose job is to maximize this alignment. The focus of the LTSS Innovator Agents this quarter was on developing and completing memoranda of agreement covering five required domains[1] of shared activity between LTSS offices and CCOs. (Some agreements contain additional optional domains of activity.) In the first iteration of these annual agreements, there were 29 individual agreements. With the assistance of the LTSS Innovator Agents to support a more regional approach, the number of individual agreements has been reduced to 18 for the current renewal. This accomplishment demonstrates a significant administrative efficiency. All but three of the 18 memoranda of understanding should be in place by the end of this quarter.

[1] The five required domains are:

1. Prioritization of high needs members
2. Development of individualized care plans
3. Transitional care practices
4. Member engagement and preferences
5. Establishing member care teams

Driver 2: Paying for value and improved outcomes

Two accomplishments in this area were noted above in the highlights section:

- In June, CCOs received their first payments for improving performance or achieving performance benchmarks on 17 measures of quality, access and patient experience of care. Over time, an increasing portion of CCO reimbursement will be performance based.
- PEBB contracts executed in June for the 2015 and 2016 plan years include clear provisions for quality reporting and performance bonuses or penalties. In addition, PEBB is legislatively required to keep its spending within a fixed rate of growth similar to the rate Oregon has committed to achieving in Medicaid and will echo this requirement in contracts.

Working under a SIM-supported contract, the Center for Evidence-based Practice continued this quarter to solicit feedback on payment reform options from Oregon's health transformation stakeholders. The center conducted an evidence review of the effectiveness of alternative payment methods as well as interviews with 18 thought leaders across Oregon. Please see Appendix 2 for an overview of this work, and Appendix 3 for a presentation on preliminary findings.

As noted in past reports, the Oregon Health Policy Board's 2013 recommendations to the Governor included a proposal to develop a methodology for establishing a health care cost growth benchmark for health entities and health plan premiums. A stakeholder work group with representatives from multiple payers and health care sectors was formed to accomplish this task and had its first meeting in May 2014. The group's charter, roster and initial meeting materials are available online: http://www.oregon.gov/oha/Pages/srg.aspx

Driver 3: Integrating care across silos and with community health improvement

Behavioral health integration

In May the Transformation Center started a focused effort to document and understand activities related to behavioral health integration in Oregon. This work includes discussions with OHA leadership about state-supported projects; listening at town hall meetings throughout the state hosted by Addictions and Mental Health; and thanks to SIM support, conducting an environmental scan of current providers and developing a statewide behavioral health strategic plan. The Transformation Center has contracted with Oregon Health & Science University under the direction of Dr. Deborah Cohen, Associate Professor, and Family Medicine Research Department, to conduct a scan of behavioral health integration in the state of Oregon. This work began in June and will continue through February of 2015. Interviews will focus on CCOs but also involve health systems, practices and community mental health services associated with CCOs. The research questions that frame this work are:

- What is currently being done to integrate behavioral health into CCO's?
- What is the CCO vision for behavioral health integration?
- What are the current strengths and weaknesses of behavioral health integration in the CCOs?

- What are the current opportunities for enhancing behavioral health integration in the CCOs?
- What are the current barriers to integrating behavioral health integration in the CCOs?
- What technical assistance is needed for those delivering the care or would they find beneficial to furthering their efforts?

In addition, the Transformation Center engaged the services of Dan Reece, MSW, LCSW, to support the development of a statewide behavioral health strategic plan to provide technical assistance to CCOs. This plan will inform the Transformation Center's technical assistance offerings to CCOs in the next project period to facilitate a smooth integration process.

Integrating housing with services

With SIM funding, Oregon is supporting evaluation of a pilot project designed to deliver medical and long-term services and supports to single adults living in multiple low-income housing units. Thanks to SIM support, the limited liability corporation forming the Housing with Services consortium was officially launched through the completed negotiation of an agreement, signing and legal filing. Nine organizations including housing, mental health, CCO constituent (Care Oregon), LTSS provider and social service organizations are partners making capital contributions to the project. Most of the infrastructure building in terms of the hardware, software, insurance, accounting and other tools to support program administration are in place, and Housing with Services has completed the development of the Health & Wellness Center. Services are due to start this upcoming summer 2014 in several of the units, and the rest over subsequent months. Timing is based on extensive efforts to work with the partners for ongoing sustainability of the project after SIM funding ends.

Community health integration

Thanks to SIM support, the Public Health Division is finalizing an analysis that will present 31 public health indicators (disease rates, health behaviors, etc.) by CCO and by race and ethnicity. These data will support CCOs as they begin implementing their community health improvement plans. Staff are beginning a review process with stakeholders before posting the results online.

Two other SIM-supported initiatives to make population health data more accessible made progress this quarter:

- A contract was fully executed for a CCO member Behavioral Risk Factor Surveillance Survey. The survey will be fielded in English, Spanish, Russian and Vietnamese starting in July and will provide key data about CCO members' health status and health risk behaviors.
- In April, the Public Health Division released version 2.2 of the Oregon Public Health Assessment Tool, which includes a redesigned, more user-friendly interface and updated mortality data. Infant mortality data were updated in June. In addition, Public Health Division staff are promoting the tool to local public health authorities and other users.

Recently the Public Health Division offered additional, non-SIM funding to the SIM-supported Regional Health Equity Coalitions (RHECs) to support chronic disease related activities, if chronic disease prevention deliverables were in alignment with their current goals and priorities.

Deliverables associated with this additional funding required that RHECs: include public health chronic disease data in needs assessments; attend the Place Matters conference; contribute at least one social media post to two statewide media campaigns (for example, tobacco-industry denormalization and Place Matters Oregon); and develop a chronic disease specific work plan. Two of the three coalitions in cohort 2 accepted this additional non-SIM funding of $50,000 for a total budget of $180,000/RHEC. Contracts are now in the process of being amended to include the additional deliverables and funding. This integrates community health efforts with efforts towards health equity.

OHA Transformation Center leaders recently met with leadership at the Federal Reserve Bank of San Francisco, which is working to promote financial institutions' investment in community health initiatives across the country. In Oregon, they are interested in helping support the integration of social determinants of health, such as housing, within CCOs. Federal Reserve Bank representatives will be overseeing a panel at an upcoming event on creative strategies that can be used to support this work, such as social impact bonds.

Improving health equity in health care and community settings

The SIM-supported Regional Health Equity Coalitions (RHECs) continued their coalition-building work this spring with a statewide meeting. In addition to all RHECs having representation at this meeting, there were also CCO Innovator Agents, Long-Term Services and Supports Innovator Agents, CCO community advisory council members, CCO staff members, community health workers, other OHA staff, evaluators and a consultant from FSG (a nonprofit consulting firm specializing in strategy, evaluation and research) who conducted a session on collective impact and evaluation. Forty-two people attended the first day and 36 attended the second day of the event. For more information on each of the sessions, see Appendix 4.

Evaluation of the cohort 2 RHECs began this quarter with a round of site visits to each of the coalitions. See the Substantive Findings section for details on these visits.

Oregon's Developing Equity Leadership through Training and Action (DELTA) initiative builds the capacity and commitment of health leaders to eliminate health disparities. Between April and June, DELTA participants received training sessions focused on the following topics: Effective Community Engagement; Transformational Communication: Tools for Cross-Cultural Understanding and Inclusion; and Health Literacy and Language Access. After each session, cohort participants are expected to complete individual training evaluations; two evaluation summaries have been compiled and are presented in Appendix 5.

The DELTA Advisory Committee met once during this quarter to review the progress of the current cohort, review content for upcoming sessions, review evaluation results of the previous cohorts and plan to build the alumni network for current and subsequent cohorts.

Driver 4: Standards for safe and effective care

Translating evidence to practice: Health Evidence Review Commission (HERC)
SIM funding continues to support the work of the OHSU Center for Evidence-based Policy toward its assessment and recommendations for improving the Health Evidence Review Commission's clinical evidence synthesis and translation work to aid the spread of the coordinated care model. During this period the center conducted three facilitated discussions with stakeholder groups representing CCOs, the state's Transformation Center and the commercial health plans making up the Oregon Health Leadership Council. In addition, the center reported on the preliminary findings at the HERC meeting in June and received additional feedback which will be used in completing their report. Results will be shared with OHA leadership and the HERC in the next quarter.

Further discussions were held between OHA, including the Transformation Center and the agency's Chief Medical Officer, and the Center for Evidence-based Policy to further refine the scope of the translational products portion of the SIM grant investment. Focused discussions with CCO and other health plan medical directors will be included as the center gathers the best evidence on translation efforts, tools useful to the provider networks and with their patients in using the evidence-based guidelines of the HERC, and in alignment with *Choosing Wisely* and other national efforts.

Shared accountability between medical and long-term services and supports settings
Shared accountability for performance on specific measures that reflect coordination of care between medical and LTSS settings is another strategy that Oregon is pursuing under this driver. Work continues to identify and refine measurement options; this quarter, the Shared Accountability subcommittee made a presentation to OHA's Metrics & Scoring Committee about the possibility of including LTSS-related metrics among the CCO incentive measure set. Technical assistance from CMS supported by the SIM grant is being sought.

Aligning standards and metrics across payers
Two accomplishments from this past quarter signal Oregon plans' and payers' commitment to performance measurement and to adopting an increasingly consistent set of metrics that align with the triple aim:

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

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

Driver 5: Testing and accelerating spread of the model

Council of Clinical Innovators

The Oregon Council of Clinical Innovators steering committee, staffed by the Transformation Center, selected and announced thirteen Clinical Innovators, (see Appendix 6 for a list of members). The steering committee is also in process of recruiting an oral health Clinical Innovator and faculty members to mentor and advise the cohort. The Council of Clinical Innovators is a statewide, multidisciplinary cadre of innovation leaders, consultants and mentors who are actively working with project teams to implement health care transformation projects in their local communities. Through their innovation projects and participation in a year-long learning experience, this select group of Clinical Innovators will develop and refine skills in leadership, quality improvement, implementation, and dissemination science to create a network of expertise supporting the Oregon coordinated care model. This pilot cohort of Clinical Innovators will participate in a year-long program from July 2014 to June 2015, beginning with the first in-person meeting July 24-25, 2014.

Learning collaboratives, training and resources to support and fuel transformation

Thanks to SIM support, the Transformation Center hosted learning collaborative activities for each of its four collaboratives during this period: 1) statewide learning collaborative for the Quality and Health Outcomes Committee (QHOC), 2) CCO community advisory council (CAC) learning collaborative, whose members include consumers and community partners including some local public health agencies; 3) Complex Care Collaborative, whose members include multiple provider disciplines; and 4) the Innovator Agents' learning collaborative. Highlights are provided below.

- The QHOC learning collaborative facilitated three sessions in this period:
  - A metrics retreat in which participants reviewed and discussed 2014 specifications for the CCO incentive measures and prioritized which measures to address in the learning collaborative
  - A session focused on colorectal cancer screening; and
  - A session featuring the SIM-supported public health community prevention projects in four communities, during which the group discussed ways CCOs can engage with public health.
- Community advisory council (CAC) learning community meetings were held each month. Topics for these meetings included community health improvement planning (by statute, community health improvement plans are a CAC deliverable and due June 30), language access and health equity. In addition, the community advisory council steering

committee met regularly each month. Their work involved supporting the development and planning of the 2014 CAC Summit and planning the CAC learning community monthly learning topics.

- On May 29-30, 2014, the statewide CAC Summit: Communities in Action was held in Eugene, Oregon. The conference included updates from Oregon Health Authority leaders, CACs sharing about their work, networking, breakout sessions and a panel of foundation funders. There were a total of 151 attendees, which included 116 CAC members and representatives representing all CCOs. Overall, a high majority of participants reported that they found the summit valuable. Many have requested more opportunities to gather and receive technical assistance. See Appendix 7 for the agenda.
- The Transformation Center hosted a day-long, well attended and received Complex Care Collaborative meeting April 29, 2014. This learning collaborative included 122 CCO leaders, clinical practice leaders and staff working to improve health outcomes for Oregonians who require complex care. See Appendix 8 for the agenda.
- The Innovator Agents learning collaborative activities focused on working with consultant Paul Krissel, an expert on the "people side" of change, to identify strategies to support transformation internal to OHA. The Innovator Agents also participated in webinars on trauma-informed care; adverse childhood experiences (ACEs) and resiliency with Elaine Walters of the Trauma Healing Project in Eugene. Ms. Walters and the Innovator Agents discussed trends in wellness that point to the potential for trauma survivors to be aided in healing by an adaptation of relationship-based care at the clinic and community level.

Also this quarter, the Transformation Center sponsored a three-day Improvement Science in Action training by the Institute for Healthcare Improvement. Over 120 CCO Transformation Fund Portfolio Managers, Quality improvement managers and their project teams gained strong skills in quality improvement concepts, tools, techniques and methods. This framework was designed to assist CCOs and their partners in organizing and implementing improvement projects and spreading the change throughout the region. See Appendix 9 for the agenda.

Data and analytic tools to support transformation

In addition to the CCO performance report described under highlighted accomplishments, OHA produced a second multi-payer dashboard in June 2014 with support from SIM resources. The dashboard provides data on health care cost and utilization, health insurance coverage, and quality of and access to care across markets including commercial insurance carriers, Medicare and Medicaid. Data for the dashboard came from the All Payers/All Claims database, Oregon Health Insurance Survey and Oregon Hospital Discharge. Trends will be tracked over time and new data sources and lines of business will be added as they become available. The multi-payer dashboard was presented to the Oregon Health Policy Board at their June meeting and is available online here: http://www.oregon.gov/oha/OHPR/RSCH/Pages/dashboards.aspx.

Thanks to SIM support, OHA has published the final 2013 performance report on the incentive and state performance measures for Medicaid. This report shows the first full year of CCO data and compares performance of CCOs to the baseline year 2011. The report also includes the first

annual quality pool payments to CCOs based on improvement toward goals on the 17 incentive measures.

OHA executed a contract with a vendor to build automated CCO metric reporting through CCO and leadership dashboards. Development of this new measurement and reporting system is underway with an anticipated initial report in August 2014.

OHA, with the assistance of the SIM Project Officer and CMMI staff, is working with the Centers for Medicare & Medicaid Services to acquire Oregon's Medicare data set to be included in the All Payers/All Claims database. This will help develop a full picture of the health care delivery system in Oregon and assist our evaluation of the coordinated care model and its impacts. Oregon will begin receiving the data in the next quarter.

As noted in past reports, the Oregon Health Policy Board's 2013 recommendations to the Governor included a proposal to develop a methodology for establishing a health care cost growth benchmark for health entities and health plan premiums. A stakeholder work group with representatives from multiple payers and health care sectors was formed to accomplish this task and had its first meeting in May 2014. The group's charter, roster and initial meeting materials are available online: http://www.oregon.gov/oha/Pages/srg.aspx

Also thanks to SIM support, OHA initiated two contracts and one RFP in this quarter that will support capacity for performance measurement, analysis and transparency:

- Michael Bailit will provide expert consultation on: health system performance measurement and metrics development; development and implementation of health care alternative payment methods (alternatives to fee-for-service payment mechanisms), including incentive payments tied to performance on quality metrics; and tools and strategies to help more purchasers adopt elements of the state's health system transformation initiatives.
- A second contract will provide data layout consulting to enhance OHA's capacity to display and present data clearly and accurately for a range of purposes that could include, but may not be limited to: CCO monthly reports, Oregon Health Policy Board dashboard reports, survey reports, data briefs and presentations.
- An RFP is in development for a contractor to develop a webpage and analysis tools to display various data sets and metrics from multiple sources. The end result should be an interactive site that allows end users to analyze and organize the data and metrics for reporting purposes.

Planned Activities for the Next Quarter and Likelihood of Achievement

Our operational plan outlines the specific activities planned for next quarter. Some key highlights are noted here.

Driver 1: Improving care coordination at all points in the system, with an emphasis on patient-centered primary care

Establishing and supporting patient-centered primary care homes

Due to a number of factors, including loss of key PCPCH program staff and an enhanced focus on certification, clinical site visits and online application activities, these two milestones were not completed in the current reporting time period. These milestones will be completed in the next reporting period instead.

- Implement revised PCPCH payment strategy for fee-for-service Medicaid clients
- Develop annual PCPCH program report

The payment strategy for fee-for-service Medicaid clients has been submitted for consideration by the agency as it develops its budget request for the next biennium. Whether it is included will be known by next quarter. The agency request budget then moves to the Governor's Office for consideration as it finalizes the Governor's Recommended Budget later in the fall.

HIT and HIE tools for care coordination

Health information technology-related activities continue in the next period and will be on track for its role in supporting the coordinated care model. OHA plans to meet with Oregon Health & Sciences University to finalize a contract for the university to administer the tele-health pilot during the next quarter. In July, the Governance and Operations Committee Council will present a business plan for a public-private partnership using shared utility model to the Oregon Health Leadership Council and CCOs. The Flat File Directory is anticipated to go live in July 2014. OHA will begin procurement for Phase 1.5 services, including the Provider Directory. The Health Information Technology Oversight Council and Advisory Group will continue to meet and provide guidance to OHA.

Coordinating medical services and long-term services and supports (LTSS)

In the fourth quarter, implementation of the Housing with Services pilot project will continue and Long-Term Services and Supports Innovator Agents will focus on supporting processes outlined in the memoranda of understanding between CCOs and long-term care agencies. The LTSS Innovator Agents will also work with the CCO Innovator Agents to complete a document describing the roles, responsibilities and lines of communication for each set of Innovator Agents. Shared accountability work will continue with monthly internal staff meetings and rescheduling a meeting with OHA-DHS Joint Policy group to discuss the project plan and seek technical assistance on LTSS metrics.

The Medicare/Medicaid Dually Eligible analyst will be hired during this period. The incumbent will be oriented to the work conducted to date and develop a work plan to accomplish the SIM

deliverables. OHA leadership recently met to ensure this effort continues and discussed how the agency can support cross-agency collaboration efforts for success.

Driver 2: Paying for value and improved outcomes

The Center for Evidence-based Practice's work to solicit feedback on payment reform options from Oregon's health transformation stakeholders is scheduled to wrap up in fall 2014. Findings from the evidence review, interviews and stakeholder feedback will be summarized in a final report to OHA. The final report will also include findings, models, tools and strategies for use in payment reform.

The center will also be completing the final report on the Health Evidence Review Commission based on interviews and stakeholder feedback, with recommendations for steps OHA and the commission can take to improve the commission's clinical evidence synthesis and translation work to help spread the coordinated care model. First steps on the translational tools for providers and patients will also be underway.

Also in the next quarter, OHSU's Center for Health Systems Effectiveness is hosting a one-day conference focused on health care payment reform initiatives in Oregon. OHA staff have participated in planning the event and will use the opportunity to connect with a variety of payers to align payment reform efforts.

The multi-payer Sustainable Healthcare Expenditures Work Group will continue meeting to develop a methodology and benchmarks for controlled health care cost growth in Oregon. The group is expected to issue its final report at the end of 2014.

Driver 3: Integrating care across silos and with community health improvement

Community health improvement

In the next demonstration period, OHA's Public Health Division, in partnership with the Transformation Center and other stakeholders, will develop the required Population Health Roadmap. Oregon is well positioned to take on this assignment. As a part of the early transformation planning work conducted in 2009, OHA developed a risk assessment and health improvement strategies addressing tobacco use, obesity and diabetes. The Public Health Division was an early adopter of voluntary accreditation and further developed and expanded a next iteration of a state level health improvement plan in 2012 (see Appendix 10). The division has supported local health departments in developing community-level health improvement plans. CCOs have also just submitted the required community health improvement plan for their service areas, and the analysis of those plans will occur over the summer. The Public Health Division and the Transformation Center will work collaboratively to identify opportunities to provide technical assistance and support to CCOs as they implement their community health improvement plans. The timing is ripe for a community-focused, integrated, statewide health improvement plan to guide population and health care delivery system strategies to continue forward movement towards achieving the triple aim.

Additional community health improvement activities planned in the next quarter include:

- Submitting Year 2 work plans and budgets from the community prevention grantees;
- Fielding the CCO Member Behavioral Risk Factor Surveillance Survey (MBRFSS);
- Continuing to update data sets in Oregon Public Health Assessment Tool (OPHAT); and
- Analyzing the community health improvement plans due from CCOs and their community advisory councils by July 1. Thanks to SIM resources, Transformation Analysts will review all the submissions and synthesize themes and areas of common strengths and potential gaps. The product of this work will help partners understand where they may find peer expertise and support OHA's development of technical assistance to ensure successful implementation of the plans.

Oral health integration

July 1, 2014, is the deadline for all CCOs to integrate dental health services into their global budget and model of care. To support this integration, the Transformation Center is beginning work on oral health guidance that utilizes the Oregon Oral Health Coalition's Oral Health Plan. The guidance will highlight opportunities for primary care providers to obtain training on oral health risk assessments and performance measures to ensure that providers, community partners and DCOs are coordinated. In addition, OHA has posted a position for a Dental Director to help lead dental health integration across efforts in Medicaid, Public Health, the Public Employees' Benefit Board, the Oregon Educators' Benefit Board and the broader community. We will report on the success of that recruitment by next quarter.

Improving health equity in health care and community settings

Next quarter's goals, objectives and activities related to the Regional Health Equity Coalitions include the following:

- Finalize amended contracts to include chronic disease prevention funding and deliverables
- Update and develop communications products related to the RHECs that can be shared with stakeholders, future funders, coalition members, steering community members, community members, CCO staff, community advisory council members and any other interested parties
- Finalize contract with Program Design and Evaluation Services to conduct RHEC-related evaluation activities
- Begin developing a RHEC evaluation plan based on the collective impact model
- Plan the RHEC meeting taking place prior to the Place Matters conference for RHECs to brainstorm and provide feedback on the evaluation plan

The DELTA project will conduct two additional training sessions: Health Equity Strategic Planning, led by Ben Duncan and Sonali Balajee, Multnomah County Health Department; and Leadership for Health Equity, led by Dr. Winston Wong, Kaiser Permanente. The program will also "graduate" the current cohort of participants. At this time there are no perceived barriers to achieving next quarter's objectives.

For the revised SIM health care interpreter project, the coming quarter will be focused on re-establishing the program operations, getting the contract funds released, engaging the contractors

and applicants, and delivering the interpreter education necessary for qualification and certification examinations to the first cohort of learning collaborative participants.

Driver 4: Standards for safe and effective care

Translating evidence to practice: Health Evidence Review Commission (HERC)

HERC will continue the work of reflecting on the evidence review process and identifying opportunities to improve effectiveness and efficiencies. Activities in the next period include:

- Receive the final report from Center for Evidence Based Policy on the process assessment and improvement project, and start to address the recommendations.
- Working with the center, complete the environmental scan of translational tools from trusted sources to help select topics and define requirements of patient decision aids or other derivative products from HERC evidence-based reports.
- Schedule a retreat for all members of HERC and its subcommittees for the fall to discuss the recommendations in the CEbP report and develop an action plan of how to increase the efficiency of HERC's process, deliverables and translation to evidence-based clinical decision tools.

As noted earlier for Quarter 3 efforts, discussions were held between OHA, including the Transformation Center and Chief Medical Officer, and the Center for Evidence-based Policy to further refine the scope of the translational products portion of the SIM grant investment. The stakeholder input from the HERC process review now due in early Demo 1 Quarter 4 will inform this portion of the work, so initial work has been delayed. Focused discussions with medical directors of CCOs and other health plans will be included as the center gathers the best evidence on translation of evidence efforts, tools useful to the provider networks and with their patients in using the evidence-based guidelines of the HERC, and in alignment with *Choosing Wisely* and other national efforts. Discussions are also underway to include the Transformation Center in developing and exploring best avenues for future dissemination and ongoing sustainability, and will be outlined going forward. It is projected that transitional tools will still be produced by the end of the grant period, but they may not be defined by individual diseases or conditions, Instead, they may be better directed towards creating resources and templates that help the state outline approaches to be used by OHA or health plans/CCOs to translate the evidence most effectively and allow regular updating in a timely manner. This will allow for future sustainability after the end of SIM for maximum effectiveness.

Project ECHO/specialty care

Rural Medicaid members have limited access to specialty care and other barriers – especially transportation barriers – that may prevent people from accessing specialty care clinics even when they are available. The Transformation Center has contracted with Providence Center for Outcomes Research and Education to perform a feasibility study that will gather information about Project ECHO and similar programs across the nation, and then will consider these models for specialty care capacity building in the context of Oregon's particular geography, population and delivery system network. The primary deliverable will be a business plan for building specialty care capacity in Oregon.

Driver 5: Testing and accelerating spread of the model

Learning collaboratives, training and other resources to support and fuel transformation

The Transformation Center is on track to meet the next quarter's goals and objectives for learning collaboratives:

- The statewide Quality and Health Outcomes Committee learning collaborative plans to host sessions on the year-end incentive measure data, which was used to award quality pool funding, at its July session. The August session will focus on incentive measure data by race and ethnicity.
- The community advisory council learning collaborative will continue to host monthly webinar meetings with the steering committee. The steering committee will have its first rotating change in membership in July to allow new representatives an opportunity to participate. The steering committee will review the CAC Summit evaluation feedback to determine next steps for the learning community.
- The Council of Clinical Innovators will begin the year-long learning program with a two-day kick-off meeting in Portland July 24-25, 2014. The program will also include monthly webinars, mentorship and technical assistance for the Clinical Innovators.

The Transformation Center is on track to develop Patient/Member Engagement Resource guides and tool kits. The Transformation Center is currently holding focus groups with interested stakeholders to learn more about their needs and barriers in implementing patient/member engagement strategies. In addition, the Transformation Center is initiating work regarding utilization of traditional health workers. The Transformation Center, in collaboration with the Office of Equity and Inclusion, is learning more about barriers and challenges from providers, payers and traditional health workers. There is a possibility of organizing a learning community on this topic and coordinating with the Traditional Health Worker Commission.

Good Ideas Bank

The Good Ideas Bank is intended to be an open, electronic platform for partners and stakeholders to post and search for promising and best practices. The intention is to support the spread of transformative practices across the delivery system. A prototype of the bank has been successfully launched online and will be publicly available after internal review is complete. Ideas that will be highlighted include changes beyond CCO activity, including hospital to home transition teams, screenings for foster care, a mental health literacy campaign and an example of online population health data sharing.

Technical Assistance Bank

The Transformation Center is developing a Technical Assistance Bank. The Transformation Center will create a menu of technical assistance topics that partners may access upon request for hands-on assistance for implementing specific quality improvement or new innovations in care. Partners will decide how to best utilize the resources by selecting the topics of most interest and need. Initial areas of assistance offerings include: community health improvement plan implementation and evaluation; community advisory council development; health equity; oral health integration; alternative payment approaches; and public health integration.

Clinician Vitality/Resiliency Initiative

Born out of a grassroots request from a number of clinicians in the state concerned about provider and caregiver burnout/well-being, a work group was formed in March that is developing a charter to further explore the statewide infrastructure needs to maintain a vibrant, engaged and healthy caregiver workforce. This group will initially focus on physicians, nurse practitioners and physician assistants. Following an environmental scan of existing resources, a proposal is being developed to create the collaborative capacity required to develop a broad-based, statewide strategic plan for addressing the need for trainings and other programming. This plan will focus on supporting clinician vitality in the current environment of health care transformation in Oregon.

Transformation Funds

The Oregon Legislature provided $30 million in general funds to support health system transformation and innovation. These resources, combined with the SIM funding, leverage capacity to build a culture of improvement as part of health systems transformation. The Transformation Center has disseminated the funding to CCOs and the next progress report is due in July. Transformation Analysts will review the reports and identify themes, notable achievements and areas of needed improvement. Additionally, the Transformation Center staff will assist the CCOs to establish their performance measures based on the training and tools provided at the Science of Improvement conference offered in May.

Projected Quarterly Accountability Targets

The Accountability Targets, Process Measure, and Self-Evaluation Measure Results table on the next pages lists Oregon's accountability milestones and related measures from the RTI/CMMI list of "process measures and milestone metrics by state," (edited per Oregon's conversations with the Project Officer, and directions from the Year 2 Operation Plan Update guidance and webinar). Per this guidance, the table format has been updated from that provided in the last quarterly report so that it is organized by Oregon's aims and drivers from our driver diagram. This ensures a clear link between the state's SIM goals and outcome and process measurement. As required in the Year 2 Operational Plan Update, Oregon submitted a revised evaluation plan. As part of this, the accountability milestones and process measures have been supplemented with some additional self-evaluation measures[2]. All three are in the table below, and are integral to Oregon's self-evaluation plan. The column at the right shows results for this reporting quarter and reports progress towards future milestones. Note that for each measure, data from the quarter under review are included if available; in cases where these data are not yet available, the most recent data available are provided. Work on some of the measures has not yet started (as per our operational plan); however, additional data points will be added in subsequent quarters as data become available.

[2] Note that the accountability targets and most process measures are also a part of Oregon's self-evaluation plan (as outlined in our Year 2 Operational Plan Update).

Accountability Target, Process Measure, and Self-Evaluation Measure Results		
Aim or Driver From Driver Diagram	**Measure (accountability milestones, process measures, and self-evaluation measures)**	**Q2 2014 (April – June 2014)**
Implementing alternative payment methodologies to focus on value and pay for improved outcomes	**Accountability Milestones**	
	Each Coordinated Care Organization (CCO) will test at least one primary care and one non-primary care alternative payment methodology	Will report after July 2014, when Transformation Plan progress reports with milestones are due.
	Each Public Employee Benefits Board (PEBB) plan will test at least one primary care and one non-primary care alternative payment methodology	Will report progress beginning in 2015 when new PEBB plans are in place.
	Oregon will adopt a methodology and benchmark for sustainable rate of health care cost growth by 2016.	The first workgroup meeting was held in May 2014. A second meeting is scheduled for July 2014.
	Process Measures	
	Number of alternative payment arrangements put in place by working with major payers or providers; to the extent we are aware of these efforts.	None new this quarter. The Center for Evidence-based Policy, working under contract with OHA, is continuing to engage payers, providers, and other stakeholders around the state about APM arrangements in place and interest in future developments.
	Proportion of CCO plan payments and CCO payments to providers that are non-FFS	52.5%
	Proportion of PEBB service payments that are non-FFS	Data collection mechanism in development for 2015 plan year; will report progress beginning in that year.
Improving care coordination at all points in the system, with an emphasis on patient-centered primary care	**Accountability Milestones**	
	500 PCPCHs recognized by 2015; 600 by July 2016	At the end of June 2014, there are 501 recognized PCPCHs in Oregon.
	Goal for training health care interpreters	During this quarter CMMI approved revised activity. Goal to be determined and progress included in future reports (goal in original submission was 150 new health care interpreters trained by July 2016).

Accountability Target, Process Measure, and Self-Evaluation Measure Results		
Aim or Driver From Driver Diagram	**Measure (accountability milestones, process measures, and self-evaluation measures)**	**Q2 2014 (April – June 2014)**
homes (PCPCH)	75% of hospitals live on Emergency Department Information Exchange (EDIE) by the end of 2014	All Oregon hospitals have signed the agreement. In the last quarter, 32% of hospitals had live feeds for EDIE and 76% were beginning the IT implementation process as of May. We expect 37 of 59 hospitals to be live by the end of the summer and all remaining hospitals to be live by the end of the year.
	Process Measures	
	Number of individuals receiving care through recognized PCPCHs	Approximately 300 PCPCHs have provided data so far, so it's not yet possible to provide a total number (this is an increase from 200 clinics reporting in the previous quarter). Among the 300 clinics reporting, the average number of patients is 7037 but the variation is large (50 min to 100,078 max)
	Number of Oregon providers who have ever received an incentive payment through Medicare or Medicaid EHR incentive program, by provider type	53[3] hospitals and 5,556 eligible professionals have received payments.
	Percentage of PCPCHs that have achieved meaningful use	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 CMS. 85% of the PCPCHs recognized under the 2014 standards (292 out of 501 practices) attested to meeting this standard.
	Number of users of CareAccord direct secure messaging	1028 CareAccord users as of June 2014.

[3] Note there was a typo in the previous report. In the previous quarterly report, this was erroneously listed as 59; it should have read 53.

Accountability Target, Process Measure, and Self-Evaluation Measure Results		
Aim or Driver From Driver Diagram	**Measure (accountability milestones, process measures, and self-evaluation measures)**	**Q2 2014 (April – June 2014)**
	Self-evaluation Measures	
	Number of traditional health workers certified in Oregon	Self-evaluation measure (not reported in previous quarters). The number of certified THWs in registry is 60.
	The Department of Human Service's Adult & People with Disabilities Division and the Area Agencies on Aging Long Term Services and Supports (LTSS) Innovator Agents must create Memoranda of Understanding with local CCOs to ensure LTSS are coordinated with the CCOs	Self-evaluation measure (not reported in previous quarters). Previously there were 29 MOUs, so work has been done to consolidate these down to 17. Of the goal of 17 MOUs, 10 were completed by 30 June 2014.
Integrating physical, behavioral, and oral health care with community health involvement	**Accountability Milestones**	
	75% of CCOs and local public health authorities (LPHAs) have OHA-supported collaborative projects on population health by July 2015	In April, our tobacco program funded six Strategies for Policy And Environmental Change, Tobacco-Free projects using funds from the Tobacco Master Settlement Agreement. Some of these communities also receive Community Prevention funds. Therefore, currently: 11 CCOs (69%) currently collaborating with 25 (74%) LPHAs
	Process Measures	
	Information on community health or prevention initiatives implemented	In this quarter we continued contract monitoring for four Community Prevention grantees. Community Prevention grantees led the June 2014 CCO Learning Collaborative to share successes and begin discussions about public health integration.
	Number of CCOs registered to access local population health data via the Oregon Public Health Assessment Tool (OPHAT)	No CCOs currently registered.

Accountability Target, Process Measure, and Self-Evaluation Measure Results		
Aim or Driver From Driver Diagram	**Measure (accountability milestones, process measures, and self-evaluation measures)**	**Q2 2014 (April – June 2014)**
	Number of Regional Health Equity Coalitions implemented	Six coalitions participated in development training in June 2014. Additional training and evaluation plan development will take place during the Place Matters conference, pre-meeting and grantee and contractors meeting in November 2014.
Reduce PMPM cost trend while maintaining or improving quality	**Self-evaluation Measures**	
	1 percentage point reduction in Medicaid PMPM expenditures by FY 2014, from 2011 baseline; 2 percentage point reduction by FY 2015	Self-evaluation measure. Reported in February 2015 (FY 2014) and February 2016 (for FY 2015)
	Medicaid quality and access should be maintained or improved even while reducing the state's PMPM cost trend	Self-evaluation measure. Reported in February 2015 (FY 2014) and February 2016 (for FY 2015)
Testing, acceleration, and spread of effective delivery system & payment innovations	**Accountability Milestones**	
	65% of dual eligibles receive care through CCOs	54.4% of duals are in CCOs as of May 15, 2014.
	75% of Public Employee Benefit Board (PEBB) lives in plans with Coordinated Care Model (CCM) elements by 2015 plan year	PEBB plans selected in last quarter. Currently reviewing plan elements to assess inclusion of coordinated care model elements.
	75% of Oregon Educators Benefit Board (OEBB) lives in plans with Coordinated Care Model (CCM) elements by 2016 plan year	OEBB RFP for 2016 plan year in development; will assess plan elements when plans have been selected and negotiations concluded.
	50% of Qualified Health Plan (QHP) lives in plans with Coordinated Care Model (CCM) elements by 2016 plan year	QHP certification criteria for 2016 not yet in development.
	Cross-payer multi-data source dashboard with interactive functionality available at the end of the project period (autumn 2016)	Second version of the dashboard released June 2014; development ongoing.
	Process Measures	
	Number of Learning Collaboratives established	The Transformation Center now has four external LCs: (1) Statewide CCO LC focused on incentive metrics; (2) LC for CCO Community Advisory Council members; (3) Complex care collaborative; and, (4) Institute for Healthcare Improvement for CCO Transformation

Accountability Target, Process Measure, and Self-Evaluation Measure Results		
Aim or Driver From Driver Diagram	**Measure (accountability milestones, process measures, and self-evaluation measures)**	**Q2 2014 (April – June 2014)**
		Fund Portfolio Managers. (A fourth internal LC for CCO Innovator Agents also exists).Oregon's Patient-Centered Primary Care Institute provides technical support and resources for transformation to practices statewide. This technical assistance includes learning collaborative opportunities for primary care practices throughout the state. In this quarter, the Institute accepted and reviewed applications for 4 learning collaboratives to launch later in 2014 and run through May 2015. A total of 31 applications were received for 24 available slots. These are: Improving Patient Experience of Care (two collaboratives); Improving Access through PCPCH; and, Patient-Centered Communication Skills, Behaviors, and Attitudes.
	Number of Learning Collaborative/quality improvement sessions held	Transformation Center learning collaborative sessions in quarter: 9 Patient-Centered Primary Care Institute learning collaborative sessions in quarter: 0 (Program was recruiting for learning collaboratives to launch later in 2014). However, two QI events were held (webinar on patient experience care surveys and an in-person Technical Assistance Expert Learning Network to share best practices).

Accountability Target, Process Measure, and Self-Evaluation Measure Results		
Aim or Driver From Driver Diagram	**Measure (accountability milestones, process measures, and self-evaluation measures)**	**Q2 2014 (April – June 2014)**
	Average number of participants in Learning Collaboratives or QI events (by role where possible)	Average of 78 participants per Transformation Center learning collaborative session. Role breakdown of attendees: 14.9% clinical; 24.9% administrative or operational lead; 12.0% QI/QA staff; 0.2% financial; and the remainder served other roles. The Patient-Centered Primary Care Institute did not hold any learning collaborative sessions (as they are recruiting), but they did hold two QI events: 31 people attended the survey webinar, and 70 people attended the Technical Assistance (TA) Expert Learning Network day.

Accountability Target, Process Measure, and Self-Evaluation Measure Results		
Aim or Driver From Driver Diagram	**Measure (accountability milestones, process measures, and self-evaluation measures)**	**Q2 2014 (April – June 2014)**
	Selected evaluation results from Learning Collaboratives or QI events	**Transformation Center Learning Collaborative Session Core Evaluation Question Results:** *89.2% of respondents found session valuable or very valuable to their work *61.2% of attendees say will attend future sessions *60.4% of attendees say will take action to change processes at organization as a result of the session *50.9% of attendees say they will reach out to colleagues, experts or OHA for more information or ideas as a result of today's session **Patient-Centered Primary Care Institute Webinar on Patient Satisfaction Surveys Evaluation Question Results:** Attendees of the webinar were given a survey; nearly half of attendees completed the survey. They are asked "How helpful was this webinar in supporting your understanding of how to use patient experience of care surveys in your practice ". Response options ranged from 1 (not at all helpful) to 5 (very helpful). The average response was 3.35. Respondents were also asked to rate the quality of the webinar (response options ranging from 1, poor, to 5, excellent). The average response was 4.21.
	Approximate number of Oregonians and percent of population covered by Coordinated Care Model (CCM)	CCM model currently implemented for Medicaid beneficiaries and (optionally) dual eligibles. 793, 557 individuals are enrolled in CCOs as of May 15, 2014, or approx. 20% of Oregon's population.

Accountability Target, Process Measure, and Self-Evaluation Measure Results		
Aim or Driver From Driver Diagram	**Measure (accountability milestones, process measures, and self-evaluation measures)**	**Q2 2014 (April – June 2014)**
	Process Measures	
Cross-cutting	Evaluation results as available from specific initiatives (e.g., congregate housing pilot project, Regional Health Equity Coalitions, etc.)	See substantive findings section below (PCPCH evaluation findings [non-SIM-funded] and Regional Health Equity Formative evaluation findings (SIM-funded)
	Percentage of Oregon community HIEs connected to CareAccord for interoperable direct secure messaging	0%
	Legislative policies, plans, or levers put in place to support health system transformation	No significant activity as Legislature was not in session. OHA Acting Director Suzanne Hoffman gave a brief informational update on health systems transformation to House and Senate Health Committees during May legislative days: https://olis.leg.state.or.us/liz/2013I1/Downloads/CommitteeMeetingDocument/37129

Substantive Findings

As noted earlier in this report, the fourth report on how Oregon's coordinated care organizations (CCOs) performed on quality measures was published on June 24. This is the first report to show a full year (2013) of performance data, and the results triggered the first incentive payment – payments for improvements in care, not just the quantity or types of services – to CCOs. All CCOs showed improvements on some measures, and 11 out of 15 met 100 percent of their improvement targets. In aggregate, the 2013 data showed significant improvements in these areas:

- Decreased emergency department visits and emergency department spending
- Increased primary care utilization and spending, as well as increased enrollment of CCO members in patient-centered primary care homes
- Increased rates of developmental screenings during the first 36 months of life
- Decreased hospitalizations for chronic conditions
- Increased adoption of electronic health records

In addition, CCOs continue to hold down costs. Oregon is staying within the capped rate of growth for Medicaid spending to meet its commitment to Centers for Medicare and Medicaid Services. See Appendix 1 for the full report.

Additional substantive findings include:

CAC Summit evaluation results

The CAC Summit evaluations showed the agenda proved to be valuable. Overall, respondents said the most helpful aspects of the summit were the opportunities to network and learn about what other CACs are doing. One participant wrote, "I appreciated the opportunity to share experiences with other CACs as well as spend extended time engaging with my local CAC members in a unique environment."

Respondents indicated that as a result of the summit, they would be most likely to take action to improve processes within their CAC or committees in which they participate (72.2%). A similar number (73.3%) of respondents indicated they would attend future summits if offered, and would take action to improve processes within their organization (57.3%). For example, one participant wrote, "The foundation presentations sparked further planning for activities for our CHIP [community health improvement plan]."

Two roundtable discussions were facilitated with CCO CAC coordinators and CAC chairs. In the CCO CAC coordinators roundtable, the most requested need was to have a learning community for CCO CAC coordinators. Similarly, in the roundtable for CAC chairs, they too wanted a network community of CAC chairs to provide a safe place for sharing and support in their roles.

Impact of patient-centered primary care home program on use and expenditures

In non-SIM funded work, researchers at Portland State University assessed the impact of the patient-centered primary care home program on use and expenditures among early adopters of

the PCPCH model. Changes observed at recognized clinics before and after their recognition were compared to changes at non-PCPCH clinics.

The principal findings were that there were no net changes in general and total primary care office visit levels among PCPCH sites in comparison to non-PCPCH sites. There was also no net change in inpatient stays. There were, however, net reductions in preventive office visits, mental health services, specialty office visits, radiology and emergency department visits. There were also net reductions in total expenditures per person among PCPCH sites in comparison to non-PCPCH sites.

The net reductions in specialty office visits, radiology, emergency department visits and total expenditures are consistent with positive expectations for the PCPCH program and medical homes in general. However, the reductions in preventive visits, preventive procedures and mental health services are not clearly consistent with the expectations for the program. More analysis into these findings will be forthcoming.

Formative evaluations of Regional Health Equity Coalitions

During this reporting period, all of the Regional Health Equity Coalitions participated in the first of the required tri-annual site visits. The overall purpose of the site visits was to: gain a better understanding of each coalition's model and its utility in addressing health equity; understand where efforts are being focused and what activities are currently being conducted; and gather themes to help develop indicators and metrics to understand what factors and efforts contribute to each coalition's success.

Participation included coalition leads, coalition members, steering committee members, stakeholders, community partners, Office of Equity and Inclusion staff, evaluators, and Health Promotion and Chronic Disease Prevention liaisons. Please see Appendix 11 for a summary of the learning from the site visits.

Lessons Learned

Community advisory council learning collaborative

Leadership development was identified as a topic of interest and need for CAC leaders. CACs have also identified recruiting and retaining members to be a continuing challenge. CACs are completing their community health improvement plans and are requesting support and technical assistance for implementation of and improvements to their plan. The use of webcam to help make CAC meetings more interactive was met with positive responses. The CAC steering committee is a valuable entity to plan and support CACs.

Council of Clinical Innovators

A lesson learned from the Council of Clinical Innovators recruitment process was that specific recruitment strategies are required to ensure a diverse applicant pool. For example, more focused recruitment is necessary to attract oral health providers and providers in communities of color. The original application process was effective for successfully recruiting a multidisciplinary group, including physicians, social workers, public health professionals, nurses and dieticians.

Complex Care Collaborative

Regarding complex care, topics that continue to emerge as key themes needing support and training are trauma-informed care implementation; chronic pain management; opioid prescribing; complex mental health care and integration into primary and community care; traditional health workers and peer services; cultural competency; engaging community members in complex care; alternative payment methods; and health information technology and its impact on case management. The Transformation Center will incorporate complex care topics into an upcoming event.

Improvement Science in Action Training follow-up

Following the Institute for Healthcare Improvement's *Improvement Science in Action* training in April, CCOs and project teams continue to request support in developing an infrastructure and culture of improvement within the CCO network. The Transformation Center is examining ways to provide technical assistance and develop improvement support capacity within the CCO structure.

Behavioral health integration

Behavioral health integration is much more complex than providing behavioral health services in primary care practices. Significant issues that have arisen which require much more study are alternative payment methods, documentation and sharing of records, engagement of community mental health services, and integrating primary care into mental health clinics (reverse integration).

Suggestions/Recommendations for Current/Future SIM States

Potential state efforts to address health equity:

The DELTA Program has been a highly effective strategy for imparting information on health equity and inclusion. OHA staff believe it is effective because it:

- Creates opportunities to share strategies and challenges across organizations and programs
- Builds camaraderie and relationships with current and future organizational partners
- Provides concrete, applicable tools
- Supports leadership to integrate health equity and inclusion strategies into organizations for improved access and quality of care
- Is manageable in terms of time, yet allows the appropriate amount of time for learning

Plan for both flexibility and sustainability

From staff working on integration of long-term services and supports, the strongest recommendation for other states is the need for flexibility in timelines and budgets. Innovative pilots such as Housing with Services and also memoranda of understanding involving unique regions and individual organizations such as CCOs must have time to meet, consider, coalesce and evolve proposals into realistic operational plans and implementation activities, especially if funding a project that will need long-range sustainability to be most effective. It is critical to allow and support the evolution of planning when innovative ideas are being developed.

Suggestions/Recommendations for CMMI SIM Team

Data

Oregon is making progress on obtaining Medicare fee-for-service data and appreciates the additional assistance through the SIM Project Officer to continue to press forward on obtaining the data.

Administrative and operational burden

Oregon continues to remain concerned about growing administrative requirements as we head into the end of our first test year and need to focus on implementation of our activities. We appreciate the consideration to not go through another readiness review, and that CMMI is only requesting an operational plan update for Demo Year 2. We hope that requirements for additional documents beyond the new risk mitigation, further delineation of our self-evaluation plans, the new-to-start population health planning activity; and the SIM learning collaborative will wrap up any new asks of us. Being unanticipated and often presented to us at the last minute, some of these have consumed a large amount of staff time, taking away from the actual spread activities.

Networking among SIM test states

We understand there will be some events bringing the SIM test states together to share their work, which can be very useful, but we do recommend some significant alignment with other events and gatherings that many of these states already attend. Several entities have learning collaboratives or large national meetings many of our staff participate in, so linking the SIM test states to a specific portion of those meetings or special event tagged onto those would require less travel and be more cost effective for states to bring teams. A brand new series of meetings would compete with many of these other events for our time and attention. Over the years, the RWJF State Network and Academy Health have had smaller focused events based on specific topics that we just sent those working in that area to learn and share with other states' experts and the technical assistance. Regular networking was accomplished through a weekly emailed update with news across the states out to project leads with links to where to find more information, with only one full state teams meeting a year. Webinars are not very useful unless topics are confirmed and details planned well in advanced so the most appropriate staff can attend, or unless the webinars are made available later for reference. We would not want any additional "homework" or assignments attached to any of these networking events/activities, which we have seen in some past joint state activities. We have plenty of work to meet our milestones and collect information for CMMI's reporting, and limited time to provide more paperwork beyond that.

Initial preview of the just announced learning system network across the test states appear to be including some of these considerations and we will continue to participate in the further refinement of the effort.

Need for technical assistance, resources and emerging issues

We actually have the greatest need for resources targeted at the staffs and provider networks of our clinical delivery systems, health plans and CCOs. What we are hearing is needed across Oregon are concrete examples of quality improvement, "good ideas," best practices and access to technical experts who are expert in implementation on the ground, in the delivery systems. We are investing in what we can afford to do, but it would be very beneficial to share from other CMMI activities such as the ACO and Shared Savings partners or others where we can get our communities real examples of innovation, and then link our community leaders for peer-to-peer advice and pitfalls in implementation – rather than just meetings on how to drive a state policy agenda with other states agency staff.

On a state level, information, good ideas and peer-to-peer links with other business best practice leaders would assist the needed internal transformation efforts underway at the Oregon Health Authority. Retooling how a Medicaid agency, Addictions and Mental Health, and Analytics units could perform day-to-day operations, moving from a regulatory slant to more of a partnership approach with our contracted health plans and CCOs would help our agency managers, and likely those in other states. Making government work better, rather than just harder, would be of great value and would enhance our relationships with our delivery systems.

One topic that is emerging, and may benefit from collaborative efforts across states, federal programs and other health care purchasers, is the threat that certain health care costs pose for our health plans and CCOs to stay under a contracted cost trend cap. The new, extremely expensive Hepatitis C drugs (at $1,000/pill or $84,000 for one course of treatment) are a topic of much consternation by both our commercial and our Medicaid CCOs, and we estimate it could impact our state budgets by at least $250 million over 12 months across Medicaid, state employees, school districts, corrections and state mental health hospital, even if only treating those more severely affected. This is just the beginning of a series of pharmaceutical products, along with the expensive "biologicals" that are emerging on the market. While initial evidence suggests enhanced effectiveness they could wipe out entire pharmaceutical budgets under a fixed rate of growth benchmark. Enhanced care coordination, reducing hospitalizations and emergency room visits and other elements of our coordinated care model can work to control utilization costs, but when the price tag is so high, it can hamper our efforts to achieve the triple aim.

Findings from Self-Evaluation

In this last quarter there was quite a bit of evaluation activity, both in terms of self-evaluation activities and coordination with the national SIM evaluation. Highlights are below:

Tracking of SIM Accountability and Process Measures (see Accountability Target Section)

- Over half (52.2%) of CCO plan payments and CCO payments to providers are non-fee-for-service. This is one of Oregon's process measures, to track the degree to which payment methodologies shift to those focusing on value and payment for improved outcomes. This quarter will serve as a baseline and progress with this aspect of the CCM within the Medicaid population will be tracked on a quarterly basis moving forward.

- In quarter one of 2014 the PCPCH program reached its 2015 goal of 500 recognized PCPCHs by 2015, and has continued to progress in quarter two, with a total of 501 recognized clinics statewide.
- Of the 501 recognized PCPCHs, 292 (85%) attested to meeting meaningful use standards. This will be tracked moving forward to ensure that technology is used appropriately to improve care coordination.
- Oregon is approaching its target of 75% of CCOs and local public health authorities collaborating on projects to improve population health by July 2015 – in the last quarter 69% of CCOs and 74% of local public health authorities had active collaborations.
- The proportion of dual eligible enrolled in a CCO remained relatively steady (54% in quarter two 2014 versus 56% in quarter 1). This is an important target as the CCOs are Oregon's mechanism for spreading the CCM to the Medicaid population.
- In the last quarter the Transformation Center instituted a process to rapidly assess the effectiveness of its learning collaboratives. Attendees are asked to respond to a standard set of questions after each learning collaborative session, allowing the Transformation Center to track satisfaction from session to session, and across learning collaboratives. Baseline results from quarter 2 2014 are promising, with 89.2% of respondents reporting that they found the session they attended valuable or very valuable to their work, and 60.4% of attendees reporting that they will take action to change processes at their organizations as a result of the learning collaborative session. These items will be tracked in future quarters so that progress can be assessed over time.
- The proportion of Oregonians covered by the CCM increased slightly from the previous quarter (from 18% to 20%). This increase is largely due to the Medicaid enrollment expansion in Oregon: This estimation currently only defines those in the Medicaid population who are CCOs as covered by the CCM (the denominator in the calculation is the Oregon population). However, in the future we will include PEBB and OEBB recipients as the CCM spreads to these populations.

Assessing the Success of the CCM in Medicaid

- As described in the Highlights Section, this quarter saw the publication of Oregon's latest Health System Transformation Performance report for CCOs. All CCOs saw improvement on at least some measures, and 11 of 15 CCOs met 100% of their improvement targets. In the aggregate, 2013 data showed decreased emergency department visits and spending; increased primary care utilization and spending; increased enrollment in PCPCHs; increased rates of developmental screenings; decreased hospitalizations for chronic conditions; and, increased use of EHRs.
- In this quarter, the independent evaluation of the spread of the CCM in Medicaid, being conducted by Mathematica Policy Research, progressed on schedule. Activities included: completion of key informant interviews; completion of the CCO Transformation Assessment Tool used to assess the degree to which individual CCOs have transformed on key CCM elements; completion of site visits at three CCOs; and continued processing of enrollment and claims data to assess outcomes.

Assessing Spread of the CCM and Determining the Relative Impact of individual Elements of the CCM

- In this quarter, the contract for an independent, formative evaluation of Transformation Center was finalized.
- The statement of work for an independent evaluation of the degree and pace of spread of the CCM across markets in Oregon was finalized in quarter 2 2014. This includes the development of a transformation typology to track qualitative changes over time in different markets, and a quantitative assessment of the spread of the CCM outside Medicaid. It is hoped the contract will be finalized in the next quarter.
- The second installment of the multi-payer dashboard was published in June 2014. The composition of the dashboard is still under development, but this installment highlighted the impact of the ACA expansion in Oregon: Medicaid enrollment in the state increased by 50% from December 2013 to April 2014, and expansion led to an increase in Medicaid participation among adults (whereas previously Oregon's Medicaid enrollees were mostly children), and post-expansion enrollment is also slightly more evenly split between men and women.

Coordination with national evaluation

OHA staff also spent time facilitating and coordinating with the national evaluation in this quarter. April was spent working with the national evaluators regarding a possible collaboration on the provider survey. Although it was ultimately decided that it was in the best interests of both parties to field separate surveys, the conversations were fruitful and will ensure that data collection efforts for both surveys are coordinated. In addition, Oregon staff worked with national evaluators on the planned consumer survey, and possible addition of questions for the national evaluation on the Oregon Health Insurance Survey.

Problems Encountered/Anticipated and Implemented or Planned Solutions

With now over 400,000 Oregonians newly signed up for coverage either through the 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 Cover Oregon, are working hard to ensure those enrolled are getting access to coverage. In addition, Cover Oregon's decision to use federal technology for QHP eligibility and enrollment in 2015 has meant that a significant amount of staff time is being dedicated to the technology transition project. OHA also faces a substantial workload in Medicaid eligibility redeterminations for those enrolled through the "fast-track" process. So while implementation and spread of the coordinated care model remain the state's focus for SIM, leadership and staff are stretched as we enter into the fourth quarter of the first Demonstration Period.

OHA has deferred establishing a Transformation Center Multi-Payer Steering Committee until later in 2014 to ensure our partners can fully engage with the Transformation Center and to await the final selection of PEBB plans under contract with the new coordinated care model elements and accountabilities to help to shape the membership.

The execution of a contract for an OHA master website plan and development of the website and data portal is still delayed. The important 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 is working to develop a realistic work plan to get this work accomplished during this period of critical technology transition.

With respect to the Housing with Services pilot project, growing community interest and planning for eventual sustainable funding have required timelines to be adjusted. The project has attracted a great deal of interest, and the number of buildings involved has grown from four to 11 with potential resident participation expanding from initial estimates of about 500 to 1500. Residents have become very interested in the program, and fostering that interest and involvement in planning (a core value) has impacted the timeline. In addition, initial concepts and tentative agreements on a financing approach have evolved based on the commitment of a health system partner, necessitating timeline adjustments, further financial planning and the seeking of additional non-SIM funding. SIM funds are supporting an evaluation that can address replication, which will be jeopardized by delaying the provision of services. The effect of increased participation, development time for innovative ideas and grant requirements will be monitored and be managed to stay on track.

Work Breakdown Structure

Please see Appendix 12 for the Work Breakdown Structure.

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