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January 24, 2014

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

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

Dear Co-Chairpersons:

NATURE OF THE REQUEST

The Oregon Health Authority (OHA) Transformation Center has compiled information in response to the budget note related to the $30 million Health System Transformation Fund.

The specific language of the budget note contained in HB 5030 stated:

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

The Oregon Health Authority will establish a process for approving and awarding the Health System Transformation Funds to Coordinated Care Organizations. CCOs will be asked to submit a proposal for up to the total dollar allocation for which they are eligible, describing the project objective, purpose and goals. Projects under implementation or proposed projects

should be innovative, scalable, transferable and related to CCO transformation plans and the overall goals of transformation with a focus on, but not limited to:
• Information technology systems and CCO infrastructure including additional investment in electronic medical records (EMR) and claims processing systems.
• Population health management, case management, disease management, and achieving quality metrics.
• Provider panel and clinic enhancements to provide extended primary care services to high risk Oregon Health Plan members.

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

AGENCY ACTION

The following is an update of the work related to the Transformation Fund budget note:

Process used for distribution
The OHA Transformation Center developed a proposal application process and timeline in collaboration with the CCOs in August 2013. As part of this discussion, the OHA Transformation Center gathered CCO's preliminary ideas so that each CCO could be aware of the other's intentions and be thoughtful and coordinated in their use of the funds.

During these discussions and prior to the submission of proposals, all 16 CCOs unanimously agreed that OHA should use $3 million of the Transformation Funds to leverage 90% federal funding to invest in statewide technology and technical assistance services to support Medicaid providers, CCOs and health system transformation efforts to share and aggregate electronic health information. The need for these statewide resources was identified through an extensive stakeholder process, including listening

sessions with CCOs, health plans, providers and other key stakeholders, including Oregon's Health Information Technology Oversight Council (HITOC). OHA anticipates that additional participants, beyond Medicaid, will wish to use later iterations of these services and will contribute to the financing and governance of those services over time. (See: OHA's State Near-Term HIT/HIE Development Strategy document for more details.)

CCOs were required to provide OHA with a brief proposal (approximately 10-12 pages) for use of their portion of the remaining $27 million Transformation Fund dollars during one of two application windows: by August 30th or Oct 25th. The two applications windows were created at the CCOs' request: some CCOs were ready to submit proposals in August, while others wanted more time to develop their proposals.

These proposals were required to include a description of the project or projects; target populations; community partnerships; timelines, including interim steps and deliverables; measurable project objectives and metrics; a description of how each CCO's proposed project is innovative, scalable, and transferable, as well as a brief explanation of how the project is relevant to the CCO's transformation plan and the overall goals of health system transformation in Oregon. In addition, CCOs were asked to identify how the projects support their transformation goals and how lessons learned would be shared with other CCOs. Lastly, CCOs were required to identify a project staff person who would be committed to participating in a learning collaborative for the Transformation Fund projects.

Review and Approval Process

The OHA Transformation Center had three main objectives for its review process of the Transformation Fund proposals:
1) ensure Transformation Funds were allocated to projects that meet the intent of the Transformation Fund (innovative, scalable, transferable and related to CCO transformation plans and the overall goals of transformation);
2) ensure projects had clear measurable objectives and reasonable budgets; and
3) to be efficient, collaborative and fair so that the Transformation Funds

could be awarded to CCOs as quickly as possible.

Transformation Center staff, including each CCO's Innovator Agents, were made available to support the development and (if necessary) refinement or clarification of each CCO's Transformation Fund proposal in order to expedite the contract development process.

Proposals were reviewed by an OHA Transformation Center executive review team. All 16 CCOs had their project proposals approved.

Dollar Amounts Distributed

Based on direction in the budget note, each CCO was provided with a base award of $1.25 million plus an additional per member allotment of the remaining amount left in the Transformation Fund. Distributions by CCO were as follows:

Transformation Fund Amount: **$30,000.000.00**
Amount Allocated for shared Statewide HIT investments: **$3,000.000.00**
Total Amount for Distribution to each CCO for Transformation Projects*:*
$27,000,000.00

CCO	**Member Enrollment**	**Base Award**	**Per Member Allocation**	**Total Award**
AllCare	27,222	$1,250,000.00	$354,152.48	$1,604,152.48
Cascade Health Alliance	10,853	$1,250,000.00	$141,198.35	$1,391,198.35
Columbia Pacific CCO	14,666	$1,250,000.00	$190,801.88	$1,440,801.88
Eastern Oregon Coordinated Care Organization	29,640	$1,250,000.00	$385,606.46	$1,635,606.46
FamilyCare	48,409	$1,250,000.00	$629,798.82	$1,879,798.82

Health Share of Oregon	154,265	$1,250,000.00	$2,006,965.27	$3,256,965.27
Intercommunity Health Plans	33,496	$1,250,000.00	$435,774.22	$1,685,774.22
Jackson CareConnect	19,044	$1,250,000.00	$247,753.18	$1,497,753.18
PacificSource CCO - Central Oregon	30,604	$1,250,000.00	$398,157.92	$1,648,157.92
PacificSource CCO - Gorge	7,293	$1,250,000.00	$94,881.16	$1,344,881.16
PrimaryHealth of Josephine County	6,045	$1,250,000.00	$78,642.34	$1,328,642.34
Trillium Community Health Plans	50,522	$1,250,000.00	$657,284.14	$1,907,284.14
Umpqua Health Alliance	16,601	$1,250,000.00	$215,980.24	$1,465,980.24
Western Oregon Advanced Health	11,975	$1,250,000.00	$155,788.02	$1,405,788.02
Willamette Valley Community Health	62,821	$1,250,000.00	$817,285.75	$2,067,285.75
Yamhill CCO	14,599	$1,250,000.00	$189,929.77	$1,439,929.77
Total of all plans	**538,054**	***$20,000,000.00***	***$7,000,000.00***	***$27,000,000.00***
Note: Enrollment is based off of an average enrollment between January 2013 and April 2013				

Projects Funded and Expected Outcomes

Nearly every CCO is funding multiple projects with their Transformation Funds. There is a wide array of projects across the 16 CCOs that reflect the individual strengths and needs of each CCO community, however, some common themes include:

HIT/HIE: Ten CCOs are using funds to invest in HIT/HIE infrastructure and/or initiatives.
PCPCH: Seven CCOs are using funds to invest in PCPCH clinics – helping more become certified and improving care provided within them.
Care Coordination: Six CCOs have projects to improve care coordination, especially between physical and mental/behavioral health providers.
Alternative Payment Models: Four CCOs have projects aimed at (or include) developing alternative payment models.
Community Grant Programs: Five CCOs are using transformation funds for a community grant program to support transformation. Three of these CCOs (EOCCO and both PacificSource CCOs) are using 100% of their funds for this.

The following is a complete summary of the projects being funded by CCO and expected outcomes:

AllCare Health Plan
AllCare's transformation funds will support their *Stewards of Change* Initiative. AllCare believes there is surplus funding throughout the social and health care system that is lost through duplication of services, delivery of unnecessary services, and safety issues that lead to avoidable poor outcomes and low quality care. Much of the surplus is currently absorbed in unnecessary costs by large hospitals and health systems that provide patient care that could instead be diverted to lower cost settings.

Building upon their innovative payment model for patient-centered primary care homes, they will adapt that model to achieve similar financial and clinical integration among their partners. Innovative payment methodologies and delivery models will support integrating physical health, mental health, dental health, and addiction recovery into non-hospital-based systems and into lower cost, preventive settings. These health care services are further enhanced through the support of community services and public health.

They will focus these efforts on high-cost and high-risk Oregon Health Plan members, and expect this model of collaboration and use of lower-cost settings to benefit all Oregon Health Plan members.

They will establish four committees for different provider types that will develop cost savings initiatives, quality measures, and tiered payment

structures for shared risk that can transform their financial and clinical models.

AllCare physicians have developed a new payment model that leaves the current system in place, while adding financial incentives for providers who meet certain objectives. For example, providers can increase their compensation by remaining open to new Medicaid patients. Some of the metrics that will be used to measure success include reducing the cost of hospital-based services and calculating the percentage of Oregon Health Plan members who rank their experience with the AllCare Health Plan as "high."

The Stewards of Change Initiative will also improve community services by funding the addition of more the 25 mental health and addiction counselors and about 60 health workers in the community. AllCare's vision of adding social services to individual care plans can easily be adapted by other communities.

Cascade Health Alliance

Cascade Health Alliance is using their transformation funds to establish five projects:

Implementation of a Health Information Exchange system: Exchange implementation will include connecting to the regional Jefferson Health Information Exchange to increase communication across the care team; improve the experience and care coordination for patients in multiple care settings; reduce hospital readmissions; and benefit from efficiencies that arise from the use of advanced HIE systems.

Youth Crisis Respite and Residential Program: The first youth crisis respite program in Klamath County will be a small, short-term residential program that offers care for youth experiencing transient psychiatric crises. Previously, youth patients who could not stay with their family or foster care homes would need to travel to expensive out-of-area services. This youth crisis respite will reduce costs for county youth mental health services, while providing more efficient and effective care in the community.

(Non) Traditional Health Care Worker and Non-Emergent Medical Transportation: Four (non) traditional community health workers will be connected with the non-emergent medical transportation system. They'll interact with and provide assistance in-home to high-health care utilizers, such as those who visit the emergency department frequently or those who could benefit from better care management.

Mobile Crisis Team: A Klamath County mobile crisis team will provide on-site, face-to-face therapeutic response to individuals experiencing a behavioral health crisis. The team replaces the current high-cost, emergency crisis response model. The team will be able to identify, assess, treat and stabilize the situation and reduce immediate risk and threat of harm. Providing intensive treatment in the community prior to the ER admission allows for safer and more effective treatment.

Care Coordination Program: Electronic health record systems will be used to improve care coordination among the many providers who may interact with a patient, including primary care physicians, specialists, nurses, and technicians. Incorporating electronic health records allows providers to access up-to-date information on patients; establish consistent treatments; transition patients to other care settings easily; share lab and other reports; and provide more efficient and effective care.

Columbia Pacific CCO

Columbia Pacific CCO will use their funds primarily to improve the delivery and integration of clinical care for members by focusing on three key areas.

Clinical interventions and improvements: Informed by their multi-disciplinary Clinical Advisory Panel (CAP), these projects will focus on clinical interventions.

- Implementing a CCO-wide opiate-prescribing and alternative pain management program that provides patients with chronic pain a tightly integrated team-based treatment program, which includes medical care, behavioral therapies, physical and movement therapy, relaxation and stress management, and education.
- Establishing ten detox beds.
- Creating crisis respite and safe holding capacity and recommendations for sustainable funding.

- Reducing inappropriate emergency department visits and hospital admissions for high-utilizers.

Medical home capacity building, provider training, and infrastructure improvements: Focusing on the PCPCH model, these projects will enhance population management, integration, and local access to service for both primary care and behavioral health clinics.

- Continuing the Primary Care Learning Collaborative: Provide technical assistance, training and other clinic support, building on previous CareOregon grants to expand and extend the learning collaborative to include behavioral health provider agency representatives interested in the PCPCH model.
- Training providers on medication assisted therapy, trauma-informed care, and SBIRT or SMART training to achieve screenings and outcomes benchmarks, and offering pharmacy supports for drug therapy coordination,
- Create PCPCH incentive payment models that reward providers for health outcomes.
- Building short-term residential crisis respite programs for individuals undergoing psychiatric crises who would otherwise remain in more expensive acute psychiatric beds.
- Implementing telemedicine for key specialty areas and diagnoses, and increasing the health care workforce capacity (primary care, behavioral and oral health and specialty providers) to accommodate the anticipated CCO membership growth.

Community development and partnerships: Provide wrap-around services and programs that support and enhance other efforts, including clinical capacity building.

- Healthy Homes Demonstration Pilot: Use the trained Community Action Team in Columbia County to assess and diagnose health risks in the home, and help arrange for funding for home rehabilitation in order to improve health.
- They will also select a community to participate in a community-wide Resilience Trumps ACEs training, which addresses the adverse effects that prolonged childhood trauma can have on brain development and offers hopeful behavioral health interventions for community members.

- The CCO will use the community health assessments from each county to address the identified health needs, which will likely include obesity, health education, prevention, and wellness activities.

Eastern Oregon CCO (EOCCO)

Eastern Oregon CCO will establish its own grant-making process, which will fund community projects that contribute to better health outcomes. Providers and community partners will submit project proposals, all which must show how they meet a demonstrated need of EOCCO members.

EOCCO will use the same grant process that OHA designed for awarding transformation funds. They will work in close partnership with the OHSU Center for Evidence-based Policy to manage the grant application and evaluation process, as well as set minimum and maximum grant request thresholds.

The goal is to implement effective, successful, and financially sustainable community projects that decrease costs, improve patient care, or improve access to preventive care. Likely projects include:

- Funding to assist Patient-Centered Primary Care Homes in achieving higher tier status
- Investments in telemedicine
- Integration of mental health providers into the primary care setting
- Employing community health workers in hospitals to reduce inappropriate ER use
- Alignment between EOCCO, schools, and public health

EOCCO will utilize an advanced analytics and actuarial team to track data and evaluate outcomes.

FamilyCare

FamilyCare CCO is using innovative systems as the foundation to better quality care and healthy individuals. Carrying this systems approach forward, FamilyCare will implement a multi-tiered investment strategy with five interrelated components.

The Integrated Patient/Provider Organized Delivery System (IPPODS) model is member- and provider-centered, and provides a more direct, hands-on and technological approach to care. Teams of care professionals will help

manage groups of providers based on region, specialty or patient population (such as diabetes as a specific condition, or particular geographic area). Simultaneously, FamilyCare will establish a "hub" of professionals focused on member services, such as Care Management or Referrals and Authorizations, who will be able to communicate with the teams in real time to coordinate care and connect members and providers to a wide range of services and professionals.

To provide members with greater options for Patient-Centered Primary Care Homes (PCPCHs), FamilyCare will provide technical assistance to small practice groups with technology investments and systems necessary to achieve PCPCH recognition status.

FamilyCare will invest in its IT infrastructure to create a more accurate and better integrated system through assessing use of electronic health records and identifying barriers. Then, it will support its contracted providers' use of electronic health records and information exchange.

To emphasize the importance of nutrition within the communities served, FamilyCare will hire a nutritionist. This directly ties into the nutrition and chronic disease elements of the Community Health Improvement Plan designed by FamilyCare's Community Advisory Council. The nutritionist will work with providers to share best practices for nutrition improvements through counseling and training, and will oversee a rotating panel of OSU graduate students interns on nutrition within clinicians' practices.

Finally, FamilyCare will invest in community education through a number of innovative pilot programs, with guidance from the Community Advisory Council. Often with partnership from community-based organizations, these programs will be distributed throughout the service region and will all be scalable, so that they may be added to additional regions following a thorough testing period.

Health Share of Oregon

Health Share of Oregon will focus on five priority areas that contribute to a regional system of care and promote the triple aim of better health, better care and lower costs. All the projects are focused on improving quality of

care through patient education and coordinated care. These projects align with their transformation plan.

A Transformation Oversight Committee will oversee the projects, authorize task forces or work groups for specific initiatives, and monitor milestones, deliverables, and metrics that demonstrate transformational achievements.

Priority 1: Strengthening Primary Care Capacity
Develop an Advanced Primary Care (APC) practice model. This supports multi-disciplinary teams in delivering coordinated care to patients with complex, chronic diseases.

Expand primary care capacity through implementation of telementoring (e.g., ECHO), which combines telehealth technology and case-based learning. Primary care providers will be trained by specialists and other providers to learn how to offer specialized care and co-manage Medicaid patients with complex health care needs.

Priority 2: Enhancing Community Health Integration
1) Expanding the Healthy Homes Asthma program: Conduct home visits to improve prevention and care for families with asthma patients.
2) Participating in the Future Generations Collaborative, which brings together Native community-based organizations, the Native community, and government agencies to improve the health of urban Natives.
3) Establishing chronic-disease self-management programs in supported housing environments to assist adults with chronic conditions in better managing their own care.
4) Developing Health Share's Community Health Improvement Plan through implementation of the Community Readiness Model.

Priority 3: Engage Members
With Community Advisory Council members and key stakeholders, develop a pilot program that will develop a patient-centered approach for assigning new members to PCPCHs based on the patient's values, preferences, and expressed needs. Additionally, implement outreach strategies for who are difficult to engage members, and identify other best practices for new patient PCPCH enrollment.

Priority 4: Improving Community Care Coordination through Information Sharing
A stakeholder group will gain consensus on information sharing needs and processes. Sharing health information across providers can increases efficiency, care management, and safety, but must be done in a manner that is appropriate, meaningful, and secure.

Priority 5: Leveraging Health Information Technology
Health Share will use a portion of its allocated transformation fund to cover initial investment required to purchase and implement key technologies to support strategic priorities. Final determination of selected technology investments will occur by June 2014.

InterCommunity Health Network CCO (IHN-CCO)
InterCommunity Health Network CCO will establish a regional health information data solution. A single data repository will aggregate data from multiple providers and health care systems. It will be used to assess current capacity, engage community partners, and perform system inventory. In the future, this system will provide a foundation for, among multiple other potential outcomes, developing a shared information model, creating standards and supports mechanisms, tracking metrics data and reporting.

The Regional Health Information Exchange will be developed by IHN in collaboration with several organizations and stakeholders. Participating organizations must accept a data use agreement and have the capacity to effectively store and manage electronic health care data in order to guarantee the highest level of security prior to exchanging sensitive health information.

This project supports region-wide care and community-based population health, supporting transformational projects through the use of shared information and advancements in technology, improving patient engagement, assisting with care and disease management, and enhancing partnerships between providers.

Over the course of the project timeline, IHN will design data sharing agreements, select vendors, establish infrastructure and supports, test scripts, integrate member and provider information, test the systems, provide outreach, and conduct training.

Jackson Care Connect

Jackson Care Connect will use its transformation funds with input from its Clinical and Community Advisory groups. Over the past year, these groups have helped Jackson Care Connect develop and implement innovative ideas, learning activities, and community partnerships. This funding will contribute to three projects that are tied together with overarching systems management and will result in shared learning.

Jackson Care Connect will hire a Portfolio Manager to support educational and facilitation needs, including management of the transformation fund projects.

The first project is an investment in data sharing and health information technology (HIT) improvements. This will increase data sharing between organizations already using electronic health records and better integrate behavioral health service organizations and social support services into the system. They will also connect to the surrounding region, in partnership with other CCOs and hospitals, through participation in the Jefferson Health Information Exchange.

The second project will support Patient-Centered Primary Care Homes (PCPCHs) in capacity building and other support for current PCPCHs and for small clinics interested in becoming PCPCHs. Establishing a local learning collaborative will offer peer support, cross-learning, and exposure to different clinical care models to help bolster the PCPCH system. It can also be tailored to local community needs. In partnership with others, they will develop a sustainable PCPCH payment model to support recognized clinics in maintaining their team-based, multi-disciplinary, integrated care delivery model.

Their third project is improving care coordination, specifically integration of behavioral and physical health, and coordinated care for high utilizers. In partnership with others, they will develop a system integration model that will inform integration activities locally and statewide, and will support participating organizations with small stipends for their time and dedication.

PacificSource Central Oregon CCO

PacificSource Central Oregon CCO will use their funds in eight key domain areas that were identified in a strategic planning process completed in early

2013. They will fund a number of projects in these eight key domain areas that include: prevention and population health; health system integration; care coordination for patients with complex medical needs; information technology systems and CCO infrastructure; workforce development; member engagement and activation; alternative payment methodologies; and research and evaluation.

They will use a transparent portfolio management model to fund and oversee projects. This process includes member engagement, and screening and assessing procurements for project proposals through a public, community RFP process. CCO committees and councils will help with the evaluation, support collaboration, and inform final funding decisions in partnership with a newly formed Grants committee, the Operations Council, the Community Advisory Council, and the Clinical Advisory Panel.

Example initiatives include:

- A maternal and child health initiative, leveraging a public health and primary care partnership to enhance access to targeted services for high-risk OHP maternity members
- A pediatric complex care coordination initiative that embeds a nurse care coordinator in its three largest pediatric practices and development of a community-wide strategy for high-risk pediatric populations through the existing Program for the Evaluation of Development and Learning
- Two chronic pain initiatives
- A community-wide care coordination strategy for adult patients with complex health care needs (Bridges Health)
- Integration of behavioral health into primary care and primary care into behavioral health settings (the latter for members with severe and persistent mental illness)
- Increased capacity for behavioral health in primary care, including expansion into pediatric, neonatal intensive care and internal medicine settings including involvement in a bi-state alternative payment study (SHAPE in Colorado)
- A community-wide effort to standardize transitions in care between regional emergency departments and long term care facilities

- Trial alternative payment methodologies involving global risk agreements in acute mental health and with a targeted Medicaid population within one large clinic system

PacificSource – Columbia Gorge CCO

The PacificSource Columbia Gorge CCO will use their transformation funds across five key portfolios that were selected in partnership with the Columbia Gorge Health Council (CGHC). Each of the areas of the portfolio management model will be overseen by a decision-making group made up of stakeholders responsible for maintaining financial viability of the portfolio, evaluating and monitoring opportunities and performance, and for making all decisions in a structured way.

To measure the appropriateness of projects and to set consistent expectations within each portfolio, the Columbia Gorge region adopted nine measurement areas: cost, health outcomes, incentive measures, member activation (knowledge and skill for self-management of care), member experience, health promotion, equity, determinants of health, and efficiency & effectiveness. Each proposed project will be assessed and approved through the RAPID (Recommender, Approver, Performer, Input, Decision Maker) model.

Each portfolio has a number of proposed or in-process projects. Thirty-five percent of the funds will be reserved for additional projects as new information is available in early 2014.

Project areas include:

- High-performing health care system: Drives change within the health care eco-system by reducing costs and improving efficiency, effectiveness and member experience. Facilitating PCPCH integration and adoption, integrating dental health into the system, creating a standard release of information form, and supporting alternative payment methods.
- Working across social and organizational cultures: Bridge cultures to increase effectiveness, address equity issues, decrease cost, and improve member experience, knowledge, skills, and education. Potential projects include outreach to high utilizers, training providers

in care management techniques, medical interpreter training, and addressing the results of the Oregon Equity and Inclusion grant.

- Engaged members: Member outreach focused on patient activation supporting more effective use of the health care system. Proposed projects include enrolling patients in the Persistent Pain Education and Opiate Reduction program; promoting maternal and child health through Text4Baby; and enrolling members through an improved on-boarding process.
- Community well-being: Improve long-term health within the larger community through education, health promotion, and addressing the determinants of health. Proposed projects include integration with the Early Learning Hubs, reducing childhood obesity through a Community Action Plan, and identifying and addressing community-wide needs through a comprehensive health system and community assessment.
- Information solutions: Investing in health information technology to improve information exchange capabilities. Projects include investing in clinical information aggregation, and creating capacity for integrated social service referrals.

65% of funding will be spread across five key portfolios; 35% will be reserved until early 2014 when results and further information becomes know.

PrimaryHealth of Josephine County

PrimaryHealth of Josephine County is using its transformation funds on seven core projects, which will improve the coordination of care, access to primary care, and the CCO's health information technology network.

Enhanced Care Delivery System Pilot: Sponsor an Enhanced Care Delivery System Pilot at the Grants Pass Clinic, a multi-specialty clinic which houses 56% of PrimaryHealth's primary care assignments. It will help improve quality and health outcomes, lower cost of care and increase patient satisfaction.

Maternal Medical Home: Work with Women's Health Center of Southern Oregon to develop a maternal medical home, where pregnant women can receive care that extends beyond the traditional obstetrical care model. It will improve birth outcomes by increasing compliance, education, and

outreach, and focusing care management resources on those women at highest risk for poor birth outcomes.

Support for Patient-Centered Primary Care Homes: Support the development and effectiveness of patient-centered primary care homes (PCPCHs) through alternate payment methodologies; pay for performance bonuses; and the provision of additional staff positions. Fostering the success of PCPCHs will help PrimaryHealth improve outcomes for all of its members.

PrimaryHealth Information Technology: Increase capacity for quality and outcome reporting by enhancing its health information technology (HIT) systems through better software and additional staff. This will guide transformational efforts and help demonstrate through data whether transformational changes in the system have created the desired improvements.

Network Health Information Technology: PrimaryHealth will solidify its connectivity to the regional Jefferson Health Information Exchange (HIE). This will allow community providers to coordinate care more effectively and efficiently and may connect to other regional platforms in the future. This project will allow PrimaryHealth to: Gain access to clinical data from contributors to the HIE; improve its ability to manage quality and cost by enhancing communication channels across the care team, reducing duplicated tests and directing patients toward more appropriate care settings and services; manage hospital readmissions by addressing the major risk factors affecting 30-day readmission; and improve the patient experience by ensuring they are seen by the right provider, at the right time to keep them healthy and manage their chronic health conditions.
Education to Support Transformation: Support necessary education to train personnel on the innovative care concepts and tools used in care transformation.

CCO Staff to Support Transformation: Lastly, employ individuals charged with monitoring, participating in, and facilitating transformational efforts.

Trillium CCO

Trillium Coordinated Care Organization is using its transformation funds on a project called the *Shared Care Plan*. The plan will address problems of limited communication and fragmented patient information by linking individuals on a member's care coordination team virtually – including the

member. This virtual link will allow teams to share information about the member and their care, even if the team is in different organizations or locations. The *Shared Care Plan* will help Trillium integrate and coordinate care for its 50,000 Medicaid members, ensuring higher quality health care and a better patient experience.

Trillium's three goals for the *Shared Care Plan* are to enhance and facilitate health information Exchange; improve care coordination and disease management to ensure improved outcomes for quality measures; and engage members in their care and well-being. It will also help further integration of physical and mental health and support the development of patient-centered primary care homes.

A secure web-based platform called Care Team Connect (CTC) will help convene a patient's team of providers across the health delivery network. It also combines risk assessments, a workflow engine and a secure data exchange to achieve robust care coordination.

The *Shared Care Plan* focuses on three main areas: care coordination and quality, patient activation, and health information exchange. It is a comprehensive coordinated care model tool that will allow Trillium to better manage the care of all its members, specifically those with a high need for patient-centered and preventive care coordination.

Umpqua Health Alliance

Umpqua Health Alliance plans will use its transformation funds on a wide range of small projects. The projects include:

- An expanded care clinic to help address the needs of the CCO's high utilizers by providing high quality primary care services. The clinic will coordinate physical, mental and dental health services, along with addiction and nurse case management services.
- Expanding the number of patient-centered primary care homes, with a focus on smaller and more rural practices.
- Collecting population metrics. Using its patient-centered electronic health record system will help support data collection. Electronic health records will also create opportunities for providers to be prompted to perform services for the patients who need them.

- Co-location of addiction services. By co-locating physical health services and addiction services, problems can be addressed at the time that an addiction is noted. By co-locating these services, UHA will increase the number of patients who see addiction counselors.
- Wellness services. Using its community health improvement plan, they will develop wellness programs, such as improved nutrition and exercise.
- Non-Emergent Medical Transportation is new to UHA and expected to be part of its provided services in July 2014. UHA plans to meet with area vendors to plan how to best serve its members' transportation needs.

Many of these projects are already in motion and will be launched by July 2014. This delivery timeline will allow for a full year of transformation in this biennium with the newly implemented projects.

Western Oregon Advanced Health

Western Oregon Advanced Health (WOAH) will use its transformation funds for four distinct projects, each of which is designed to support the triple aim and WOAH's transformation plan.

WOAH's first project will deliver a robust health information exchange, which will support health system transformation. They will expand on the region's existing efforts, which have been developed over the last three years through an informal association known locally as the Bay Area Community Health Information Alliance (BACHIA). The project will help BACHIA advance the planning, development, and implementation of the health information exchange. The critical needs that these funds will specifically be used for include a variety of highly specialized technical consulting services including planning, technical assistance, HIE vendor oversight, quality and analytics, clinical transformation, and replication and policy development.

The second project involves improving WOAH's advanced health analytics, supporting its strategic mission to meet and exceed Oregon's CCO incentive measures, while at the same time improving health outcomes and reducing costs. The analytic tools are based in part, on risk stratification, and will assist their providers to make the transition from symptom-driven care, to

forecasted care that is coordinated, preventive, and assisted by advanced care coordinators and case managers.

The third project WOAH will undertake is establishing a system of Medication Therapy Management. Certain prescription medications for mental illness are known to contribute to the development of diabetes. This initiative will help track and care for patients who have been diagnosed with mental illness and are taking those medications.

Finally, WOAH will use their remaining transformation funds to retain its contracted personnel who support the above projects, along with the portfolio of projects that are currently included in their Transformation Plan.

Willamette Valley Community Health

Willamette Valley Community Health's (WVCH) primary goals are improving access to care, better coordinating care, and making care more cost effective. They will use their transformation funds on four projects.

The first project is a community health information sharing initiative. To resolve fragmentation of information in the health care system, this initiative will make pertinent patient information available to community health providers. The plan will be scaled to include all patients in the community, not just Oregon Health Plan members.

Second, WVCH will improve patient outcomes through development of its patient-centered primary care home program. By adopting the core concepts of the model across its provider network, they will be able to increase the quality of care that their members receive. Eventually, they hope that patient-centered primary care homes can become part of robust "health care neighborhoods," which will be able to truly connect communities of patients, providers, and local organizations to improve overall community health.

The third project will help WVCH ensure that children with complex medical conditions are receiving comprehensive care. Almost 14% of children in their service area have special health care needs, and those children interact with multiple parts of the health care system. This project will develop a centralized care coordination system for children that cross

physical, mental and children's health services. Children and families with the most complex needs will be assigned a Family Support Coordinator to help coordinate the child's care.

Lastly, they will use transformation funds to collaborate with the early learning education system. Through partnership with its local Early Learning Hub, they can collaborate to help parents, providers and early learning providers to improve the well-being of children from conception to kindergarten.

Yamhill CCO

The Yamhill coordinated care organization's transformation plan will guide its transformation fund projects. It has eight initiative areas, all which help in achieving Oregon's triple aim of better health, better care and lower costs. Their eight projects focus on coordinated primary care, population health, chronic pain management, and health information exchange and data coordination. Funds will also be used to develop an alternative payment model.

One of Yamhill CCO's main goals is to improve primary care and care coordination. They'll work on this through their population health management initiative. The program helps patients who frequent the emergency department by connecting them with primary care services and other community resources. This provides alternatives to high-cost health care settings. The program also focuses on care coordination between delivery settings. Increasing access to primary care is part of this work.

Yamhill CCO is also working to ensure all providers are certified tier 3 patient-centered primary care homes. Additionally, they are developing maternal medical homes for all OB/Gyn providers. These initiatives will help members get appropriate care, while also decreasing costs by more efficiently utilizing the CCO's provider network.

Yamhill will also be working to provide timely primary care access to all of its members. They'll do this by expanding the CCO's primary care provider teams, which are comprised of physicians, advanced practitioners and (non) traditional health care workers. The team makes sure that the full spectrum of a patient's care is coordinated and focused on prevention. Additionally, this initiative will be used to fund the start-up of a bilateral integration care

model, which helps coordinate physical and behavioral health care by placing primary care physicians into mental health clinics and behavioral health specialists into physical health settings. Bilateral integration will foster timely patient-centered care in a single setting.

In addition to improving primary care and making sure patients are treated in a timely and effective manner, Yamhill CCO is using their transformation fund dollars to system improvements. A large portion of their funds will be used to develop a viable alternative payment model; improving and supporting local health information exchange tools; and to improve data coordination across the CCO.

Preliminary Results Available (including outcome measures)

Preliminary results are not yet available as projects are just getting started, but initial reports from CCOs will be available in February 2014 and more detailed progress reports in June 2014.

Expected Next Steps

CCOs will provide preliminary updates to OHA by February 1, 2014 and more detailed progress reports in June 2014.

In order to support shared learning and the success of these projects, The Transformation Center is bringing in IHI (Institute for Healthcare Improvement) to provide technical assistance to CCO staff and providers working on these projects. IHI will provide training to CCO staff this spring, designed to provide a framework to assist them in organizing and implementing their Transformation Fund improvement projects and enhance their understanding of quality improvement concepts, tools, techniques and methods. Sessions will include clarifying project aims, measuring improvement, testing change, scaling up, system maps, case studies, and developing a framework for spreading improvements system-wide.

The OHA Transformation Center and its Innovator Agents will work with CCOs to support the sharing of best and emerging practices from these projects throughout the life of the projects.

ACTION REQUESTED
Acknowledge receipt of report.

LEGISLATION AFFECTED
None

Sincerely,

Tina Edlund

Tina Edlund
Acting Director
Oregon Health Authority

CC: Linda Ames, Legislative Fiscal Office
Ken Rocco, Legislative Fiscal Office
Kate Nass, Department of Administrative Services

Health System Transformation Fund
Proposal Requirements

Background

The Health System Transformation Fund provides a strategic investment in Coordinated Care Organizations to engage in projects that support better health, better health care and lower costs in their communities. Projects must be innovative, scalable, transferable and related to CCO transformation plans and the overall goals of transformation, including but not limited to the following focus areas:

- Information technology systems and CCO infrastructure, including additional investment in electronic medical records (EMR) and claims processing systems;

- Population health management, case management, disease management, and achieving quality metrics;

- Provider panel and clinic enhancements to provide extended primary care services to high-risk Oregon Health Plan members; and

- Projects designed to improve patient engagement in and patient accountability for a patient's own health, disease prevention and wellness activities.

Transformation Funds may not be used to enhance reimbursements nor supplant state covered services.

Awards: Each CCO will be provided with a base award of $1.25 million plus an additional per member allotment of the remaining amount left in the Transformation Fund. OHA will notify the CCOs of the exact amount of their funding awards no later than August 9th. Award amounts will be posted on the Transformation Center website.

Project Period: Funding from the Transformation Fund is available to CCOs for transformation projects and activities through June 30, 2015.

Proposal Instructions:

Each CCO must submit a short proposal (approximately 10-12 pages) describing its Transformation Fund project. Page numbers are an estimate for guidance purposes, not a requirement. Proposals must contain the following elements:

- **Executive Summary** (*1 page)*
  - Brief summary of the project(s) including project goals.

- **Project Description** (*4-5 pages)*
  - Describe the project for which your CCO intends to use its transformation funds. Identify the target populations; who will be working on the project, including CCO staff and community partners, if relevant; and the tasks they will undertake.

- **Project Timeline** (*1 page)*
  - Project timeline, including key interim steps and deliverables.

- **Measurable Project Objectives and Metrics** *(1-2 pages*)
  - Share the goals your CCO expects to have reached by the end of the proposed project. In addition, present the key evaluation metrics your CCO will use to measure progress toward reaching these goals.

- **Spread of Innovation** *(1-2 pages)*
  - Describe how your CCO's proposed project is innovative, scalable, and transferable. Briefly explain how the project is relevant to your CCO's transformation plan and the overall goals of health system transformation in Oregon. In addition, identify what staff will be committed to participating in a learning collaborative for the Transformation Fund projects through the duration of the project(s).

- **Budget & Budget Narrative** *(2 pages)*
  - Provide a budget for the project using the attached budget template, and provide a separate 1-page budget narrative.

Use of Funds

Funded activities may include, but are not limited to: personnel, travel expenses, meetings and supplies, consultants, and indirect expenses

affiliated with the project such as administrative support, telephone, and computers.

Based on best practice guidance from experts on the science of innovation, we encourage CCOs to use these funds to support a CCO staff person to oversee CCO transformation activities, including but not limited to the oversight of the proposed project. The Institute for Healthcare Improvement (IHI) identifies this role as the "Portfolio Manager" and describes the position as responsible for monitoring the "learning system" and "aligning the work with the strategy and vision set by the Leadership Team… The Portfolio Manager provides the day-to-day line of sight from the Leadership Team to the execution work of the Project Team(s), and works in lock-step with the individual(s) designated to monitor system-level measurement of your projects over time."

Note that the Transformation Funds cannot be used to enhance reimbursements nor support state covered services. These funds may be used for pilot projects testing the use of flexible or other innovative services. In addition, organization-wide indirect costs and capital expenditures are not eligible for funding.

Review and Approval Process

The Transformation Center will review and approve Transformation Fund proposals during two application periods: one with a proposal due date of August 30th and contract effective date of October 1, 2013; the other with a proposal due date of October 25th and a contract effective date of December 1, 2013.

The review process has three main objectives:
1) ensure Transformation Funds are allocated to projects that meet the intent of the Transformation Fund (innovative, scalable, transferable and related to CCO transformation plans and the overall goals of transformation);
2) ensure projects have clear measurable objectives and reasonable budgets; and
3) to be efficient, collaborative and fair so that the Transformation Funds may be awarded to CCOs as quickly as possible.

Transformation Center staff, including each CCO's Innovator Agents will be available to support the development and (if necessary) refinement or clarification of each CCO's Transformation Fund proposal in order to expedite the contract development process.

Application Period 1 Timeline

Proposals Due	8/30/13
Proposal Review Completed	9/6/13
Time for proposal clarification or refinement (if needed) and contract negotiations	9/9/13 – 9/30/13
Transformation Fund contracts effective	10/1/13

Application Period 2 Timeline

Proposals Due	10/25/13
Proposal Review Completed	11/8/13
Time for proposal clarification or refinement (if needed) and contract negotiations	11/9/13 – 11/30/13
Transformation Fund contracts effective	12/1/13

The Transformation Fund provides us with a wonderful opportunity to invest in innovation and learn from each other. As a reminder, these awards are non-competitive: each CCO will receive a set amount and can decide how to invest those funds in whatever way works best as long as projects meet the parameters of the fund. A CCO's funding amount will not change if it chooses to submit its proposal during Application Period 2 instead of Application Period 1. Regardless of the start date of a Transformation Fund project, all funds must be spent by June 30, 2015.

Questions

We look forward to working with you on these grants and are here to help you with your proposals. Please contact your innovator agent or Cathy Kaufmann, Transformation Center Director, at 503.927.6340 or cathy.kaufmann@state.or.us if you have any questions.