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Oregon's Health System Transformation

Quarterly Progress Report

MEASUREMENT PERIOD
Baseline Year 2011 and
October – December 2012

PUBLISHING DATE
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MESSAGE FROM DIRECTOR BRUCE GOLDBERG, M.D.

Lower costs through better health and better care

I am pleased to present the first status report for Oregon's Medicaid Transformation. Here you will find information that has never before been gathered together and published about our state's Medicaid services.

This first report shows our starting point on key measurements of the health care people receive in every part of our state. Every quarter we will update the information to show changes at the statewide and coordinated care organization levels — and how we are doing compared to the goals we have set for the next 10 years.

These measures were chosen in an open and public process to represent the health care needs and challenges of a Medicaid population. Through these measures we will have the tools we need to truly reform the health system. Success will come through better health for the population we serve. By focusing on services that we know improve health and integrating physical and mental health services, we will lower costs and create a more functional health system that works better for everyone.

One promise of Oregon's health system transformation is our state's commitment to reduce the trend of Medicaid spending by two percentage points by the end of 2014. This report includes important financial data that allow us to examine how we are doing in achieving that goal. Data on utilization and cost of hospital, laboratory and imaging, and primary care services are also included as part of our commitment to financial transparency. These are important and valuable data, especially when combined with quality reporting.

This report also shows some of the innovative actions happening on the ground that are designed to meet these goals. From community health workers in Salem to emergency room diversion in Grants Pass, our state's coordinated care organizations are taking patient-centered care to new levels to the benefit of us all.

The data in this first report largely describe where we are starting — our baseline. This is the beginning of what will be a long journey toward a transformed health care system in Oregon. Each subsequent report will show the impact of health system transformation on health outcomes and on cost, quality and access, and future reports will also have a breakdown by race and ethnicity. As we take bold steps forward, I am confident the path before us is clear and we are on it together.

Bruce Goldberg
Director, Oregon Health Authority

EXECUTIVE SUMMARY

Across Oregon, coordinated care organizations (CCOs) are working on a local level to transform the health care delivery system to bring better health, better care and lower costs to Oregonians. To provide status updates on the state's progress towards those goals, the Oregon Health Authority (OHA) will publish quarterly reports showing performance data, financial data, and progress toward reaching benchmarks, beginning with the 2011 baseline data shown in this report. OHA will also highlight promising practices in local communities – innovations which ultimately will help improve health and lower costs over time.

The first CCOs began in August of 2012. The baseline data in this report come from 2011, gathered from CCO predecessor organizations. These baselines will allow us to judge our progress on specific metrics from a time before the coordinated care model began in our state. Each measure has a correlating benchmark value, which is typically based on national data for high-achieving Medicaid programs.

Subsequent quarterly reports will show changes in care quality and access using these metrics; they will illustrate the progress that we are making in reaching benchmarks in a number of areas.

This report also includes preliminary financial data about specific health care services from baseline calendar year 2011 and compares it to data from the last quarter of 2012. The information will be more complete in future reports to catch the lags between providing the services and reporting them. Future reports will track changes in individual CCO financial expenditures and use of health services. Over time, this financial information will show progress towards the statewide goal of lowering cost for the health care system.

Lastly, the reports include health system transformation work going on around the state. CCO progress indicators include the development of patient-centered primary care homes, use of non-traditional health workers, and an account of promising practices already being implemented by CCOs across Oregon.

In summary, by looking at 2011 data from the organizations that preceded CCOs, this first quarterly report shows where we are starting from and where we need to go to get to better health, better care and lower costs.

Measuring the quality of care

Oregon's coordinated care organizations (CCOs) are charged with improving care, making quality care accessible and curbing the rising cost of health care. Well-designed measurements called metrics will help the state measure how well CCOs meet those goals. The Oregon Health Authority selected a set of metrics to be a part of OHA's overall quality strategy and help track the performance of CCOs. These metrics help keep CCOs and OHA accountable to the clients we serve as we aim to improve health and health care.

This section displays statewide baseline data and CCO-specific baseline data, where available, both for 2011. The 2011 baseline data come from the organizations that were predecessors to the CCOs. OHA will report future data quarterly as they become available.

OHA's Metrics and Scoring Committee developed 17 outcome and quality measures. Each year, OHA will award CCOs funds from a quality pool based on their performance on these 17 measures during the previous calendar year. This report indicates which measures are CCO incentive measures and shows the baseline results for 11 of them.

OHA also has agreed to report to the U.S. Centers for Medicare and Medicaid Services (CMS) on 16 additional state performance measures. This report includes baseline results for 16 of these metrics. These measures will allow OHA and CCOs to see where improvement is being made and where more work is needed. Some of the metrics contain subsets of the same measurement – outcomes for different age groups, for example. When that is the case, each is displayed as a separate metric.

Finally, a handful of metrics show results from October through December 2012 and compare them to the 2011 baseline results. These results can be found on page 32 of this report. Although this information is not complete due to billing claims that will continue to be submitted, it gives a preview of how we are doing in improving Oregon's health system. This information will be expanded as more data become available.

Most of the information in this report comes from administrative (billing) claims. Claims data reflect information submitted by providers to payers as a part of the billing process. While claims data have limitations, they provide useful information about services provided by a very large segment of the Oregon health care delivery network. Other data sources include Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, Oregon Department of Human Services (DHS) custody records, Oregon vital statistics, immunization data from Oregon Public Health and the Physician Workforce Survey.

Updated data will be provided quarterly. Baselines reported for some of the measures may change as methods are revised. In future reports, PacificSource Community Solutions will be reported as two distinct CCOs: PacificSource Community Solutions Columbia Gorge Region and PacificSource Community Solutions Central Oregon Region.

PERFORMANCE METRICS

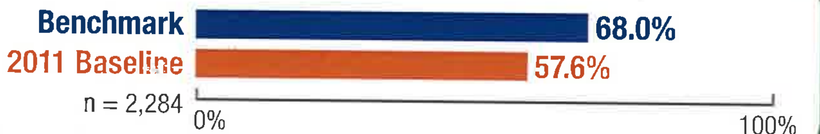
Statewide Metrics

Improving behavioral health and physical health coordination

Follow-up after hospitalization for mental illness

Percentage of patients (ages 6 and older) who received appropriate follow-up care within 7 days of being discharged from the hospital for mental illness.

(CCO Incentive Measure)



Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile

Alcohol or other substance misuse (SBIRT)

Percentage of adult patients (ages 18 and older) who had appropriate screening and intervention for alcohol or other substance abuse in a primary care setting.

(CCO Incentive Measure)

Data source: Administrative (billing) claims

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS

Statewide Metrics

Improving behavioral health and physical health coordination

Follow-up care for children prescribed attention deficit-hyperactivity disorder (ADHD) medications (initiation phase)

Percentage of children (ages 6-12) who had one follow-up visit with a provider during the 30 days after receiving a new prescription for ADHD medication.

(CCO Incentive Measure)

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile

Follow-up care for children prescribed ADHD medications (continuation and maintenance phase)

Percentage of children (ages 6-12) who remained on ADHD medication for 210 days after receiving a new prescription and who had at least two follow-up visits with a provider within 270 days after the Initiation Phase.

(CCO Incentive Measure)

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

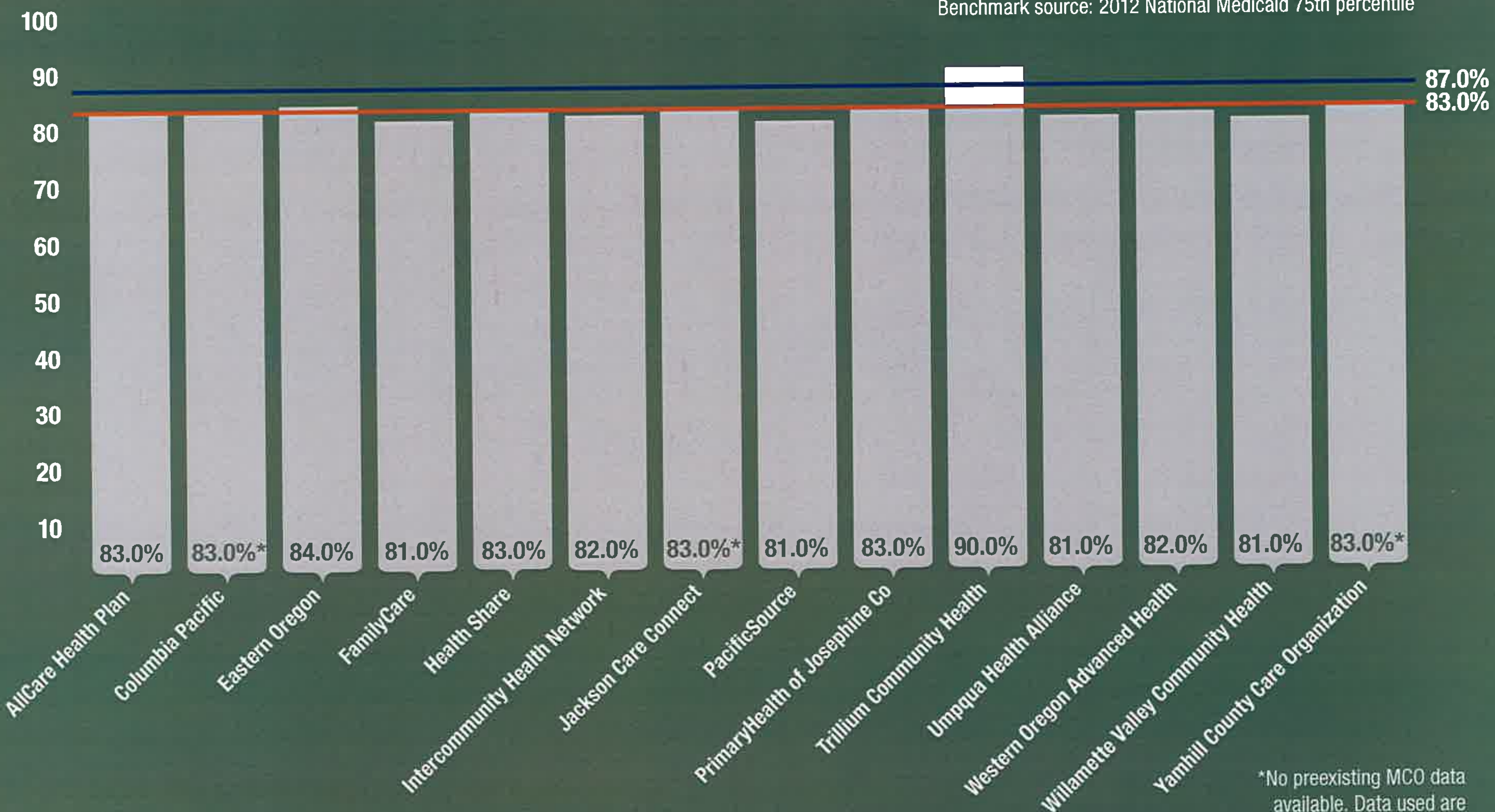
PERFORMANCE METRICS

CCO Baselines

Access to care (CAHPS)

Percentage of patients (adults and children) who thought they received appointments and care when they needed them.

(CCO Incentive Measure)



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

*No preexisting MCO data available. Data used are state-level baseline.

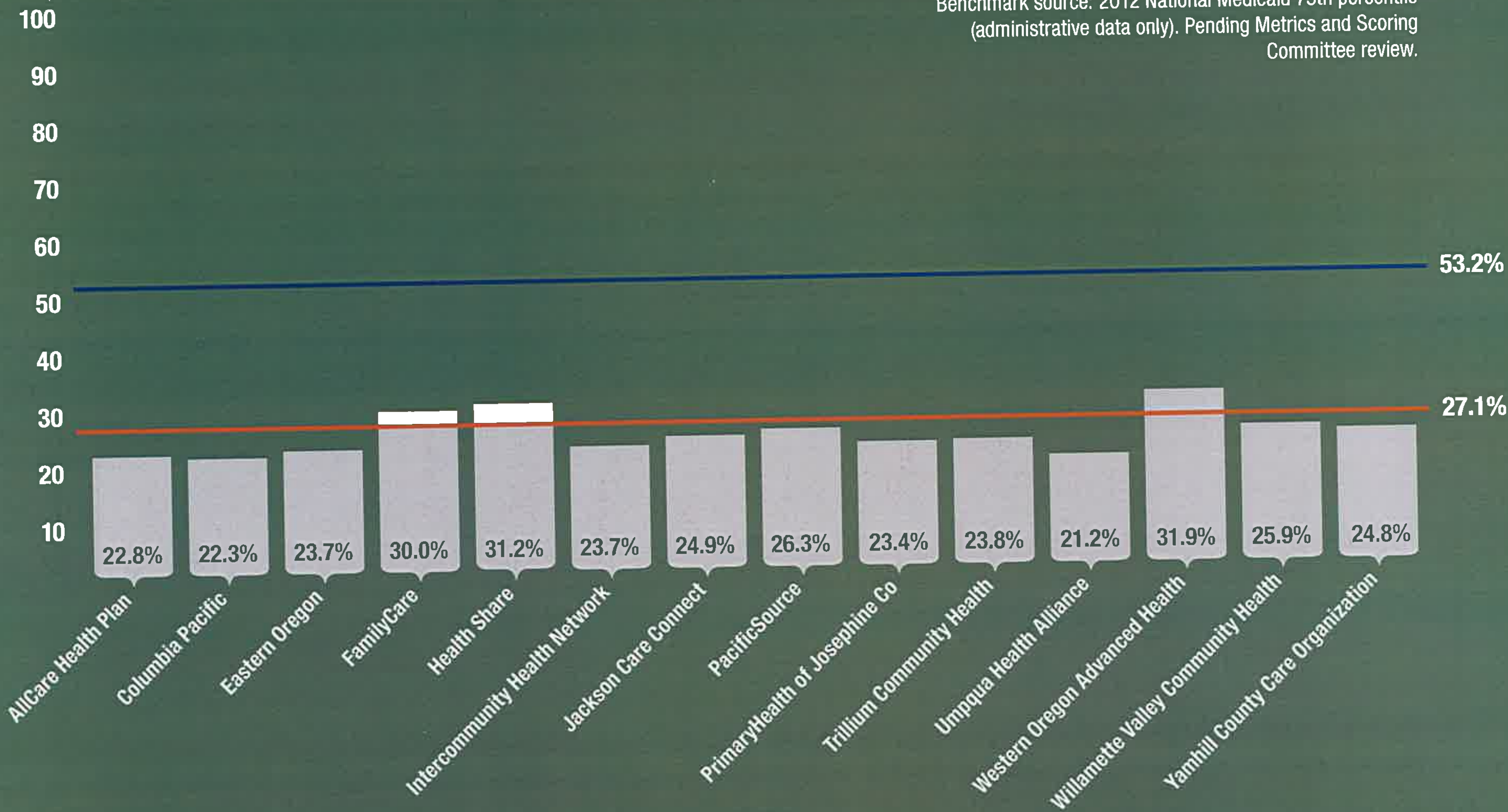
Adolescent well-care visits

Well-care visits help support healthy growth, development and behaviors in adolescents. These data show the percentage of adolescents (ages 12-21) who had at least one well-care visit in the measurement year.

(CCO Incentive Measure)

State Benchmark	53.2%
2011 State Baseline	27.1%
	n = 85,062

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 75th percentile (administrative data only). Pending Metrics and Scoring Committee review.



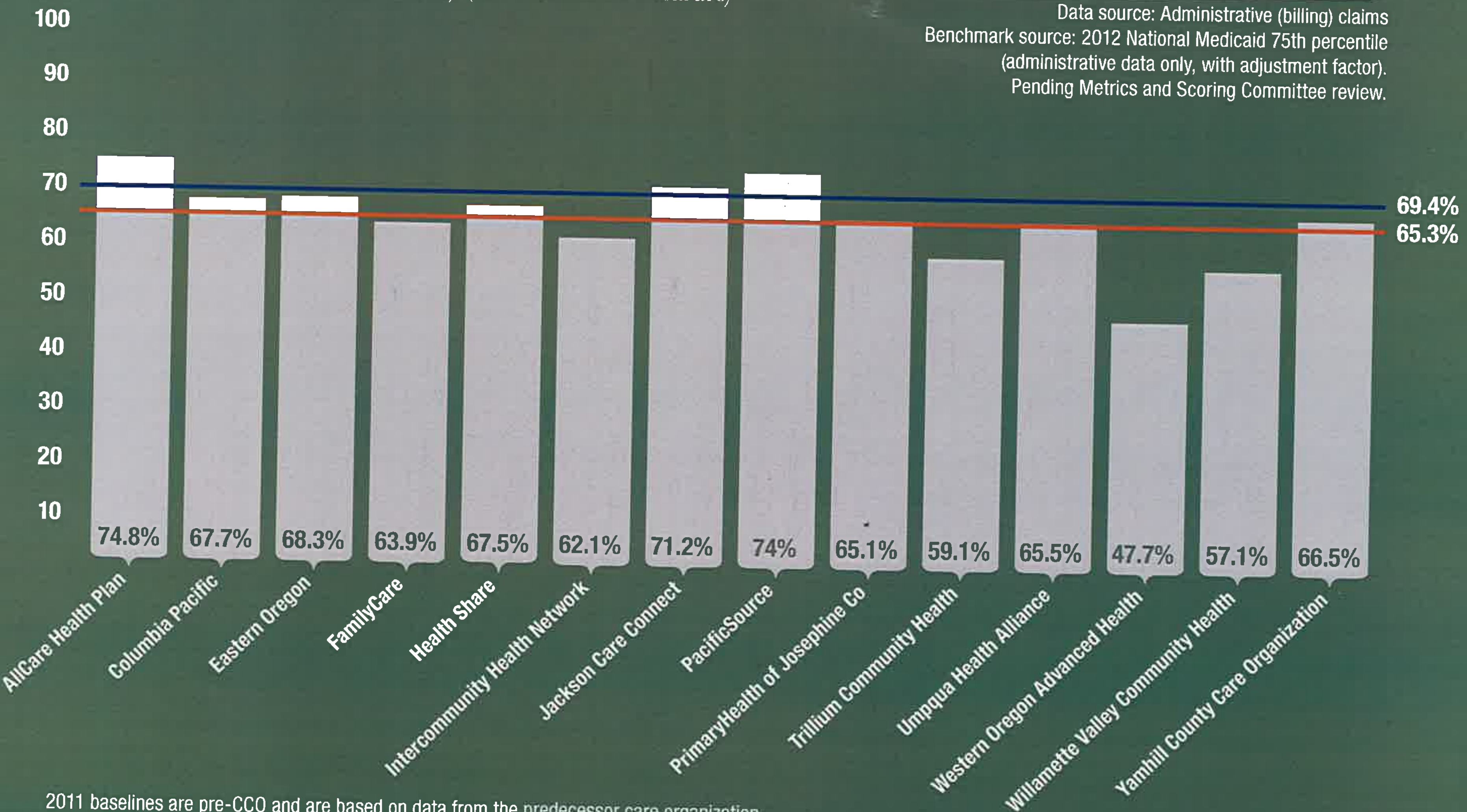
2011 baselines are pre-CCO and are based on data from the predecessor care organization.

Timeliness of prenatal care

Care during a pregnancy (prenatal care) supports the delivery of a healthy baby and helps a woman prepare to become a mother. These data show the percentage of pregnant women who received a prenatal care visit within the first trimester (or within 42 days of CCO enrollment). (CCO Incentive Measure)

State Benchmark 69.4%
2011 State Baseline 65.3%
n = 15,128

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 75th percentile (administrative data only, with adjustment factor).
Pending Metrics and Scoring Committee review.



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS

CCO Baselines

Follow-up after hospitalization for mental illness

Percentage of patients (ages 6 and older) who received appropriate follow-up care within 7 days of being discharged from the hospital for mental illness. (CCO Incentive Measure)

State Benchmark	68.0%
2011 State Baseline	57.6%
	n = 2,284

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

*CCO data are suppressed because of low denominator (fewer than 30 instances).

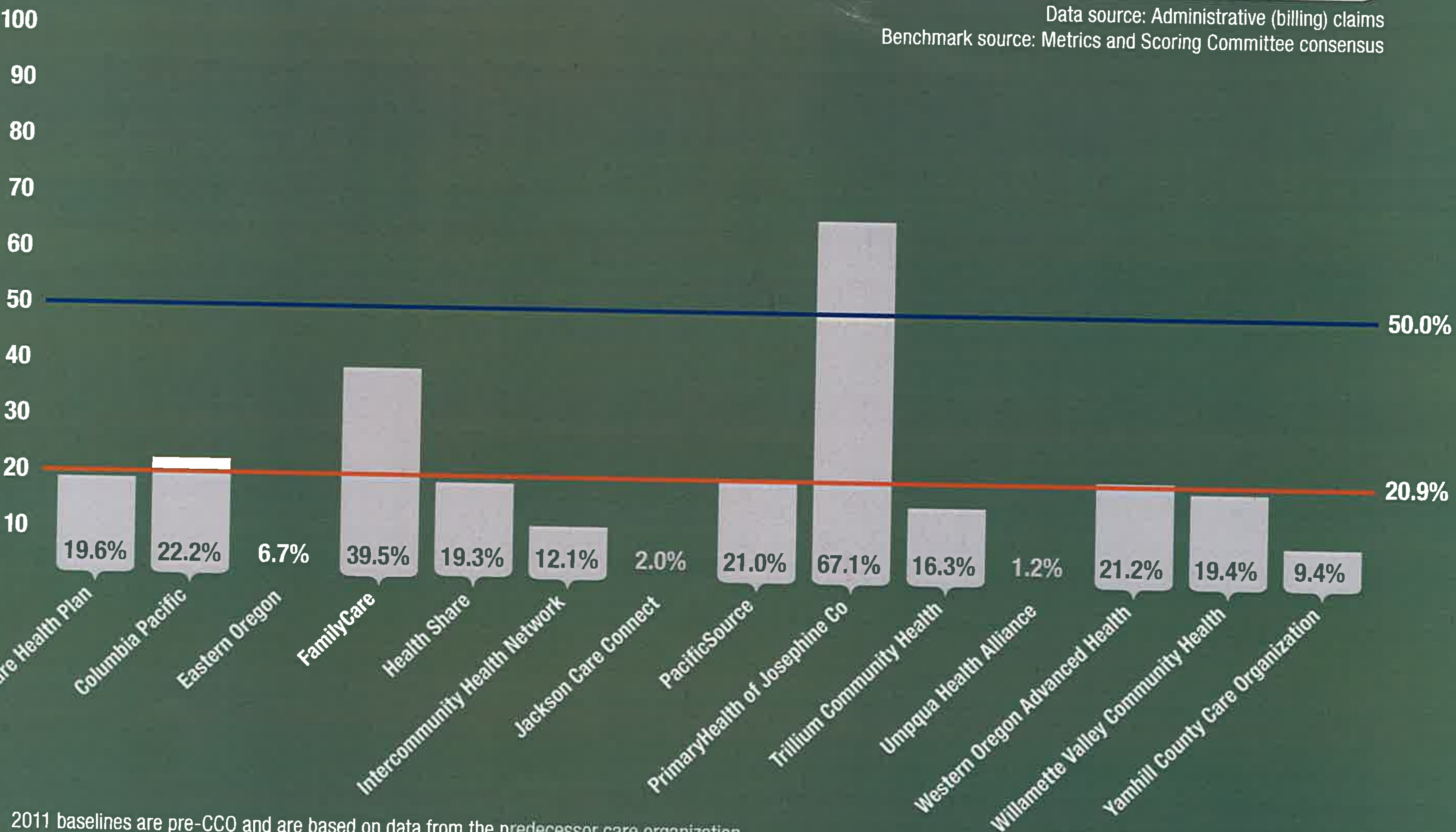
PERFORMANCE METRICS

CCO Baselines

Developmental screening in the first 36 months of life

Percentage of children up to 3 years old who had at least three screenings for delays in development, behavior and social skills.

(CCO Incentive Measure)



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

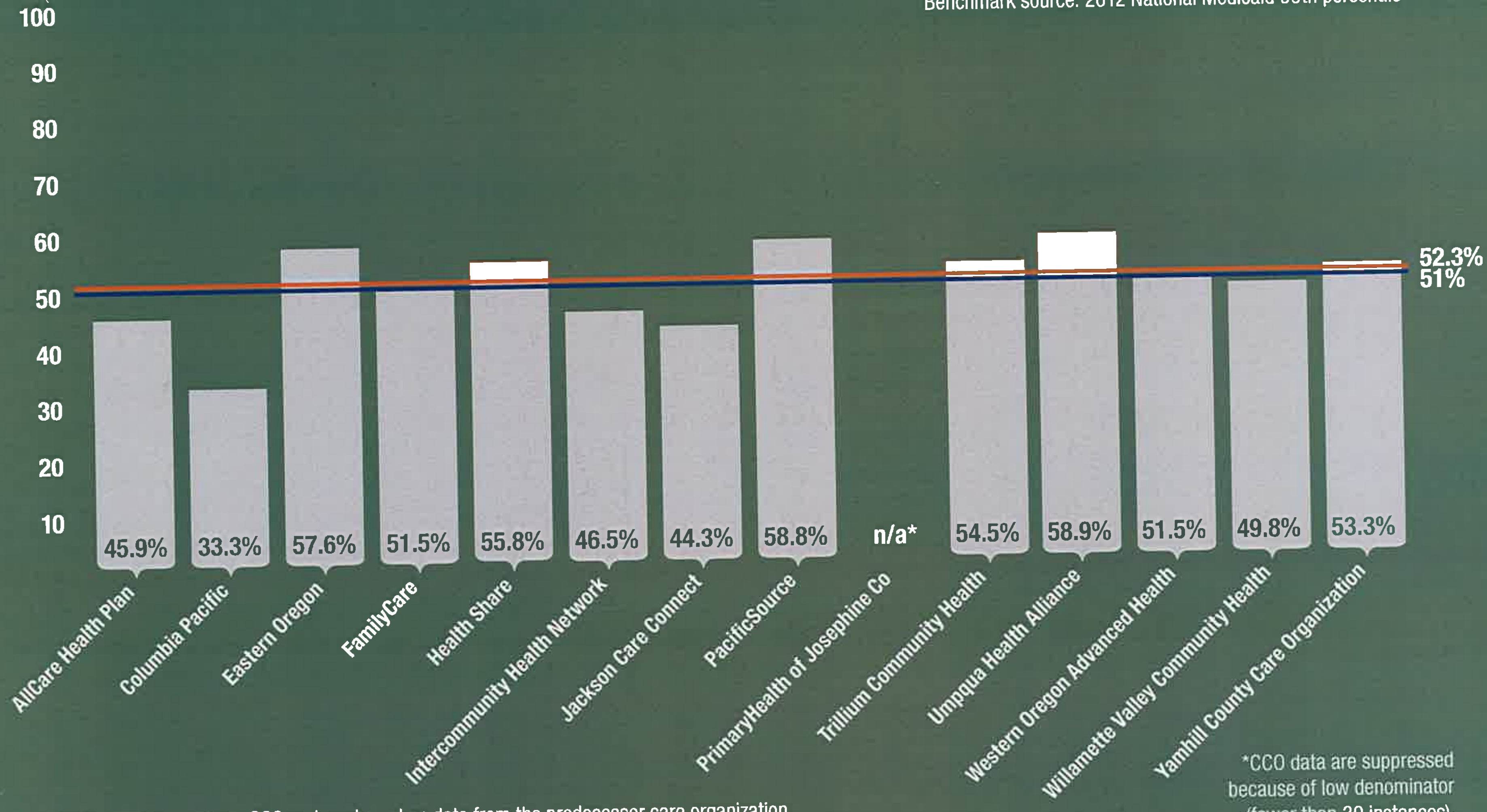
Follow-up care for children prescribed ADHD meds (initiation phase)

Percentage of children (ages 6-12) who had one follow-up visit with a provider during the 30 days after receiving a new prescription for ADHD medication. (CCO Incentive Measure)

State Benchmark	51.0%
2011 State Baseline	52.3%

n = 2,406

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile



*CCO data are suppressed because of low denominator (fewer than 30 instances).

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS

CCO Baselines

Follow-up care for children prescribed ADHD meds (continuation and maintenance phase)

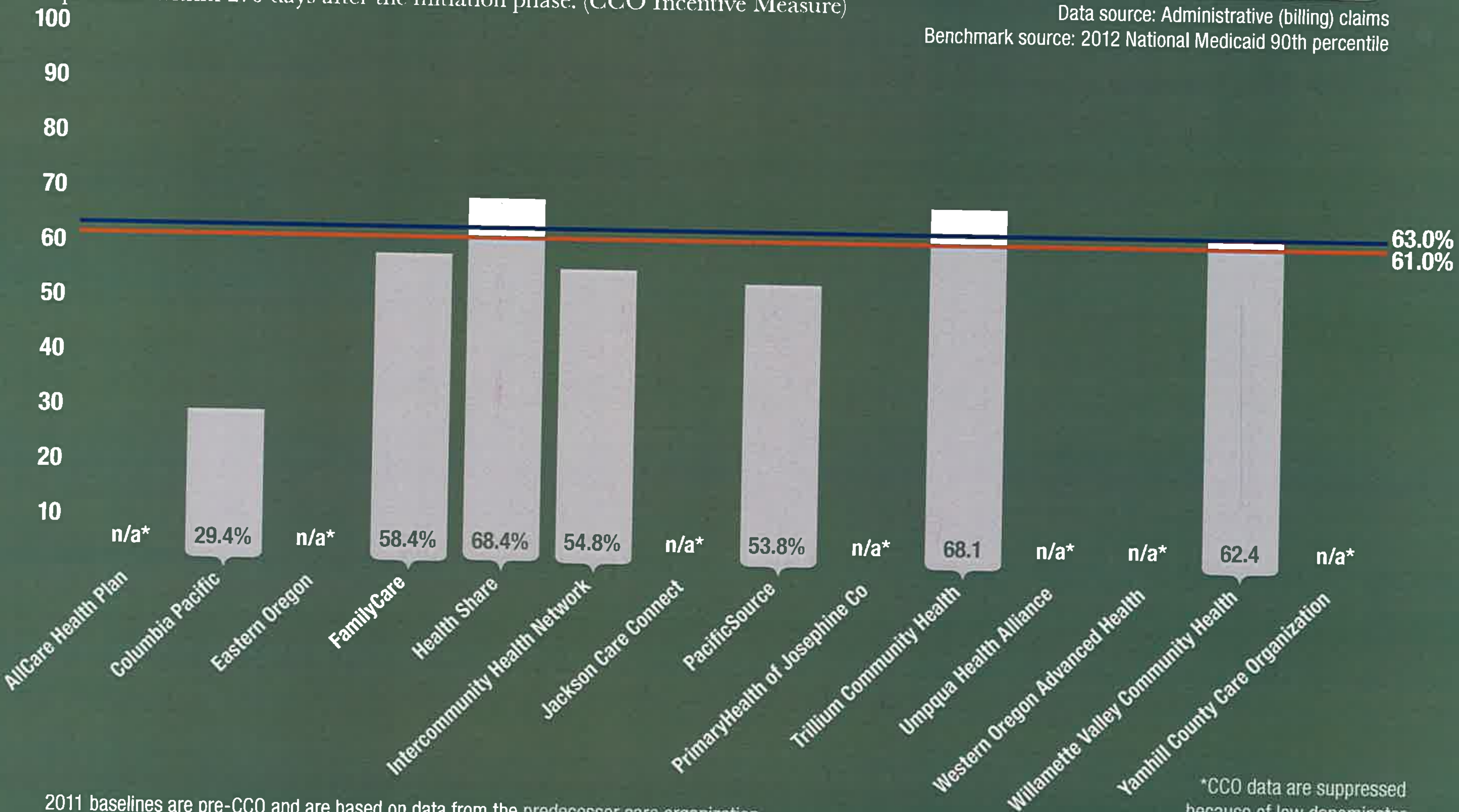
Percentage of children (ages 6-12) who remained on ADHD medication for 210 days after receiving a new prescription and who had at least two follow-up visits with a provider within 270 days after the initiation phase. (CCO Incentive Measure)

State Benchmark 63.0%

2011 State Baseline 61.0%

n = 875

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

*CCO data are suppressed because of low denominator (fewer than 30 instances).

PERFORMANCE METRICS

CCO Baselines

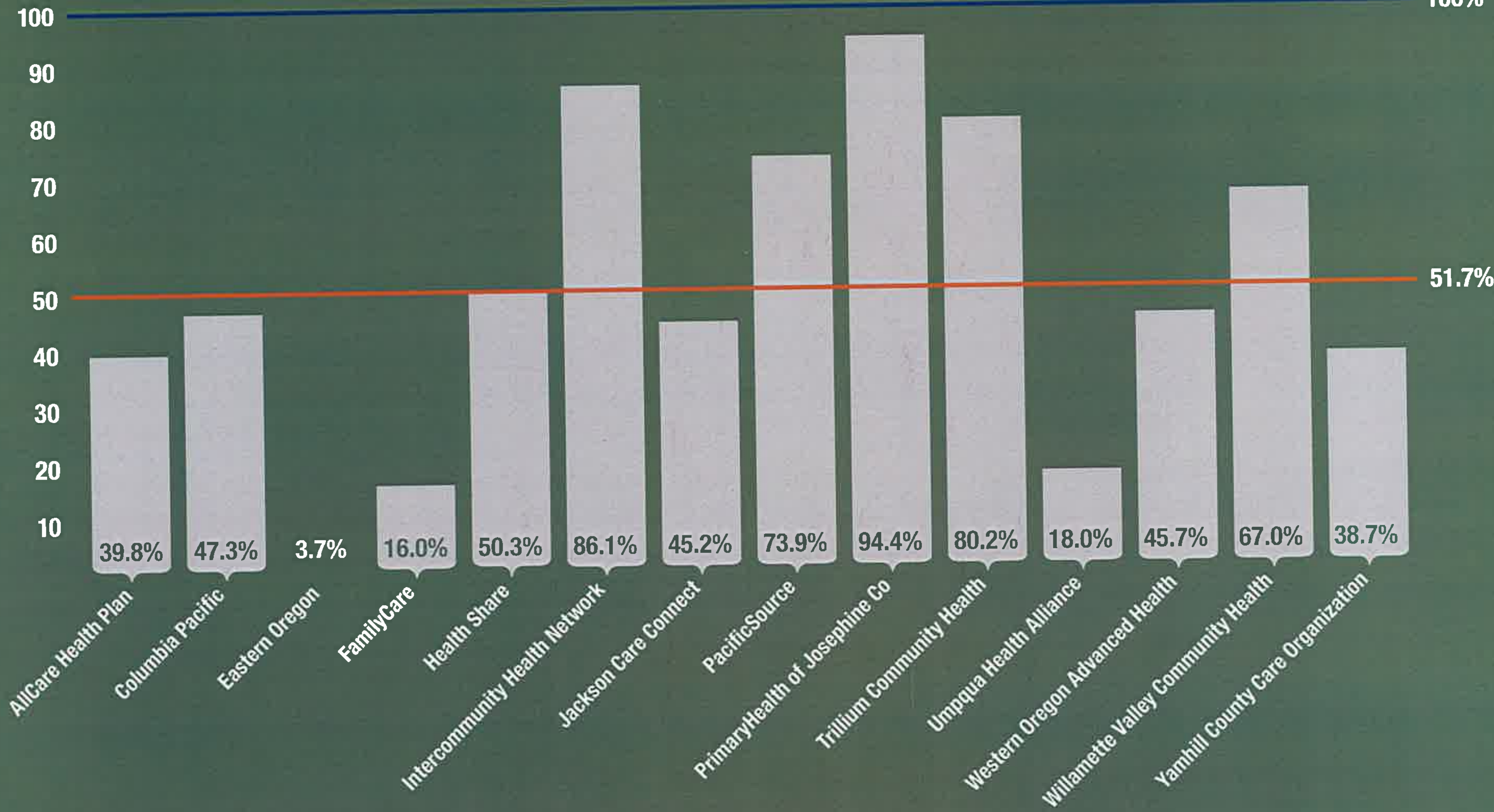
Patient-centered primary care home enrollment

Percentage of patients who were enrolled in a recognized patient-centered primary care home. (CCO Incentive Measure)

State Benchmark 100%

2012 State Baseline 51.7%

Data source: CCO self-report
Benchmark source: Metrics and Scoring Committee consensus



PERFORMANCE METRICS

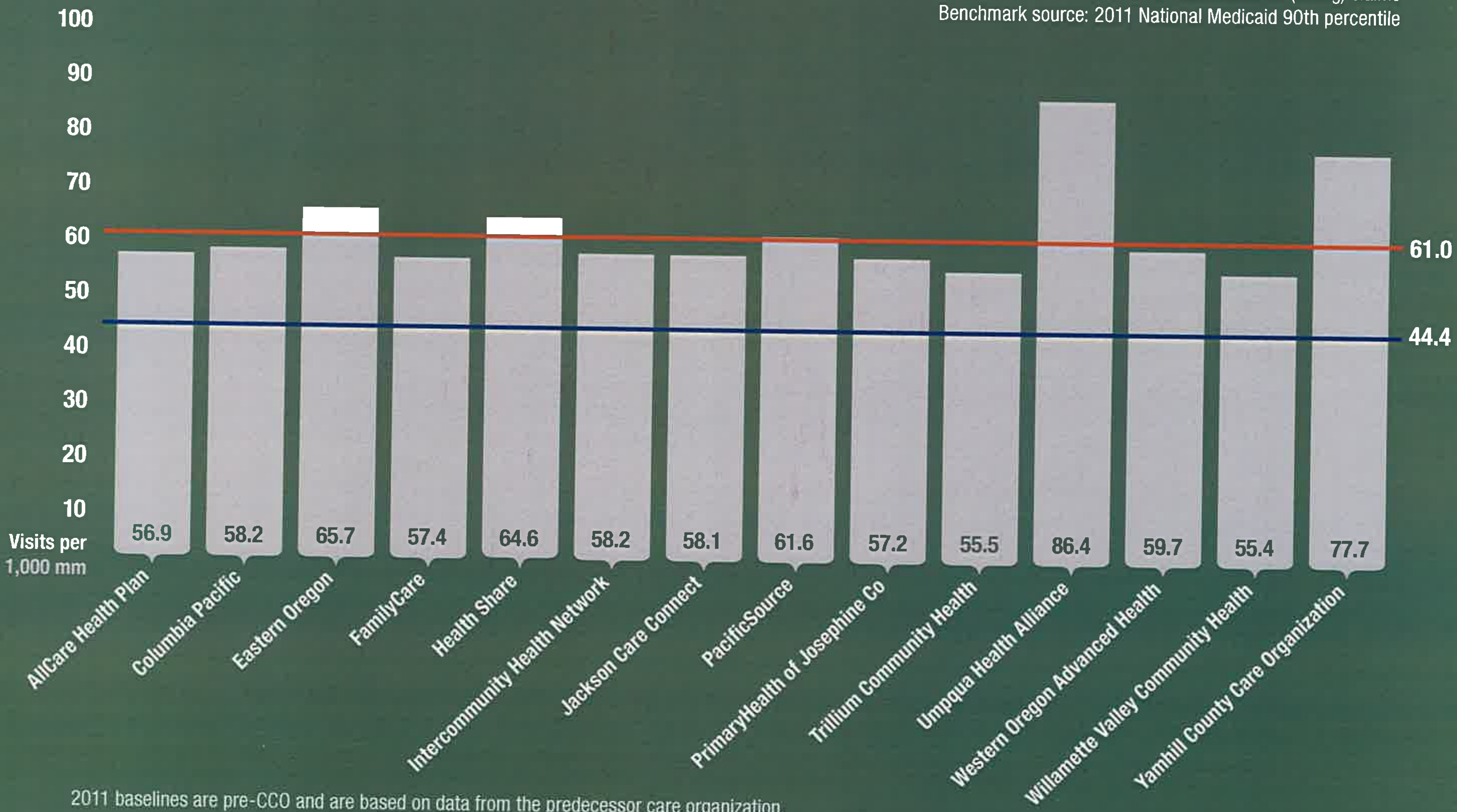
CCO Baselines

Ambulatory care: Emergency department utilization

Rate of patient visits to an emergency department.
(CCO Incentive Measure)

State Benchmark 44.4/1,000 member months
2011 State Baseline 61.0/1,000 member months
(A lower score is better.)

Data source: Administrative (billing) claims
Benchmark source: 2011 National Medicaid 90th percentile



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS

CCO Baselines

Ambulatory care: Outpatient utilization

Rate of patient visits to a clinic or urgent care.

(CCO Incentive Measure)

State Benchmark 439.0/1,000 member months

2011 State Baseline 364.2/1,000 member months

Data source: Administrative (billing) claims
Benchmark source: 2011 National Medicaid 90th percentile

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
Preliminary Quarterly Data

Quality Data

CATEGORIES	OREGON PRE-CCO BASELINE**	BENCHMARK	OCT-DEC 2012 PRELIMINARY DATA*
Prevention Quality Indicators (per 100,000 member years)			
PQI 01: Diabetes Short-Term Complication Admission Rate	192.9	62.7	254.1
PQI 05: Chronic Obstructive Pulmonary Disease Admission Rate	454.6	559.0	322.5
PQI 08: Congestive Heart Failure Admission Rate	336.9	380.7	248.2
PQI 15: Adult Asthma Admission Rate	53.4	63.4	64.5
Ambulatory Care (per 1,000 member months)			
Outpatient Utilization	364.2	439.0	310.5
Emergency Department Utilization	61.0	44.4	50.8

May 2013

* Based on encounter data received and processed through 4/12/13. No incurred but not reported (IBNR) claims have been assessed. These data will fluctuate and should be considered preliminary.
** Oregon baseline measures are state-wide values from calendar year (CY) 2011 and are based upon predecessor Managed Care Organization (MCO)s.
+ Data will be available in the next quarterly report

PRELIMINARY FINANCIAL DATA

Bending the cost curve

The Oregon Health Authority developed a report card or "dashboard" report to track progress made toward lowering costs and improving the quality of health care. The dashboard contains preliminary data on key metrics that are tightly linked to success or failure in executing the transformation strategy. That means this dashboard is a snapshot of the goals or targets set by the organization in its strategic plan.

As a baseline, OHA used data that show the encounters people have had with the health care system, including such things as clinic visits and prescription drug utilization. These data were submitted for calendar year 2011 by plans that covered Medicaid members before CCOs were formed. The intent in future dashboards is to track measures by individual CCOs as well as a statewide total. Financial benchmarks also are being developed as reference points to track the progress made in meeting overarching goals for Oregon.

This preliminary financial dashboard covers data from the fourth quarter of 2012 (Oct. 1 to Dec. 31). It includes data on services provided during that period for which claims have been received and processed through April 26, 2013. At this point, we have no data on services that have been provided but have not yet been recorded or invoiced. As a result, values will be recalculated and reported as additional data become available. Initial data also may be incomplete due to delays in submitting data to OHA. It is presented to begin to show the kind of data that will be reported on a quarterly basis.

This is the first step in collecting and sharing financial data. Future dashboards will be updated when more complete data are submitted. Financial data in future quarterly reports will be more complete and will improve over time. Future reports also will track changes in individual CCO financial expenditures and use of health services.

True health care transformation will come from setting meaningful goals, measuring our progress toward those goals, and holding ourselves accountable to those goals.

PRELIMINARY FINANCIAL DATA

Quarterly Data

UTILIZATION DATA

CATEGORIES	OREGON PRE-CCO BASELINE**	BENCHMARK	OCT-DEC 2012 PRELIMINARY DATA*
UTILIZATION DATA (ANNUALIZED / 1000 MEMBERS)			
Inpatient - Medical /Surgical Patient Days	252.6	In Development	218.3
Inpatient - Maternity Patient Days	73.8	In Development	60.0
Inpatient - Newborn Patient Days	88.8	In Development	66.7
Inpatient - Mental Health Patient Days	55.7	In Development	53.9
Outpatient - Primary Care Medical Visits (Includes Immun/Inject)	2,800.3	In Development	2,927.5
Outpatient - Specialty Care Visits	3,917.8	In Development	3,514.3
Outpatient - Mental Health Visits	912.6	In Development	953.2
Outpatient - Dental Visits (Preventive)	532.9	In Development	Data Pending
Outpatient - Emergency Department Visits	See emergency department utilization quality data on page 32.		
Outpatient - Pharmacy Prescriptions Filled	9,297.7	In Development	7,947.3
Outpatient - Labs and Radiology (Service Units)	4,739.3	In Development	4,300.0
Outpatient - Freestanding Ambulatory Surgical Center Procedures	24.6	In Development	20.1

May 2013

* Includes claim data received and processed through 4/26/13. At this point, there is no data on services that have happened, but have yet to be recorded or invoiced.
This initial dashboard is also incomplete due to lags in submitting data to OHA.
As a result, this data is very preliminary. The values will be recalculated and reported as additional data are made available.
This is the first step in collecting and sharing data, and future dashboards will be updated when more complete data is submitted.

** Oregon baseline measures are statewide values from CY 2011 and are based upon predecessor managed care organization (MCOs).

PRELIMINARY FINANCIAL DATA

Quarterly Data

COST DATA

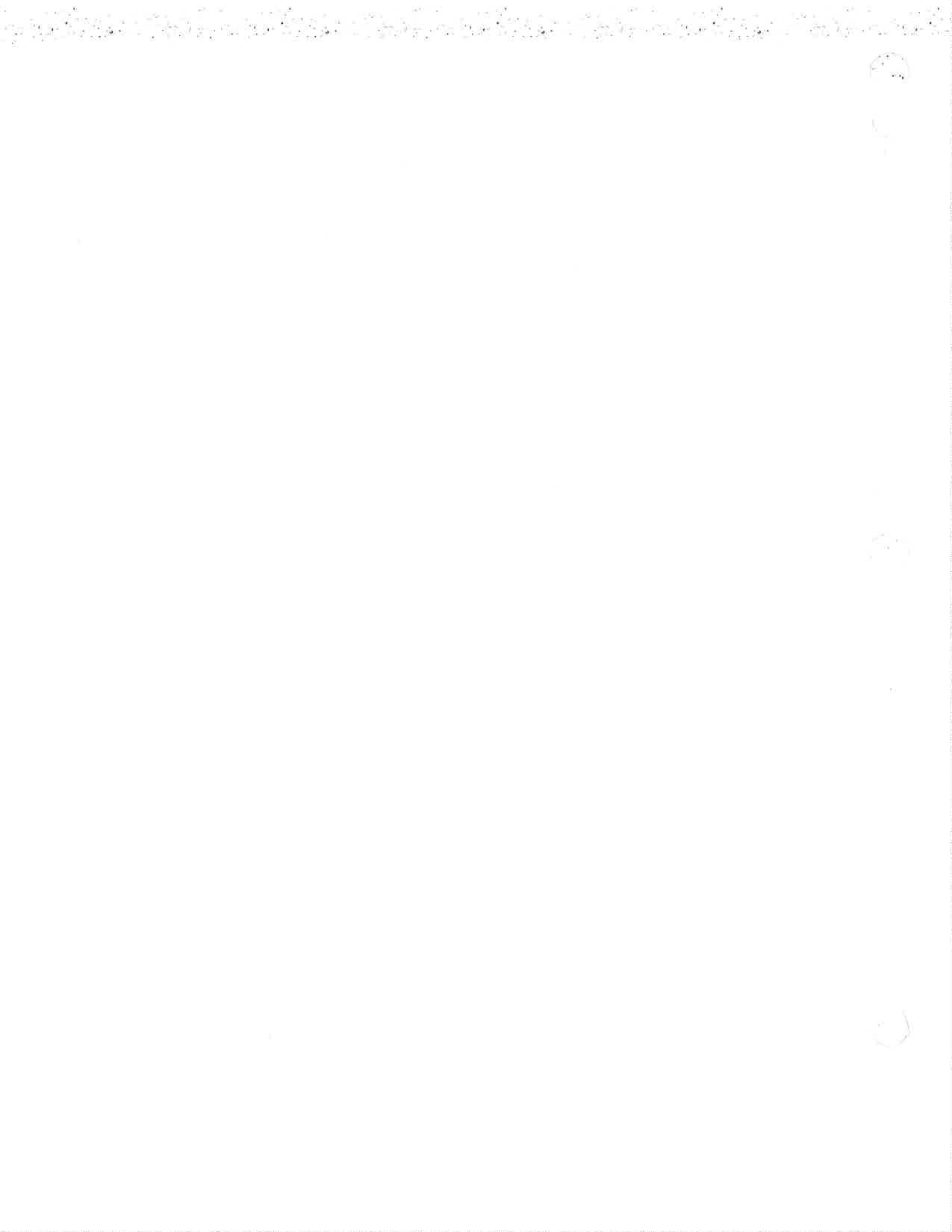
CATEGORIES	OREGON PRE-CCO BASELINE**	BENCHMARK	OCT-DEC 2012 PRELIMINARY DATA*
	Cost PMPM	Cost PMPM	Cost PMPM
Inpatient - Medical / Surgical	$35.64	In Development	$36.98
Inpatient - Maternity	$7.28	In Development	$8.12
Inpatient - Newborn	$6.71	In Development	$6.02
Inpatient - Mental Health	$3.12	In Development	$3.06
Outpatient - Primary Care	$19.99	In Development	$20.61
Outpatient - Specialty Care	$24.88	In Development	$22.14
Outpatient - Mental Health	$18.86	In Development	$17.65
Outpatient - Dental	$9.52	In Development	Data Pending
Outpatient - Emergency Department	$8.73	In Development	$6.60
Outpatient - Pharmacy Prescriptions	$30.80	In Development	$27.91
Outpatient - Labs and Radiology	$19.25	In Development	$16.44
Outpatient - Freestanding Ambulatory Surgical Center Procedures	$1.52	In Development	$1.44
Outpatient - Health Related Services	$0.00	In Development	$0.00
Outpatient - Other Hospital Services	$32.24	In Development	$26.80

May 2013

PMPM-*Per Member Per Month*

* Includes claim data received and processed through 4/26/13. At this point, there is no data on services that have happened, but have yet to be recorded or invoiced. This initial dashboard is also incomplete due to lags in submitting data to OHA. As a result, this data is very preliminary. The values will be recalculated and reported as additional data are made available. This is the first step in collecting and sharing data, and future dashboards will be updated when more complete data is submitted.

** Oregon baseline measures are statewide values from CY 2011 and are based upon predecessor managed care organization (MCOs).



OHA's new Health System Transformation Center

The Oregon Health Authority is working to establish the Oregon Health System Transformation Center using funds from the Centers for Medicare and Medicaid Innovation's state innovation model (SIM) grant awarded to Oregon April 1 of this year. Oregon was one of six states to receive the grant to test innovative approaches to improving health care and lowering costs across health care systems including Medicaid, Medicare, and the private sector.

The transformation center will help coordinated care organizations achieve the ultimate goals of better health, better care and lower costs for Oregonians and help extend the coordinated care model to other payers. The center will support CCOs, and the adoption of the coordinated care model throughout the health care system, by providing technical assistance and opportunities for peer-to-peer sharing of best practices among CCOs and other health plans and payers.

Innovator agents are the first component of the transformation center to be put into place. Innovator agents are required by statute to be resources for CCOs, and as such, will help CCOs and OHA work together to achieve transformation goals.

Each CCO is assigned an Innovator Agent to serve as a single point of contact between the CCO and OHA. The innovator agent provides data-driven feedback to the CCO on a monthly basis and assists CCO providers and community advisory councils develop strategies to support quality improvement, adopt innovations in care, and measure health outcomes.

Peer-to-peer learning opportunities are another critical component of the transformation center. The center will establish and coordinate a learning collaborative structure through which CCOs and other plans and payers can learn from recognized experts and each other.

The center also will develop a Council of Clinical Innovators who, along with the medical directors of each CCO and other health plans, will serve as advisors and champions for key innovations in the delivery and coordination of care. The council will build upon the strong partnerships created with Oregon's physician, specialty and other provider associations during the development of the coordinated care model.

Working with innovator agents and community partners, the transformation center will develop multiple strategies for effective community and stakeholder engagement around health system transformation and the implementation of the coordinated care model. These strategies will include conferences and workshops, materials (such as research, policy and practice guides), and communication and outreach to support the coordinated care model.

Non-traditional health workers

Background

Oregon's health system transformation and the federal Affordable Care Act have emphasized the essential role of non-traditional health workers in promoting health and delivering care. While many titles have been applied to these workers, state legislation has named community health workers, peer wellness specialists, personal health navigators and doulas as important members of health care teams, with distinct roles in supporting the Oregon Health Authority.

Non-traditional health workers in Oregon

Between January and April of this year, the Oregon Health Authority worked with the Oregon Employment Department to estimate the number of non-traditional health workers (NTHWs) employed statewide. Through a recent survey, it is estimated there are nearly 500 employed in this field, primarily in local health clinics, community-based health clinics and tribal clinics. Additionally, survey results indicated there are approximately 200 volunteer non-traditional health workers. Although there are workers in this field statewide, Portland metro and Willamette Valley organizations employ the majority, with nearly 75 percent of the total. These figures help the state better understand the potential need for, and availability of, non-traditional health workers, as well as provide a basis of evidence for training programs pursuing state approval.

NTHW certification

Last fall, the Oregon Health Authority convened a stakeholder committee. The committee developed temporary administrative rules governing certification and registry enrollment pathways for non-traditional health workers.

In order for these services to qualify for funding through the Oregon Health Plan (Medicaid), non-traditional health workers must be certified and registered by OHA after successful completion of an approved training program. With the exception of doulas, non-traditional health workers seeking certification must complete 80-plus hours of training through an approved training program and meet required competencies.

Doulas also can be certified through successful completion of an approved training program, or, if they are already certified by a nationally recognized organization, they must complete six additional hours of approved cultural competency training to be certified in Oregon.

Provisional certification and grandfathering

Individuals who have completed, or are in the middle of completing, a training program prior to the filing of these rules will qualify for a one-year temporary certification, during which time they must fulfill the requirements to attain full certification. Additionally, individuals who already have 3,000 hours of employment or volunteer experience as non-traditional health workers can be certified with fewer hours of training to fill any competency gaps.

NTHW registry

Upon certification, non-traditional health workers will be entered into a central registry maintained by OHA.

Next steps

The Oregon Health Authority has developed and is testing certification and training approval applications for user-friendliness and objectivity. We anticipate that we will begin certifying non-traditional health workers by June 2013.

OHA will hold a webinar for coordinated care organizations regarding the use of non-traditional health workers and payments.

In the meantime, the NTHW Steering Committee will begin a permanent rulemaking process. The committee will establish rules for continuing education, age requirements, certification maintenance, and training program renewal.

Patient-Centered Primary Care Home Program

The Patient-Centered Primary Care Home Program is part of Oregon's efforts to fulfill a vision of better health, better care and lower costs for all Oregonians.

The Oregon Legislature established the Patient-Centered Primary Care Home Program (PCPCH) in 2009 through passage of House Bill 2009. The program sets the standards for care, identifies primary care homes and promotes their development, and encourages Oregonians to seek care through recognized primary care homes.

Primary care homes and coordinated care organizations

Primary care homes are at the heart of Oregon's health system transformation efforts. To the extent possible, coordinated care organizations (CCOs) are required to include recognized primary care homes in their networks of care. Expanding the availability of primary care homes will provide better access to quality care and strengthen the primary care networks within CCOs. More than 300,000 (about 60 percent) of CCO members currently receive care at a primary care home. This number is expected to grow over time.

The core attributes of primary care homes

Key standards for primary care home recognition:

- Accessible: Care is available when patients need it.
- Accountable: Clinics take responsibility for the population and community they serve and provide high-quality, evidence-based care.
- Comprehensive: Patients get the care, information and services they need to stay healthy.
- Continuous: Providers know their patients and work with them to improve their health over time.
- Coordinated: Care is integrated and clinics help patients navigate the health care system to get the care they need in a safe and timely way.
- Patient- and family-centered: Individuals and families are the most important part of a patient's health care. Care should draw on a patient's strengths to set goals and communication should be culturally competent and understandable for all.

Access to primary care homes

With more than 360 recognized clinics across the state, many Oregonians now receive care in a primary care home. The program is currently reaching out to and developing resources to assist other clinics around Oregon that could be eligible for recognition.

OTHER KEY PROGRESS INDICATORS

Delivery System Update

Various types of clinics are recognized as primary care homes:

- Family practices
- Pediatric clinics
- School-based health centers
- Internal medicine clinics
- Solo providers
- Community mental health centers
- Rural health centers
- Women's health clinics
- Federally qualified health centers
- Tribal medical clinics

All major cities and many rural communities in Oregon already have recognized primary care homes. Right now, the program is focusing on helping more clinics in Eastern Oregon gain recognition.

What patients say about the care they receive at recognized primary care homes

- "The team working with my doctor knows about me. This saves me a lot of time." - Bryant Campbell, Portland
- "I am not just looked at for my physical health but they see me as a whole person." – Amy Morris, Salem
- "They explain things to me. They give me the skills to improve my health." – Michelle Lee, Medford
- "They give me all the information and care we need. It's a team approach," - Jamie Belleque, Eugene

Patient-Centered Primary Care institute and learning collaborative

The Patient-Centered Primary Care institute, launched in fall 2012, connects primary care clinics to a broad array of technical assistance and resources to help them adopt the patient-centered model of care. The Institute selected 25 practices from across Oregon to participate in its first Learning Collaborative. The Learning Collaborative will incorporate multiple learning methods to maximize opportunities for the selected practices to learn from each other and from technical experts in topic areas aligned with PCPCH program standards. The Institute also is developing a comprehensive website of resources, hosting monthly webinars on core quality improvement topics, and conducting a train-the-trainer program for quality improvement professionals. Please visit www.pcpci.org for more information.

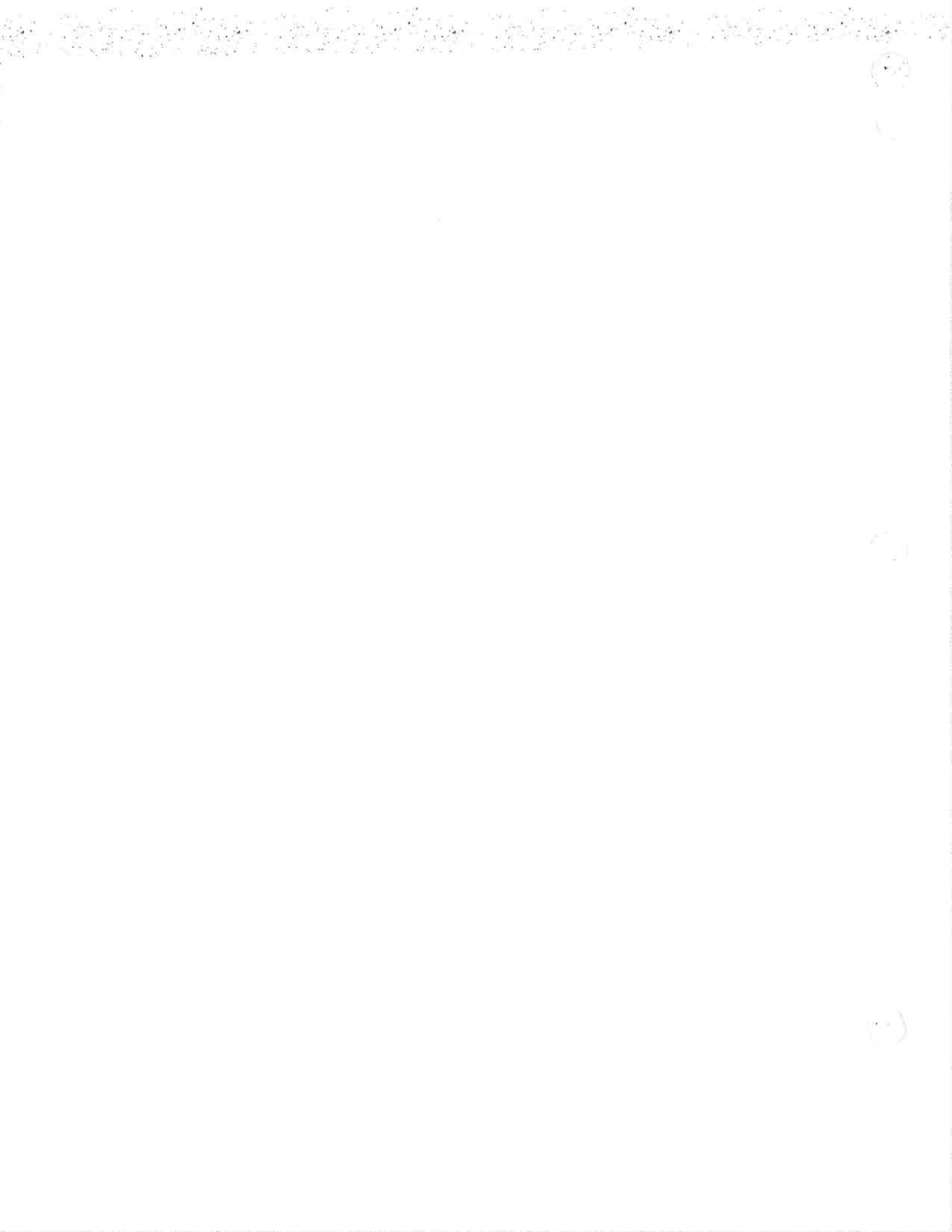
The Patient-Centered Primary Care Institute is a public-private partnership with the Oregon Health Authority, Oregon Health Care Quality Corporation, and the Northwest Health Foundation.

Incentives for recognized clinics

Oregon is working toward a system that rewards high-quality, efficient care that results in better health outcomes. Aligning payments to promote quality, instead of basing them on a fee-for-service model, will help primary care homes focus on what's really important — health. The program is working with both public and private health plans to align payment methods to support the patient-centered model of care.

Information and resources

Please visit www.PrimaryCareHome.oregon.gov to learn more. You can watch a video about patient-centered care, and view a map of the primary care homes in your area.



AllCare Health Plan

Case management of patients prevents costly emergency room visits

At AllCare, teams are working closely with about 500 patients a month who frequently use local hospital emergency departments. The coordinated care organization is already seeing a downward trend in emergency visits from this group of patients.

One woman had been to the ED four times in one month. They learned she was having housing problems, law enforcement issues, was often homeless, and had uncontrolled diabetes, high blood pressure, pain, and severe mental health issues.

First they connected her to primary care, then they found her supported housing. While she was an AllCare client, she stayed out of the emergency room and her physical and mental health conditions improved.

"The community wrapped around her," said Richard Lewis, a clinical social worker who worked with her. "It's so simple."

AllCare Health Plan, a coordinated care organization serving people in Curry, Josephine, Jackson and parts of Douglas counties

The community really wrapped around her. It's so simple really.

Richard Lewis, social worker with the AllCare Health Plan

Columbia Pacific Coordinated Care Organization

Integrated care improves patients' health

Part of Columbia Pacific CCO, the Tillamook County Health Department takes a three-pronged approach to health, combining public health, physical health, and now behavioral health services in their local health clinics.

This January, the Health Department collaborated with Tillamook Family Counseling Center to hire a behavioral health consultant and embed her in the county's clinics. The consultant now sees up to five patients each day, and expects to see as many as eight per day in the coming months.

Recently, the clinic saw a young child with a serious health problem that pointed toward an issue with the parent. A pediatric nurse practitioner introduced the family to the behavioral consultant, who found that the parent was overwhelmed with multiple psychosocial stresses. With support, the parent was able to get the child's health back on track.

Physician assistant Marty Caudle says integrating mental health into primary care is, "A huge benefit to us as providers, to the clinic as a whole, and to comprehensive care for all of our patients on the Oregon Health Plan."

Eastern Oregon Coordinated Care Organization

Teams work to help patients prevent additional hospitalizations

Eastern Oregon Coordinated Care Organization is working to help patients – particularly those who come to the emergency department frequently – avoid unnecessary hospital readmissions.

Teams confer with mental, physical and other health service providers to create a plan with the patient.

This coordination wasn't possible in the past, says Toni Olin, R.N., C.C.M., ODS Medical Management manager.

"We might have made suggestions about what a patient needed after being discharged, but we couldn't put all the services in place without all the partners and providers in the CCO," says Olin. "This is exactly how health care is supposed to work."

FamilyCare Inc.

Focus on primary care means more focus on patients

Improved access to primary care is one of the focuses of the coordinated care model. To that end, FamilyCare has increased the rates it is paying to primary care providers from $50 to $75 per visit. The goal is to encourage more primary care and allow provider clinics to focus more on patients.

Investing money now in primary care will save money in the long term, according to FamilyCare. Chronic diseases such as diabetes, severe mental illness, and other conditions are better treated in a primary care setting to avoid more acute care down the road.

Health Share of Oregon

Hospital-to-home transition program creates bridge for better health

The Care Transitions Innovation, or C-TraIn, program at OHSU helps patients manage after hospital discharge.

Key members of the Care Transitions Innovations (C-TraIn) team have included, from left, Devan Kansagara, M.D., M.C.R; Stephanie Peña, R.N.; Jackie Sharpe, PharmD; Char Riley; Nic Granum; Honora Englander, M.D.; and LeAnn Michaels.

Luis Ubiles' blood pressure was life-threateningly high when he was rushed to Oregon Health & Science University. He had lost his job and his health insurance, and couldn't afford his blood pressure medications. C-TraIn connected him with Old Town Clinic in Portland, which gave him 30 days of medication then connected him to free prescriptions. A team nurse visited him in the hospital and then at home.

"The care I've had has been fantastic. I don't ever want to have any more close calls," he said.

> ***We create a bridge from hospital to home***
>
> Honora Englander, M.D.

InterCommunity Health Network

Keeping patients from returning to the hospital

Within 48 hours after discharge, a Hospital-to-Home Program transition coach visits high-risk patients in their homes. The goal is to ensure they get the care they need and avoid hospital readmission.

Barbara Nay, R.N., makes sure patients receive follow-up care and other needed services. She also coaches on how to recognize when a 911 call is necessary and when it isn't.

Nationally, readmission rates are 17- 22 percent for patients with chronic diseases. Early estimates show that the readmission rate for the 37 patients in the program since January is below 10 percent.

Debbie Wilmot, left and Barbara Nay, right, are transitions coaches in the Hospital-to-Home program in the InterCommunity Health Network Coordinated Care Organization.

Jackson Care Connect

Patient-centered care helps patients heal mentally and physically

More than 40 percent of Jackson Care Connect's members have patient-centered primary care homes. This type of care is exactly what its name implies: it is focused on providing the patient with a wrap-around of services.

J and his mother, Shawna Shoffner

One example is Shawna Shoffner, who was suffering from depression and severe post-traumatic stress disorder (PTSD) after the death of her son, Van, who was killed in a car accident when he was 19. She found help at a patient-centered primary care home, La Clinica. The health care team helped her find grief counseling, group therapy and a pain management group.

Without this type of patient-centered care, Shoffner and many other patients would not be recovering their mental and physical health.

PacificSource Community Solutions, Central Oregon Region

Combining mental and physical health care in Deschutes County is saving lives

People with serious mental illness die an average of 25 years earlier than others, largely due to treatable medical conditions. This is a stark reality that tugged at Deschutes County mental health care providers. As part of the PacificSource Community Solutions CCO, Deschutes County Health Services and Mosaic Medical have begun offering mental and physical health care at one location in Bend at Health Services Annex, which opened last year.

Travis Sammon, supervisor of Deschutes County's Assertive Community Treatment and Patricia von Riedl, peer support specialist, Deschutes Behavioral Health

The outcome of this combined care is already beginning to show. The county previously averaged one death per month of a person with severe mental health issues. There has been only one such death in the past 14 months.

> *Now patients are getting what they need at the Health Services Annex*
>
> Travis Sammon

PacificSource Community Solutions Coordinated Care Organization, Columbia Gorge Region

New collaborations bring new information to help patients

PacificSource Community Solutions has determined that in the Columbia Gorge, about 3 percent of members are driving about 40 percent of costs. These are high-risk patients with multiple or severe chronic conditions, often with overlapping behavioral health needs. The costs range from $50,000 to $500,000 per patient per year.

The CCO is also comparing geographic data in the counties it serves to determine patterns of patients using multiple emergency departments. Before forming a CCO, this type of data analysis and use of medical services was not possible.

"We never knew this type of information. It's exciting to know we can combine of our individual efforts as a community and come up with answers and solutions," says Kristen Dillon, M.D., a family practice physician who serves on the CCO board.

"It's exciting to know we can combine of our individual efforts as a community and come up with answers and solutions," says Kristen Dillon, M.D. a family practice physician who serves on the CCO board.

PrimaryHealth of Josephine County

Collaboration pays off for better patient care

PrimaryHealth of Josephine County created a Community Learning Collaborative to promote better communication for improved patient care. This group includes physical, behavioral, primary care, and women's health care providers.

"It is in everyone's interest to collaborate — especially the patients'," said Jessica Norton, R.N., primary care home coordinator for Grants Pass Clinic.

The collaborative has worked especially hard to ensure safe and secure sharing of electronic medical records, to eliminate redundant and unnecessary testing, and better coordinate care. Strides also have been made to get hospital discharge information to the patient's primary care provider within 48 hours.

Kevin Molteni, M.D., is part of the care team of the Community Learning Collaborative at the Grants Pass Clinic.

Trillium Community Health Plan

Investment in tobacco cessation and prevention lowers cost, saves lives

When a community health assessment revealed that nearly 40 percent of pregnant women in the Lane County CCO's population use tobacco, Trillium Community Health Plan developed an innovative program to help them quit.

Trillium Community Health is investing $180,000 to train health screeners and tobacco cessation counselors who will enroll pregnant women in an incentive program that rewards former tobacco users who test nicotine-free during and after their pregnancies. The investment will be more than offset, the CCO says, in saved costs and improved infant, child and parent health over the coming years.

Trillium Community Health has committed to investing $800,000 annually in prevention efforts targeting tobacco use, obesity, depression and immunization.

Umpqua Health Alliance

Comprehensive services for highest-need members

Umpqua Health Alliance coordinated care organization is bringing physical, mental and oral care together under a single roof at the Umpqua Community Health Center in Roseburg. The expanded care clinic will serve the county's highest-need Oregon Health Plan members.

The CCO looked at pharmacy, emergency room and claims data to identify up to 100 members who could benefit the most from the expanded care model. Most of those people had multiple chronic illnesses that included undertreated oral health and mental health issues. The clinic will track 17 indicators of each of these members' health every month and make quarterly reports to the CCO board.

PHOTO: Umpqua Expanded Care Clinic staff, clockwise from top left: Bill Duhon L.C.S.W., Shawna Quaintance, M.A., Melissa Reppenhagen, R.N., Christi Parazoo, chief operations officer, Jennifer Micek, M.D., Darby Baker, receptionist

Western Oregon Advanced Health

Foster kids get the physical and mental health help they need — and quickly

The Foster Education and Resources, or FEARsome clinic was created specifically for foster children.

FEARsome Clinic staff: Dr. Carla McKelvey, pediatrician, Judy Sanders, mental health therapist, Cathy Houston, medical assistant and in the back, Dane Smith, M.D., oral surgeon.

"It is called FEARsome because we believe our foster parents are fearsome in their advocacy for their foster children. It's also called FEARsome because foster children need to learn how to be fearsome by gaining in self-esteem and self-confidence. We want kids to be strong and ready to face the world," says Carla McKelvey, M.D., pediatrician at North Bend Medical Center in Coos Bay.

The clinic provides a one-stop shop for foster children to receive the state-required health checkups, which includes mental health and developmental assessments and physical and dental health screenings. These must be done within 30 days of placement. This makes it easier for foster parents and helps children get off to a better start.

> ***We want kids to be strong and ready to face the world***
>
> Carla McKelvey,

Willamette Valley Community Health

Changing how patients use emergency departments

Willamette Valley Community Health is looking for ways to help 15 to 20 patients with chronic illness who are the highest users of the emergency department.

The CCO started using interdisciplinary teams that include the patient, a psychiatrist, a nurse case manager, the patient's medical provider, and a non-traditional health worker.

Since the non-traditional health worker program began late last year emergency department use by this group of patients has declined by 50-60 percent. The non-traditional health worker goes to patients' medical appointments, advocates for them and assists with navigating the health care system — whatever is needed to achieve better health. The CCO is now hiring two more workers.

From left: Nicolette Venegas, non-traditional health worker; Kim Schmaltz, nurse case manager, Veronica Sheffield, nurse case manager director.

Yamhill County Care Organization

Yamhill CCO leverages local innovation

When a primary care provider refers a patient to a behavioral health professional at another location, many patients fail to follow through with care. The rate of follow-through improves dramatically when physical health care providers can refer patients to behavioral health care providers within the same clinic.

This year, with a grant from the Yamhill CCO, the graduate department of clinical psychology at nearby George Fox University will train and place behavioral health consultants in six primary care clinics across Yamhill County. Training includes lessons in adapting to primary care environments and workflow.

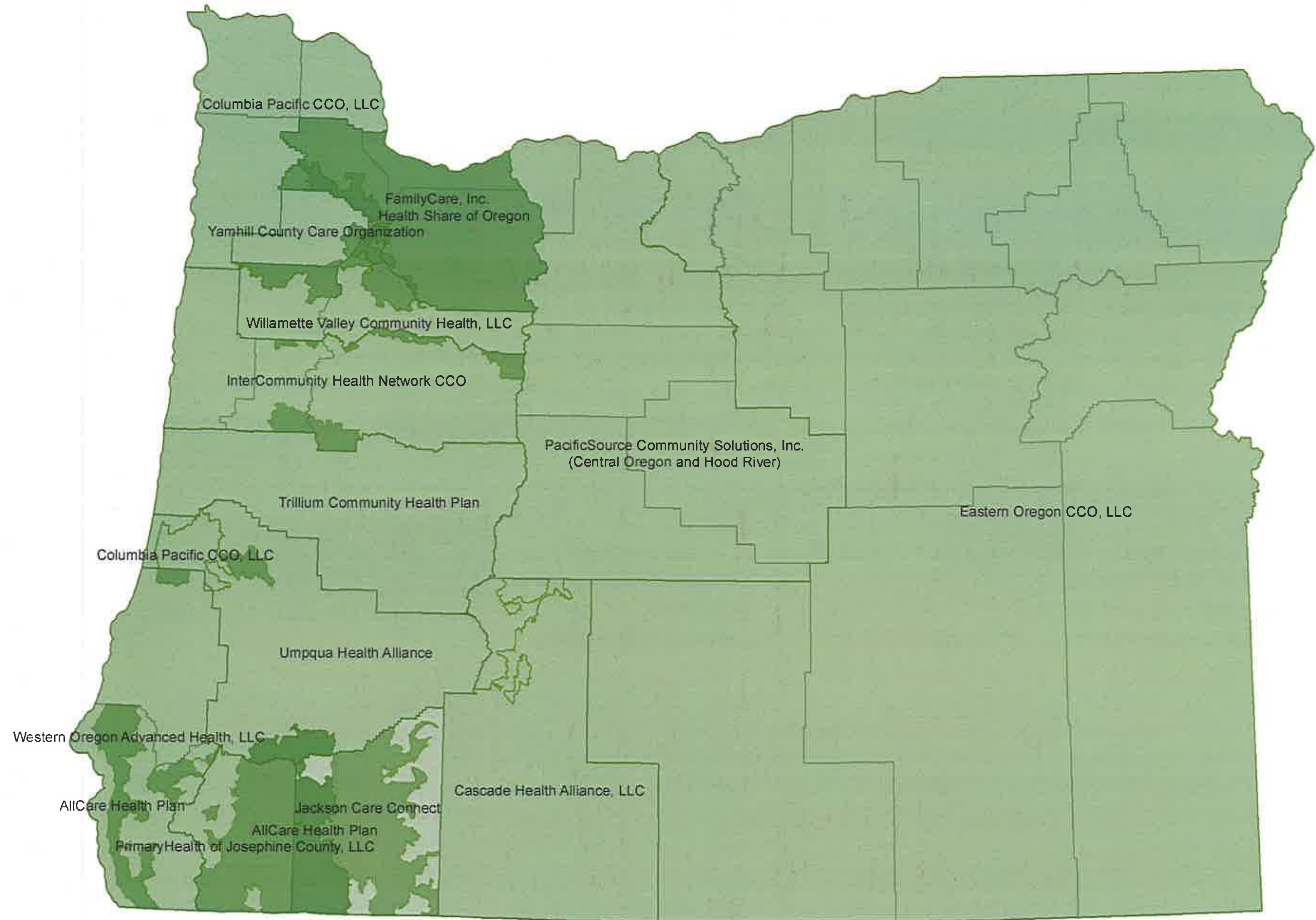
The program is one of four initiatives funded through the Yamhill CCO's "Invest Forward" grant program.

APPENDIX
Coordinated Care Organization Service Areas

CCO Name	Service Area by County
AllCare Health Plan	Curry, Josephine, Jackson, Douglas (partial)
Cascade Health Alliance	Klamath County (partial)
Columbia Pacific Coordinated Care Organization	Clatsop, Columbia, Coos (partial), Douglas (partial), Tillamook
Eastern Oregon Coordinated Care Organization	Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union Wallowa Wheeler
FamilyCare	Clackamas, Marion (partial), Multnomah, Washington
Health Share of Oregon	Clackamas, Multnomah, Washington
Intercommunity Health Network CCO	Benton, Lincoln, Linn
Jackson Care Connect	Jackson
PacificSource Community Solutions (Central Oregon Region)	Crook, Deschutes, Jefferson, Klamath (partial)
PacificSource Community Solutions (Columbia Gorge Region)	Hood River, Wasco
PrimaryHealth of Josephine County	Douglas (partial), Jackson (partial), Josephine
Trillium Community Health Plan	Lane
Umpqua Health Alliance	Douglas (most)
Western Oregon Advanced Health	Coos, Curry
Willamette Valley Community Health	Marion, Polk (most)
Yamhill County CCO	Clackamas (partial), Marion (partial), Polk (partial), Yamhill

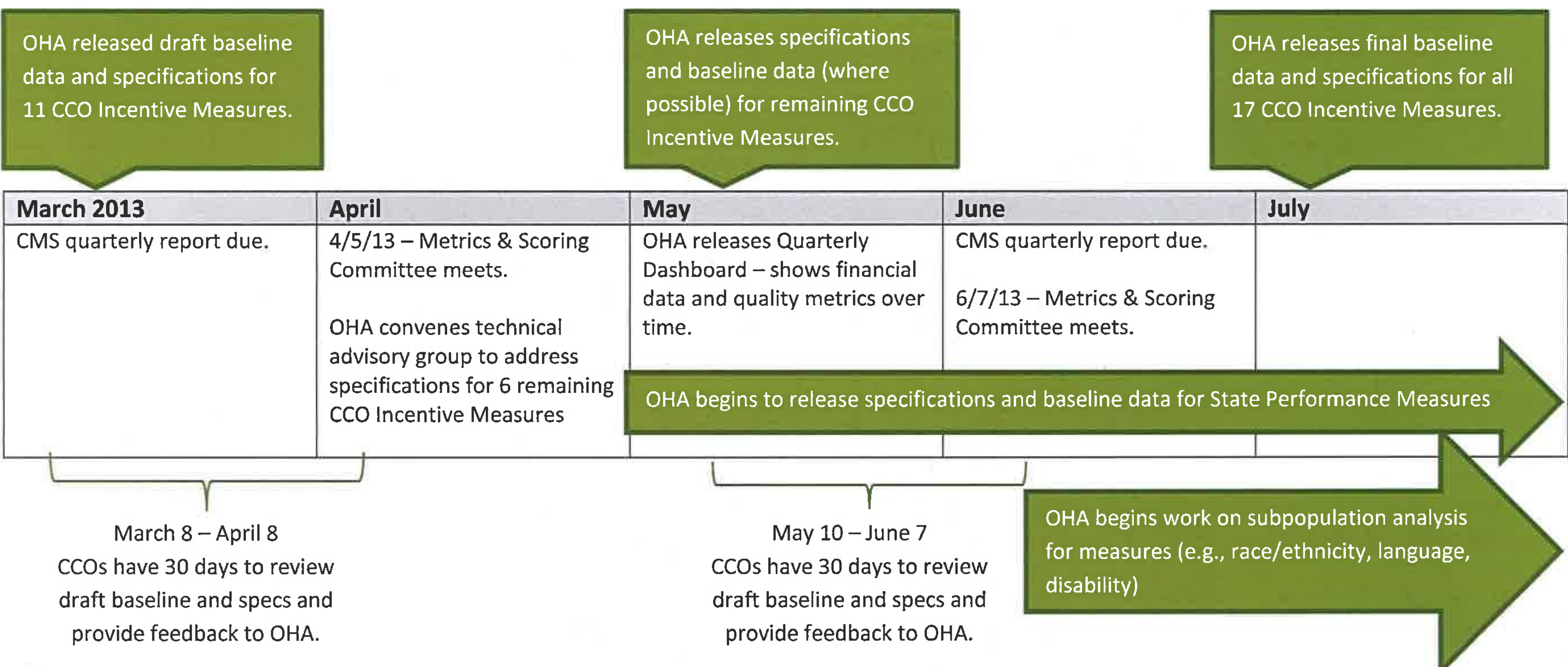
APPENDIX

Coordinated Care Organization Service Areas



APPENDIX

Timeline: CCO Incentive Measures and Quality Pool Year 1



APPENDIX

Timeline: CCO Incentive Measures and Quality Pool Year 1

August 2013	September	October	November	December
OHA Quarterly Dashboard released.	CMS quarterly report due.		OHA Quarterly Dashboard released.	CMS quarterly report due.

OHA continues work on subpopulation analysis for measures. Releases analysis for CY 2011 baseline.

January 2013 – December 2013: CCO Incentive Measurement Year 1

OHA releases CY 2013 results for 17 CCO Incentive Measures.

Quality Pool funding is disbursed.

January 2014	February	March	April	May	June
	OHA Quarterly Dashboard released.	CMS quarterly report due.		OHA Quarterly Dashboard released.	CMS quarterly report due.

Critical period for CY 2013 claims submission. If claims are not submitted by March, OHA cannot include them in analysis to meet the June deadline.

OHA analyzes CY 2013 data for CCO Incentive Measurement Year 1.

APPENDIX
OHA Contacts and Online Information

For questions about performance metrics, contact:

Lori Coyner

Director of Accountability and Quality

Oregon Health Authority

Email: lori.a.coyner@state.or.us

For questions about financial metrics, contact:

Jeff Fritsche

Finance Director

Oregon Health Authority

Email: Jeffrey.P.Fritsche@state.or.us

For more information about baseline data and technical specifications for measures, visit:

http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx

For more information about coordinated care organizations, visit:

www.health.oregon.gov

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