Oregon Health Plan

Section 1115 Quarterly Report

1/1/2016 – 3/31/2016
Demonstration Year (DY): 14 (7/1/2015 – 6/30/2016)
Demonstration Quarter (DQ): 3/2016
Federal Fiscal Quarter (FQ): 2/2016

Oregon Health Authority

Oregon HEALTH PLAN

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I. Introduction

A. Letter from the State Medicaid Director

From January through March 2016, the Oregon Health Authority (OHA) continued to move forward in meeting the goals of the Oregon Health Plan (OHP) demonstration.

- **Lever 1: Improving care coordination** – As of March 30, 2016, there were 610 recognized clinics in the state (surpassing Oregon's goal of 500 clinics by 2015). This represents 61% of the estimated number of primary care clinics in Oregon. The proportion of CCO members enrolled in a PCPCH has continued to increase from the baseline of 51.8% to 87.5% as of the December 2014 – November 2015 reporting period, ranging from 73.5% to 99.9% among CCOs.
- **Lever 2: Implementing alternative payment methodologies (APMs)** – As required through Senate Bill 231 (2015), the Transformation Center is convening a new Primary Care Payment Reform Collaborative. The purpose of this collaborative is to convene payers to share best practices on APMs for primary care and initiative alignment. The first meeting is scheduled for April 15, 2016. In this quarter, the planning committee identified and interviewed stakeholders who will participate in the Collaborative.
- **Lever 3: Integrating physical, behavioral and oral health care** – The Behavioral Health Home Learning Collaborative (BHHLC) assists organizations with integrating primary care into behavioral health settings. In this quarter, all ten sites that participated in Year 2 opted to continue, and one site that had participated in Year 1 asked to rejoin, meaning OHA is currently working with eleven sites through December 2016.
- **Lever 4: Increased efficiency in providing care** – From calendar year 2014 to December 2014 – November 2015, the following measures of efficient and effective care for which data were available improved (see Appendix E for details):
    - Emergency department visits per 1,000 member months decreased by 1.7% (from 47.3 per 1,000 member months to 46.5 per 1,000 member months).
    - Potentially avoidable hospital admissions per 1,000 member months decreased for the following conditions: chronic obstructive pulmonary disease (13.3%), adult asthma (9.6%), and diabetes short-term complications (4.6%). However, potentially avoidable hospital admissions per 1,000 member months for congestive heart failure increased by 10.3%.
    - Developmental screening in the first 36 months of life increased from 42.6% to 54.0%. In addition, Adolescent Well-Care Visits increased from 32.0% to 36.8%.
- **Lever 5: Implementation of health-related flexible services** – In this quarter, the Transformation Center convened a meeting of internal stakeholders to discuss OHA's recent posting of revised Oregon Administrative Rules for flexible services. It was decided that the OARs will need to be revisited later in 2016 in the event of any changes in flexible services as a result of Oregon's CMS 1115 waiver renewal. In the meantime, OHA will address any questions about the OARs on a case-by-case basis.
- **Lever 6: Innovations through the Transformation Center** - CCOs have sought technical assistance through the Transformation Center and are taking action to implement the learnings, including evaluating the impact of programs that target social determinant issues, engaging members, integrating behavioral health and designing and implementing alternative payment methods.

Lori Coyner, State Medicaid Director

B. Demonstration description

The Oregon Health Plan (OHP) is the state's demonstration project under Section 1115 of the Social Security Act, funded through titles XIX and XXI of the Social Security Act.

Phase I of OHP started on February 1, 1994, for Medicaid clients in the Poverty Level Medical (PLM) and Aid to Families with Dependent Children (AFDC, now known as Temporary Assistance to Needy Families/TANF) populations. One year later, Phase II added persons who are aged, blind, and disabled, and it added children in state custody/foster care.

Following the creation of the Title XXI Program in 1997, the State Children's Health Insurance Program (SCHIP) was incorporated into the OHP, providing SCHIP-eligible people with the same benefits and delivery system available to Medicaid clients.

The OHP 2 demonstration began November 1, 2002, which established the OHP Plus and OHP Standard benefit packages, and included the Family Health Insurance Assistance Program. In 2007 and 2009, more children became eligible through expanded SCHIP eligibility and the creation of the Healthy Kids program.

On July 5, 2012, the Centers for Medicare and Medicaid Services (CMS) approved the current demonstration, Oregon's **Health Care Transformation**, through June 30, 2017. Key features include:

- **Coordinated care organizations (CCOs):** The State established CCOs as the delivery system for Medicaid and CHIP services.
- **Flexibility in use of federal funds:** The State has ability to use Medicaid dollars for flexible services (*e.g.*, non-traditional health care workers), to be used for health-related care that is authorized under managed care rules and regulations. CCOs will have broad flexibility in creating the array of services necessary to improve care delivery and enrollee health.
- **Federal investment:** The federal government agreed to provide federal financial participation (FFP) for several health care programs that had been previously supported entirely by State funds. These are called Designated State Health Programs (DSHP). Expenditure authority for DSHP is limited to $704 million FFP over the demonstration period July 5, 2012 through June 30, 2017, allocated by Demonstration Year (DY) as follows:

DY	Time Period	FFP Limit
11	07/1/12-06/30/13	$230 M
12	07/1/13-06/30/14	$230 M
13	07/1/14-06/30/15	$108 M

DY	Time Period	FFP Limit
14	07/1/15-06/30/16	$ 68 M
15	07/1/16-06/30/17	$ 68 M

- **Workforce:** To support the new model of care within CCOs, Oregon established a loan repayment program for primary care physicians who agree to work in rural or underserved communities in Oregon, and will complete training for 300 community health workers by 2015. As mandated by House Bill 3396 (2015 Regular Session), Oregon will do further evaluation and research to determine how to best recruit and retain health care providers to practice in rural and medically underserved areas of the state.

The primary goals of the Oregon demonstration are:

- **Improving health for all Oregonians**: The State is committed to fostering innovative approaches to improving population health through a focus on linking community health and services with the clinical delivery system. Population health efforts, Public Health Modernization and alignment with schools and the education system are integral to improving the health of all Oregonians by going beyond the walls of the clinics and hospitals.

- **Improving health care:** The State is working to coordinate physical, behavioral and oral health care and increase the focus on prevention and improved care. Individuals can get the care and services they need, coordinated regionally with access to statewide resources when needed, by a team of health professionals who understand their culture and speak their language.
- **Reducing the growth in Medicaid spending:** The state has agreed to reduce per capita medical trend, the growth in per capita spending, by 2 percentage points by the end of the second year of the demonstration period from an assumed trend rate of 5.4 percent as calculated by federal Office of Management and Budget.

In December 2013, conforming amendments for the Affordable Care Act and the full implementation of the Tribal Uncompensated Care amendment to the 1115 Demonstration were approved.

In June 2014, the Hospital Transformation Performance Program (HTPP) was approved, and OHA and CMS concluded final negotiations regarding the measures included in the program in September 2014. This two-year program will offer hospitals incentive payments to support quality improvement.

C. State contacts

Demonstration and Quarterly Reports

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II. Title

Oregon Health Plan Section 1115 Quarterly Report
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III. Events affecting health care delivery

A. Overview of significant events across the state

Category of event	Impact? (Yes/No)			Interventions or actions taken? (Yes/No)
	Demonstration goals	Beneficiaries	Delivery system	
A. Enrollment progress	No	No	No	
B. Benefits	No	No	No	
C. CCO Complaints and Grievances	-	-	-	
D. Quality of care – CCO / MCO / FFS	-	-	-	
E. Access	No	No	No	
F. Provider Workforce	No	No	No	
G. CCO networks	No	No	No	

Detail on impacts or interventions

Nothing to report this quarter.

B. Complaints and grievances

For this quarter, all CCOs reported using the updated complaint categories as reflected in the chart below. (Complaints received internally within OHA are reported in the narrative portion of this report.)

There are six main categories:

1. Access to providers and services;
2. Interaction with provider or plan;
3. Consumer rights;
4. Clinical care,
5. Quality of services
6. Client billing issues.

These categories are required under the Special Terms and Conditions of Oregon's current 1115 demonstration.

CCO complaints

Table 2 – Complaints and grievances

This chart shows the individual line items that are required under each main category. Some of the line item categories have been updated and implemented as of 10/01/2015. All CCOs are reporting in these updated categories for this quarterly report. The chart includes:

- The total of all complaints reported statewide by the sixteen coordinated care organizations (CCOs) for the quarter.
- Total number of statewide complaints that were resolved within the quarter,
- total number of statewide complaints that were pended at the end of the quarter,
- Average rate of enrollment during the quarter as reported by the CCOs,
- Rate per enrollee, which is based on the average total enrollment and calculated per 1000 members.

Complaint or grievance type	Number reported
ACCESS TO PROVIDERS AND SERVICES	
a) Provider's office unresponsive, not available, difficult to contact for appointment or information.	508
b) Plan unresponsive, not available or difficult to contact for appointment or information.	76
c) Provider's office too far away, not convenient	14
d) Unable to schedule appointment in a timely manner.	112
e) Providers office closed to new patients	26
f) Referral or 2nd opinion denied/refused by provider.	39
g) Referral or 2nd opinion denied/refused by plan	36
h) Unable to be seen in a timely manner for urgent/ emergent care	13
i) Provider not available to give necessary care	106
j) Eligibility issues	38
k) Female or male provider preferred, but not available	7
l) NEMT not provided, late pick up resulting in missed appointment, problems with coordination of transportation services	582
m) Dismissed by provider as a result of past due billing issues	5
n) Dismissed by clinic as a result of past due billing issues	2
INTERACTION WITH PROVIDER OR PLAN	
a) Provider rude or inappropriate comments or behavior	191
b) Plan rude or inappropriate comments or behavior	304
c) Provider explanation/instruction inadequate/incomplete	44
d) Plan explanation/instruction inadequate/incomplete	193
e) Wait too long in office before receiving care	221
f) Member not treated with respect and due consideration for his/her dignity & privacy	46
g) Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity, interpreter services not available	38
h) Plan's office or staff exhibits language or cultural barriers or lack of cultural sensitivity	5
i) Lack of coordination among providers	7
j) Wants to change providers; provider not a good fit	1
k) Member has difficulty understanding provider due to language or cultural barriers	32
l) Client dismissed by provider (member misbehavior, missed appointments, etc.)	31
m) Client dismissed by clinic (member misbehavior, missed appointments, etc.)	7
CONSUMER RIGHTS	
a) Provider's office has physical barrier(s), is not ADA compliant (preventing access from street level or to lavatory or to examination room or no special adaptations or doors)	19
b) Concern over confidentiality	19
c) Member dissatisfaction with treatment plan (not involved, didn't understand, choices not reflected, not person centered, disagrees, tooth not restorable, preference for individual settings vs. group.	98
d) No choice of clinician, or clinician of choice not available.	17

Complaint or grievance type	Number reported
e) Fraud and financial abuse (services billed not provided, service provided in two appointments that should have been provided in one.)	13
f) Provider bias barrier (age, race, religion, sexual orientation, mental/physical health marital status, Medicaid/Medicare)	16
g) Complaint/appeal process not explained, lack of adequate or understandable NOA	5
h) Not informed of consumer rights	1
i) Denied member access to medical records (other than as restricted)	5
j) Did not respond to member's request to amend inaccurate or incomplete information in the medical record (includes right to submit a statement of disagreement)	7
k) Advanced or Mental Health Directive not discussed or offered or followed	0
l) Restraint or seclusion used other than to assure member's immediate safety	1
CLINICAL CARE changed to Quality of Care	
a) Received appropriate care, but experienced adverse outcome, complications, misdiagnosis or concern related to provider care.	105
b) Testing/assessment insufficient, inadequate or omitted	57
c) Concern about prescriber or medication or medication management issues (prescribed non-formulary medication, unable to get prescription filled or therapeutic alternative recommended by Provider.	148
d) Member neglect or physical, mental, or psychological abuse	12
e) Provider office unsafe/unsanitary environment or equipment	68
f) Lack of appropriate individualized setting in treatment	17
QUALITY OF SERVICE	
a) Delay in receiving, or concern regarding quality of materials and supplies (DME) or dental	64
b) Lack of access to medical records or unable to make changes	8
c) Benefits not covered	48
CLIENT BILLING ISSUES	
a) Co-pays	7
b) Premiums	3
c) Billing OHP clients without approved waiver	172
Miscellaneous	15
Total	**3594**
Total resolved in the quarter	**3239**
Total pending at the end of the quarter	**55**
Total average enrollment numbers as reported by the CCOs as of 3/31/2016	**980,042**
Total rate per 1000 members	**3.67**

Attached separately is a summary of the statewide complaints and grievances reported by the CCOs in the six main categories. The chart includes the following:

- Summary totals per main category, per CCO,
- Number of complaints pended per category, per CCO at the end of this quarterly reporting period,
- Number of complaints resolved per category, per CCO at the end of this quarterly reporting period,
- The range of number of complaints and grievances per category, per CCO in this quarterly reporting period. (range indicates the following: **lowest number** = lowest number of complaints received in the category; **highest number** = highest number of complaints received in the category.)

Trends related to complaints and grievances

Total rate per 1000 members statewide this quarter in all categories is 3.67. This is a slight decrease from the previous quarter at 3.91 rate per 1000 members. The rate per 1000 members statewide averages enrollment for all 16 CCOs during the reporting period.

Rates per 1000 members among the individual 16 CCOs show the lowest rate per 1000 members for one CCO was .59 and the highest was 11.68 for another CCO. This is a decrease from last quarter, when the highest rate was 15.05 rate per 1000 members.

Review of the data indicates the Non-Emergency Transportation (NEMT) complaints decreased from 25% of the total complaints in the previous quarter to 16% of the total complaints this quarter. NEMT is a subcategory within the main category of Access to Providers and Services.

Further review of CCO data, reports and analysis indicate other subcategories within the Access to Providers and Services category had the highest range of complaints.

The rate per 1000 members for the Access to Providers and Services category was 1.60. This is a slight increase over last quarter's rate of 1.50 per 1000 members.

The Interaction with the Provider or Plan category rate per 1000 members is 1.14 this quarter, which is a decrease from last quarter's rate of 1.39.

Interventions

Two CCOs reported their NEMT contracted providers incorrectly submitted all complaints about members, and from members regarding services. The data should only reflect complaints from members regarding NEMT services. One CCO reported their NEMT contracted provider added several vehicles to their service and as a result saw fewer complaints. CCOs also reported they are continuing to provide training to NEMT providers.

OHA staff continues reviewing the NEMT data to assist CCOs in taking appropriate steps to resolve the issue statewide. OHA has initiated the rule change process to clarify expectations around the NEMT process.

Statewide, CCOs reported they are providing training to their contracted providers to encourage standardization in reporting complaints. Some CCOs indicate they have seen increases in complaint categories due to improved, standardized reporting. Health Systems continues to provide technical assistance training via a statewide Webinar regarding submitting quarterly data. The quality of the data submitted by the CCOs continues to improve in timeliness and standardization.

Fee-for-service (FFS) complaints

During the current quarterly reporting period, the OHA Client Services Unit received 6658 calls related to CCOs for this quarter. This is a slight increase from the last reporting period, but not a significant change from the average calls per quarter over the past year. The highest number of calls relating to the CCOs continues to be Client Choice/Enrollment and Disenrollment, with request for General Information/ Client Materials being the next highest.

The number of calls regarding FFS members received by the OHA Client Services Unit were 5447 for the current quarterly reporting period. The highest number of calls were regarding Client Enrollment, General Information and Third Party Liability.

C. Appeals and hearings

Table 2.1 – Appeals and hearings – statewide report – all categories of CCO appeals and contested case hearings for the current quarter

The following table lists the total number of Notices of Action (NOAs) issued by CCOs for the quarter by NOA reason, followed by the total number of appeals and contested case hearings requested in response to these NOAs, and the range reported across all CCOs.

Notice of Action (NOA) reason	Total NOAs issued	Total appeal requests	Range of appeal requests
a) Denial or limited authorization of a requested service.	28194	1976	17-508
b) Single PHP service area, denial to obtain services outside the PHP panel	177	11	0-7
c) Termination, suspension or reduction of previously authorized covered services	710	42	0-40
d) Failure to act within the timeframes provided in § 438.408(b)	3	0	0
e) Failure to provide services in a timely manner, as defined by the State	0	0	0
f) Denial of payment, at the time of any action affecting the claim.	16035	598	0-208
Total	45119	**2627**	**21-508**
Number per 1000 members	**46.04**	**2.68**	**0.85-6.31**
Number overturned at plan level	**-**	**826**	**5-233**
Appeal decisions pending	**-**	**30**	**0-15**
Number of contested case hearings requested	**-**	**770**	**4-149**
Overturned prior to hearing	**-**	**219**	**1-61**
Overturn rate	**-**	**28%**	**11-50%**
Hearing decision pending	**-**	**-**	**-**
Hearing requests per 1000 members	**-**	**0.79**	**0.3-1.87**

Contested case hearings

The following table[1] represents the contested case hearings that were processed during the fourth quarter of 2015.

Plan Name	Total hearing outcomes	Average plan enrollment *	Per 1000 members
ALLCARE HEALTH PLAN, INC.	39	50,668	0.7697
CASCADE HEALTH ALLIANCE	15	17,193	0.8724
COLUMBIA PACIFIC CCO, LLC	12	25,799	0.4651
EASTERN OREGON CCO, LLC	13	49,736	0.2614
FAMILYCARE, CCO	107	128,317	0.8339
HEALTH SHARE OF OREGON	138	235,978	0.5848
INTERCOMMUNITY HEALTH NETWORK	31	56,774	0.5460
JACKSON CARE CONNECT	13	30,278	0.4294
KAISER PERMANENTE OR PLUS, LLC	1		
PACIFICSOURCE COMM. SOLUTIONS	99	53,687	1.8440
PACIFICSOURCE COMM. SOLUTIONS - GORGE	4	13,282	0.3012
PRIMARYHEALTH JOSEPHINE CO CCO	6	11,720	0.5119
TRILLIUM COMM. HEALTH PLAN	48	94,087	0.5102
UMPQUA HEALTH ALLIANCE, DCIPA	35	27,343	1.2800
WESTERN OREGON ADVANCED HEALTH	25	20,713	1.2070
WILLAMETTE VALLEY COMM. HEALTH	120	101,985	1.1766

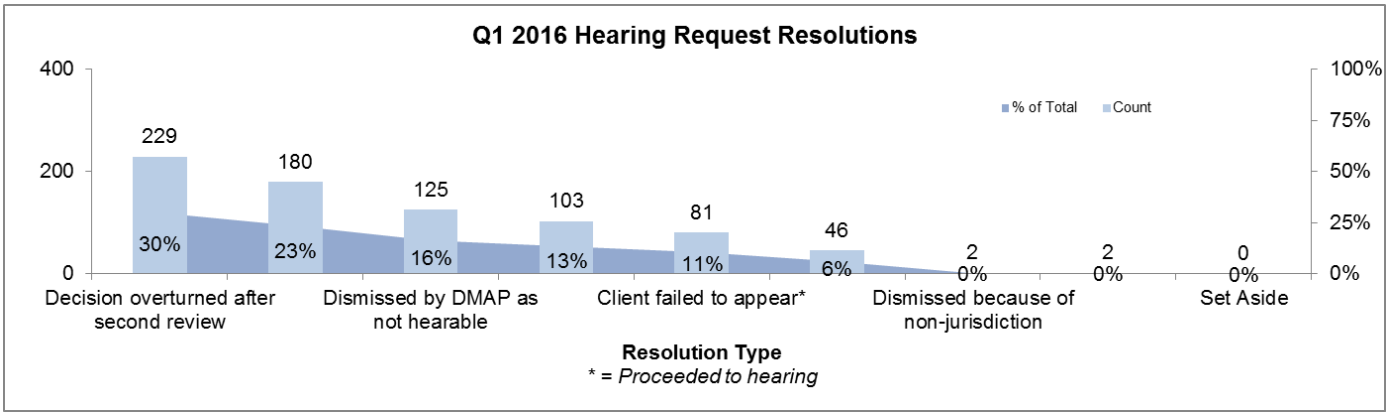
[1] Data Source: New_HearingLog.mdb & DSSURS; Data Extraction Date: 04/22/2016

Plan Name	Total hearing outcomes	Average plan enrollment *	Per 1000 members
YAMHILL CO CARE ORGANIZATION	8	23,719	0.3373
ACCESS DENTAL PLAN, LLC		2,172	0.0000
ADVANTAGE DENTAL	3	24,723	0.1213
CAPITOL DENTAL CARE INC	2	15,687	0.1275
CARE OREGON DENTAL	1	2,288	0.4371
FAMILY DENTAL CARE		2,165	0.0000
MANAGED DENTAL CARE OF OREGON		2,221	0.0000
ODS COMMUNITY HEALTH INC		8,143	0.0000
FFS	48	245,995	0.1951
Total	**768**	**1,244,673**	**0.6170**

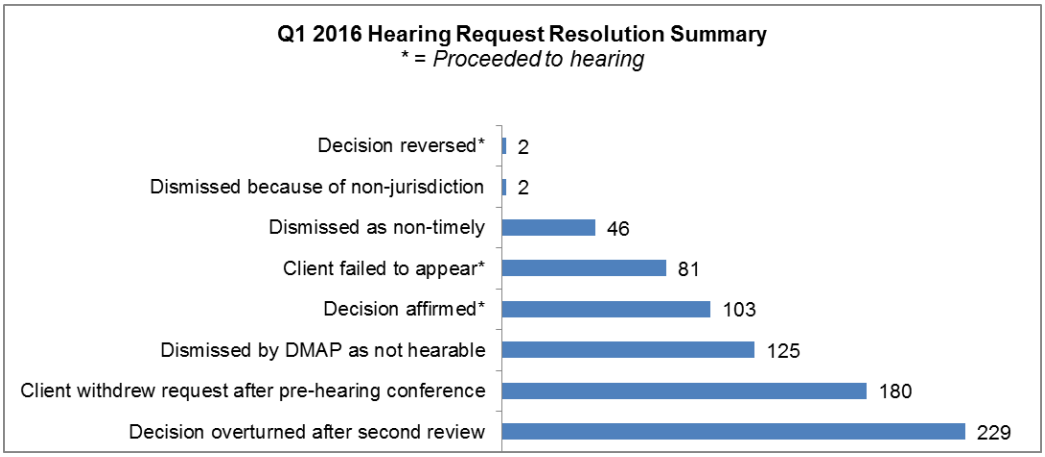
The following chart shows the outcomes of the hearings completed this quarter.

Outcome	Count	% of Total
Decision overturned after second review	229	30%
Client withdrew request after pre-hearing conference	180	23%
Dismissed by OHA as not hearable	125	16%
Decision affirmed	103	13%
Client failed to appear	81	11%
Dismissed as non-timely	46	6%
Dismissed because of non-jurisdiction	2	0%
Decision reversed	2	0%
Set aside	0	0%
Total outcomes	**768**	

Trends[2]



[2] Data Source: New_HearingLog.mdb; Data Extraction Date: 04/22/2016



Interventions

No report this quarter.

D. Implementation of 1% withhold

During this quarter, OHA analyzed encounter data received for completeness and accuracy for the subject months of June 2015 through August 2015. All CCOs met the Administrative Performance (AP) standard for all subject months and no 1% withholds occurred. Future reports may contain the following information:

Table 3 – Summary

Metric	Frequency	
	Quarterly	Annually
Actual amount paid of monthly PMPM capitation rate broken out by: ■ Average/mean PMPM ■ Eligibility group ■ Admin component ■ Health services component For the first year, this will be 99% and NOT include the 1% withhold, which is reflected under incentives agreement (or policy)	X	X
Actual amount paid in incentives monthly broken out by: ■ Total by CCO ■ Average/mean PMPM incentive ■ The over/under 100% of capitation rate by CCO and by average enrollee PMPM	X	X
Best accounting of the flexible services provided broken out by: ■ Services that are not Medicaid state plan services but DO have encounter data (e.g., alternative providers) ■ Services that are not reflected in encounter data (e.g., air-conditioners, sneakers)	X	X
CCO sub-contractual payment arrangements – narrative ■ Description of innovative (i.e., non-FFS) reimbursement and incentive arrangements between CCOs and sub-contracted service delivery network		X
Encounter data analysis ■ Spending in top 25 services by eligibility group and by CCO	X	X

Metric	Frequency	
	Quarterly	Annually
■ To the extent that this can be further indexed to the payment arrangements listed above, that would be helpful analysis as well		

E. Statewide workforce development

Health Care Interpreter (HCI) program update

Background

The utilization of language services, such as interpretation by qualified and certified HCIs, has been shown to improve cross-cultural communication, leading to increased compliance with recommended treatment plans, improved health care outcomes, overall reduction of healthcare cost, and ultimately, reduction in health disparities.

The HCI Learning Collaborative was set up by OEI with support from a CMMI SIM grant to train and certify 150 interpreters by September 2016. OHA expects that the availability of qualified and certified health care interpreters will help preserve access to health care services for Limited English Proficient (LEP) populations. Current and future access to health care services for LEP populations is necessary because the state has seen its minority population grow from 6 percent in 1980 to 22 percent in 2015. This population is projected to double to 44 percent by 2060[3].

Learning collaborative (LC) structure and process

Five LCs were initially planned around the state to train interpreters, but a sixth training was added to accommodate growing demand. Each LC has two main components (online and in-person). This format models the environment interpreters work in. Each collaborative (online and in-person session) provides a total of sixty hours of training for each participant. The required modules for the sixty-hour training are shown in the table below:

Structure of HCI training

Course	Required hours of training
Medical terminology	
Anatomy and physiology	
Health care interpreting concepts and modes	52
Health care interpreting ethics	8
Total	**60**

Participants who successfully complete their sixty-hour training may choose to complete an OEI application and provide all supporting documentation to become qualified. Participants who choose certification, which is a higher recognition level, must successfully complete their certification exam before completing and submitting their OEI approved application form and attachments. Certification exams are currently available only in the following languages: Arabic, Cantonese, Korean, Mandarin, Russian, Spanish and Vietnamese.

[3] Teixeira, Frey & Griffin (2015) State of Change: The Demographic Evolution of the American Electorate, 1974-2060. Available at (https://www.americanprogress.org/issues/progressive-movement/report/2015/02/24/107261/states-of-change).

HCI governance and meetings

The Council on Health Care Interpreters is set up as the main community advisory group for OHA/OEI on HCI policy and program improvement. The council works closely with its two subcommittees: The Legislative and Policy Subcommittee, and Education and Training Subcommittee. The council meets quarterly, but the subcommittees meet monthly. OEI also organizes quarterly stakeholder sessions. The sessions brings together diverse groups of community members who have direct or indirect interests in the HCI program. OEI convenes and resources all of these meetings.

Accomplishments/output

From its inception in 2015, the HCI LC program has successfully completed 4 LC trainings and started the 5th training which is scheduled to be completed on May 21. The sixth training in Portland will be held on June 20-21 (online) and June 27-July 2 (in-person).

About 134 interpreters have so far completed their required 60-hour training and are waiting for certification testing. The table below summarizes the number of trained interpreters and the languages they interpret in. Once the Portland trainings are complete, OHA expects to train an additional 55 HCIs, which will raise the total number of trained HCIs to 189, exceeding the goal of 150 trained HCIs.

Health care interpreter training

Venue	Number of trainees	Completed training (%)	Target language									
			Hispanic	Russian	Korean	Vietnamese	Arabic	Persian	Serbian	Burmese	Chinese	Somali
Bend	17	17 (100%)	16						1			
Portland	39	35 (90%)	21	3		4	2	2		1	2	
Pendleton	21	21 (100%)	18	2	1							
Medford	40	29 (72.5%)	29									
Wilsonville (online training)	32	32 (100%)	16	4	6	1		1			4	1
Portland												
Total	**149**	**134 (90%)**	**100 (74.5%)**	**9 (6.7%)**	**1 (0.7%)**	**10 (7.5%)**	**2 (2%)**	**3 (2%)**	**1 (0.7%)**	**1 (0.7%)**	**6 (4.5%)**	**1 (0.7%)**

HCI Rules Advisory Committee:

As part of updating OHA's HCI program policies, OEI convened a Rules Advisory Committee (RAC) in 2015 to review the HCI law (House Bill 2419) and propose changes. After extensive consultation and meetings, OEI produced a draft document. OHA organized a public hearing on April 20, 2016, to discuss proposed rule changes to HB 2419. Based on the feedback received during the public hearing, OHA expects the proposed policy changes to be implemented by July 2016.

Outcomes and impact of learning collaborative

- Four of the six LCs -- Bend, Portland, Pendleton and Medford -- have been completed so far. The online session of Wilsonville training is also completed. It is expected that the final training session in Portland, and the testing (language and certification) for trainees will be completed on schedule.
- It is also expected that by the time the SIM grant ends in September 2016, OHA will exceed the program goal of training more than 150 qualified and certified interpreters.
- The HCI program has also created the awareness on the importance of using qualified and certified HCIs.
- Completed RAC on HB 2419
- Completed review of HCI council by-laws

Developing Building Equity Leadership through Training and Action (DELTA)

Purpose

Developing Building Equity Leadership through Training and Action (DELTA) is a comprehensive leadership training initiative for building and strengthening capacity of Oregon's public health and healthcare system in health equity and diversity development. A cohort of 25 individuals representing community leaders, policy makers, administrators and clinicians are recruited each year from communities of color, the Oregon Health Authority, hospitals and health systems and coordinated care organizations (CCOs) for participation in the program, which includes training, project work implementing CLAS standards, coaching/mentorship and application of skills for nine months.

Goals

Goals of the DELTA program include the following:

- Build the capacity and commitment of Oregon's health leaders to eliminate health disparities
- Develop collaborative approaches and partnerships to promote health equity across Oregon's health promoting systems
- Inspire leaders to act individually and collectively as proactive change agents to address significant challenges and barriers to achieving optimal health outcomes for all Oregonians

Upon completion of the program, this cohort will act as drivers of equity and inclusion within Oregon's health promoting systems. Cohort members are eligible for up to 42 Continuing Medical Education credits and apply the skills they acquire from the training to facilitate the development and institutionalization of health equity and inclusion strategies in their organizational settings. In doing so, health equity, diversity development and inclusion is built into planning, policies, programs, practices, and resource distribution of these organizations.

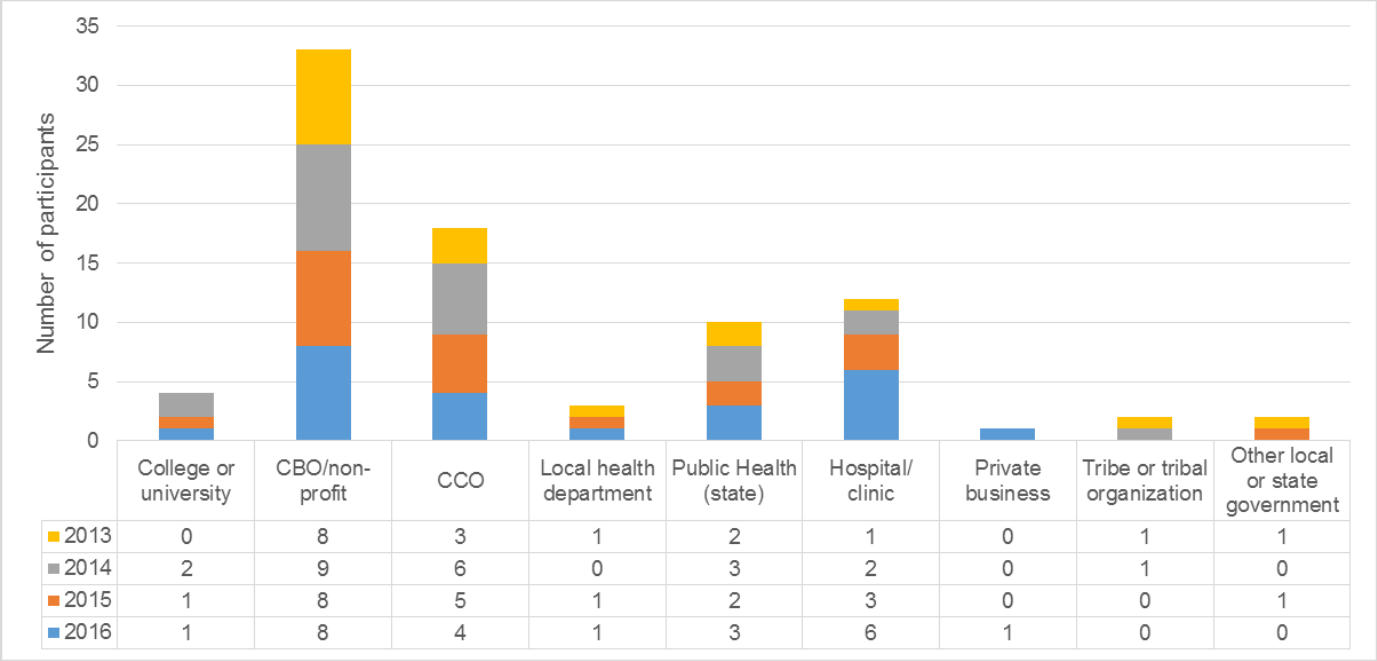
Structure/process

- 25 individuals accepted through application process each fall;
- 40 hours of classroom training extending over a nine-month period;
- 250 hours (10 hours X 25 participants) of individual coaching and consulting to cohort members on hands-on application of the skills acquired from the training overlapping with the last three months of the classroom training.

In addition, from April 2016 – July 2016, OEI will hold a regionally-focused smaller cohort pilot in the towns of Pendleton, The Dalles, Madras and Prineville to cover similar curriculum over the course of eight sessions.

Output/accomplishments to date

The following chart provides a snapshot of the composition of the statewide DELTA cohort members from 2013 to 2016. Please note that starting in 2015, the DELTA cohort expanded to include non-health organizations (education, environment, housing & law enforcement) to build a stronger understanding of the social determinants of health.



Outcomes/impacts

The majority of respondents participating in post-program surveys and six-month key informant interviews indicated:

- Their organizations either had a plan or were in the process of developing, or intended to develop, a plan related to the equity, diversity and inclusion concepts as a result of the DELTA training;
- Better understanding of concepts such as Community Partner Engagement, Diversity Hiring and Retention, Implicit Bias, Race, Ethnicity and Language Data Collection, Health Literacy, Language Access;
- The relationships they made during their training have continued, as a group or network, and are used to overcome challenges in advancing health equity.

Traditional Health Workers program

Table 4 - Traditional Health Workers (THW)

THW Program	Total number certified statewide		Number of approved training programs	
	Current Qtr.	Cumulative	Current Qtr.	Cumulative
Community Health Workers (CHW)	80	367	0	10
Personal Health Navigators (PHN)	2	4	0	1
Peer wellness/support specialists	131	469	4	21
Other THW (Doulas)	4	23	0	1

Narrative detail on regional distribution of certified THWs and THW training programs; news about relevant recruitment efforts or challenges

THW-related policy

Rulemaking continues to implement House Bill 2024 from the 2015 Legislative session. This bill requires OHA to work with coordinated care organization (CCOs) and dental care organizations (DCOs) to develop certification requirements for THWs to provide dental health education and dental disease prevention services. The final rules will be completed no later than July 1, 2016.

New background check rules are being established that may have an impact on THW background checks. Rules were finalized December 2015. THW program staff has received updates from the DHS/OHA Background Check Unit on processing background checks.

The THW Commission Scope of Practice Committee is finalizing the updates to the scope of practice for each THW Worker type. The Community Health Worker scope of practice is finished. All other worker type scopes will have been completed in March/April 2016.

Regional Health Equity Coalitions

Background Info

The **Regional Health Equity Coalitions** (RHECs) are community-driven, cross-sector, collaborative groups organized at a regional level to identify policy, system and environmental solutions that increase health equity for underserved and underrepresented communities experiencing health disparities.

There are currently six RHECs spanning 11 Oregon counties and the Warm Springs Tribe. The majority (5 out of 6) coalitions' regions cover mostly rural areas, and have high proportions of diverse, underserved communities that are often considered "difficult to reach" or even "invisible" populations, as shown in the table below:

RHEC Regions

RHEC	Area served and community composition
Klamath RHEC (KRHEC)	Klamath County: Rural and frontier areas, Confederated Klamath Tribes, Chiloquin & surrounding areas
Let's Talk Diversity (LTD)	Jefferson County (the most diverse Oregon county per capita) and Confederated Tribes of Warm Springs: Rural, frontier and small town settings
Linn-Benton Health Equity Alliance (LBHEA)	Benton & Linn Counties: Mixture of large and small towns, and rural settings throughout
Mid-Columbia Health Equity Alliance (MCHEA)	Hood River & Wasco Counties: Small town and rural settings. High prevalence of Latinos, including monolingual and bilingual Spanish-speakers.
Oregon Health Equity Alliance (OHEA)	Multnomah, Clackamas & Washington Counties: containing 44% of the state population, mostly urban; includes some rural settings
Southern Oregon Health Equity Coalition (SO-Health-E)	Jackson & Josephine Counties: Rural and small town settings

According to data collected January 2016, the RHECs collectively have 1,491 active coalition members, and work with 218 local agencies and organizations.

Over the course of only six months (July 2015 – December 2015), the RHECs held 118 outreach events which reached 609 organizations and 12,674 individual participants.

Based on the coalitions' regions and the state's population, the RHECs have the ability to impact approximately 68% of Oregon's most vulnerable populations.[4]

[4] US Census. American Community Survey (ACS), 2014 estimates.

Populations served by the RHECs

Region	Total population (% of state)	Populations served as % of region						
		African American/ Black	Asian	Pacific Islanders	American Indian/ Alaska Native	Multiple race	Latino/ Hispanic	White non-Hispanic
State of Oregon	**3,970,239 (100%)**	79,405 (2%)	170,720 (4.3%)	15,881 (0.4%)	71,464 (1.8%)	158,810 (3.6%)	516,131 (12.5%)	3,493,810 (87.9%)
Klamath RHEC (KRHEC)	**65,455 (2%)**	589 (0.9%)	655 (1%)	131 (0.2%)	3,076 (4.7%)	2,618 (4%)	7,789 (11.9%)	58,451 (89.3%)
Let's Talk Diversity (LTD)	**22,192 (0.5%)**	133 (0.6%)	200 (0.9%)	67 (0.3%)	4,216 (19%)	732 (3.3%)	4,350 (19.6%)	16,755 (75.5%)
Linn-Benton Health Equity Alliance (LBHEA)	**205,672 (5%)**	1,851 (0.9%)	7,404 (3.6%)	617 (0.3%)	2,468 (1.2%)	6,993 (3.4%)	15,837 (7.7%)	186,750 (90.8%)
Mid-Columbia Health Equity Alliance (MCHEA)	**394,972 (10%)**	2,370 (0.6%)	3,555 (0.9%)	1,185 (0.3%)	9,874 (2.5%)	8,689 (2.2%)	70,305 (17.8%)	368,904 (93.4%)
Oregon Health Equity Alliance (OHEA)	**1,734,682 (44%)**	52,040 (3%)	123,162 (7.1%)	8,673 (0.5%)	20,816 (1.2%)	67,653 (3.9%)	208,162 (12%)	1,462,337 (84.3%)
Southern Oregon Health Equity Coalition (SO-Health-E)	**293,886 (7%)**	2,057 (0.7%)	3,527 (1.2%)	882 (0.3%)	4,408 (1.5%)	9,698 (3.3%)	27,919 (9.5%)	273,608 (93.1%)
Total reach of RHECs	**2,716,859 (68%)**	**59,040 (74.4%)**	**138,503 (81.1%)**	**11,555 (72.8%)**	**44,858 (62.8%)**	**96,383 (61%)**	**334,362 (64.8%)**	**2,366,805 (67.7%)**

Partnerships

Coalitions partner with community organizations, coordinated care organizations (CCOs) and health systems to promote health equity by sharing their expertise and building a bridge between these organizations and culturally and linguistically diverse communities.

RHEC evaluation

OHA and the RHECs are working collaboratively to measure the effectiveness of the RHEC model and their strategies. Five outcome measures and eight corresponding indicators assess:

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

Below are examples of progress within those outcome and indicator areas over the past couple of years.

Example outcome/accomplishment

One of the primary priorities of one RHECs is to ensure healthcare access for all communities in Oregon. They work with communities to develop policies that improve access to health care and address social determinants of health, providing community education, gathering and analyzing data on health disparities,

and identifying and prioritizing policy solutions. Recently, one of the RHECs released a report to highlight the remaining gaps in the healthcare system which prevent Oregonians from receiving needed care.

Health professional graduates participating in Medicaid

Nothing to report this quarter. This data is produced semi-annually and reflected in the appropriate Quarterly Reports.

F. Table 5- Significant CCO/MCO network changes during current quarter

Approval and contracting with new plans	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
-				

Changes in CCO/MCO networks	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
Addition of contract with FamilyCare and OHSU effective 3/1/2016	Addition of major hospital/ specialty network	Increase in access	1	130,000

Rate certifications	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
-				

Enrollment/disenrollment	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
No issues	-	-	-	-

CCO/MCO contract compliance	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
Some CCOs on compliance status agreements for pended encounter claims.	-	-	2	-
OHA issued a corrective action plan to Columbia Pacific CCO in Feb, 2016 to improve the children fidelity wraparound access and delivery of services.	Would give access to this high needs child population per contract requirements.	Would give access to this high needs child population per contract requirements.	1	

Relevant financial performance	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
No changes – all CCO's performing to standards	-	-	-	-

Other	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
-	-	-	1	-

G. Transformation Center

The Transformation Center continues to assist CCOs through Innovator Agent leadership, learning collaboratives and technical assistance.

Key highlights from this quarter:

Behavioral health integration

This quarter, the Transformation Center made progress on initiatives to support behavioral health integration:

- The Patient-Centered Primary Care Institute is creating an online **behavioral health integration resource library**, which will include virtual site visits, topic-specific interviews and an in-person training for practice facilitators.
- **Behavioral health integration technical assistance consultation** has launched for CCOs and their provider networks to implement their 2015-2017 Transformation Plans and achieve the integration standards established by the Patient-Centered Primary Care Home Standards Advisory Committee. Staff have met with 13 CCOs to discuss integration needs. Work is underway to match CCOs with appropriate consultants.
- In February, OHA released a solicitation ($300,000 maximum) to select an organization to establish a statewide **Project ECHO** (Extension for Community Healthcare Outcomes) tele-mentoring infrastructure with initial focus on adult and psychiatric medication management. One proposal was received and contracting is moving forward to add an ECHO clinic focused on pediatric psychiatric medications.

Population health

Community Advisory Council supports

In alignment with the Transformation Center's new strategic focus on providing targeted technical assistance, the Transformation Center is providing targeted support to CCO community advisory councils (CACs) for CAC member recruitment and engagement. In February, the Transformation Center convened a CAC recruitment and engagement committee to guide the development of this new work. Committee members include CCO staff and CAC members, and subcommittees are focusing on: 1) developing and sharing CAC recruitment and engagement materials; and 2) planning an all-day event for CAC leaders on May 24 in Eugene to focus on CAC recruitment and engagement strategies.

In addition, the Transformation Center contracted with Intersect Video to produce a 30-second public service announcement for local CAC member recruitment. A separate version will be created and shared with each CAC to use in their communities.

Community Health Improvement Plan Implementation Grants

The Transformation Center's Community Health Improvement Plan Implementation Grants were announced in January and all 16 CCOs submitted applications. The grants include up to $30,000 per CCO to support the implementation of strategies identified in their community health improvement plans. Applications included activities such as chronic disease self-management, diabetes prevention, tobacco treatment specialist training, trauma informed care training, motivational interviewing training, community engagement and needs assessment initiatives, health and early learning program expansions, and member education through social marketing.

Among the applicants, 13 have moved toward grant execution, and three are awaiting CMMI approval. While CCOs will have until December 31, 2016, to complete their grant-funded activities, the funds are meant to spark longer-term population health transformation at the community level.

Health Equity Consultations

The Transformation Center, in collaboration with the Office of Equity and Inclusion, will be conducting pilot consultations on health equity with two CCOs – Willamette Valley Community Health and Yamhill CCO – in May. Consultant Ignatius Bau will provide each CCO with a comprehensive health equity analysis of their Transformation Plan, Community Health Improvement Plan and CCO incentive metric data to identify health equity opportunities.

Clinical delivery supports

Statewide CCO Learning Collaborative for the Quality and Health Outcomes Committee

This quarter, the Transformation Center facilitated two statewide CCO learning collaborative sessions. In January, the collaborative focused on behavioral and physical integration for people with serious behavioral health conditions through behavioral health homes. In March, the collaborative focused on transgender health. Multiple CCOs are interested in bringing transgender health trainings to their communities.

More information about the CCO learning collaborative is available at transformationcenter.org/cco.

Council of Clinical Innovators

During this quarter, the Clinical Innovation Fellows program held an online meetings on leading up and delegating, and organizational trauma and resilience. Graduates from last year's cohort were invited to attend these online meetings, with unanimous agreement from the current cohort. In March, the program held an in-person meeting focused on spokesperson and media training, leading into the future and effective teams. In addition, on a monthly basis, all fellows met with their faculty mentors individually and in small groups with two to three other fellows. To provide further support for the fellows' projects and professional development, each fellow was offered 10 hours of technical assistance through the Technical Assistance Bank.

The call for applications for the third cohort of Clinical Innovation Fellows was released in January, with applications due April 15, 2016.

More information about the Council of Clinical Innovators is available at transformationcenter.org/cci.

Alternative (Value-based) Payment Method support

Alternative Payment Method technical assistance

Based on an application process, three CCOs were selected for technical assistance through the Center for Evidence-Based Policy (CEbP) at the Oregon Health and Science University to identify and implement value-based payment models. After launch meetings, it was determined that CEbP did not have the appropriate expertise for two of the CCOs, and the Transformation Center is in the process of connecting these CCOs with different technical assistance providers. The CEbP will continue to work with Cascade Health Alliance.

Primary Care Payment Reform Collaborative

As required through Senate Bill 231, the Transformation Center is convening a Primary Care Payment Reform Collaborative. The purpose of this collaborative is to convene payers to share best practices on primary care alternative payment methods and initiative alignment. This quarter the Transformation Center confirmed 46 participants for the collaborative, including payers, providers, purchasers and consumers. Interviews were conducted with all participants to inform the direction of the collaborative and meeting content. The first meeting will be held in April, and Chris Koller, President, Milbank Memorial Fund, will present findings from multi-payer collaborative work across the country.

Behavioral Health Integration Alternative Payment Method Grants

The Transformation Center issued a solicitation ($300,000 maximum) to select up to three health care payers or purchasers to receive funding for implementing value-based payments for integrated care. Proposals are due May 2.

Transformation Center CCO Technical Assistance Bank

As a result of requests from CCOs and their CACs, in October 2014 the Transformation Center began offering CCOs and their CACs the opportunity to receive technical assistance (TA) in key areas to help foster health system transformation.

- In addition to support and technical assistance provided by other parts of OHA, for Year One each CCO was designated 35 hours of free consultation from outside consultants on contract with the Transformation Center. The designated 35 hours included 10 hours of consultation to support CACs and other community-based work and the hours were accessible through September 2015.
- Starting October 2015, a new allocation of 35 hours per CCO was made available. The Transformation Center continues to recommend that 10 of those 35 hours be used to support CACs and other community-based work.

As of March 2016, the Transformation Center had received 33 TA Bank requests from CCOs, for a total of 505 anticipated TA hours upon completion of those requests. Five of the 32 requests came during Year Two of the TA Bank for 136 of the 505 anticipated TA hours. Half of these requests focused on organizational development, primarily for CACs, including community health assessments and community health improvement plans. Other requests focused on health equity, quality improvement and measurement, program evaluation and alternative payment methods (see chart below).

TA Bank evaluation results for eleven of 26 completed projects show that 100% of CCOs rated the assistance as very valuable (82%) or valuable (18%), and 91% of CCOs rated the assistance as very effective in meeting the project goals (64%) or effective (27%).

To continue to provide technical assistance through September 2016, in May 2015 the Transformation Center released a request for applications (RFA) for consultants to contract as technical assistance providers. The RFA has resulted in 28 new contractors being available to provide technical assistance on a variety of topics. The Transformation Center continues to communicate with the Office of Equity and Inclusion, Office of Health Information Technology, Public Health Division, Office of Health Policy and Research, and the Child Well-being Team to ensure coordination of OHA technical assistance for the topics listed below.

TA Bank technical assistance topics:

1. Alternative payment methods
2. Behavioral health integration
3. Community health improvement plan (CHIP) review, implementation and evaluation
4. Early learning systems and strategies
5. Engagement strategies for person and family-centered health care systems
6. Health information technology
7. Health systems leadership*
8. Improving childhood immunization**
9. Improving health equity
10. Oral health integration
11. Organizational development for CCOs and/or CCO community advisory councils
12. Other topics upon request
13. Primary care transformation, including patient-centered primary care homes
14. Program Evaluation

15. Project management*
16. Public health integration
17. Quality improvement science
18. Tobacco cessation**

*Topics added to the Technical Assistance Bank during the RFA development process.

**Topics added to the Technical Assistance Bank during the Transformation Center's strategic plan to support CCOs in meeting key population health incentive metrics.

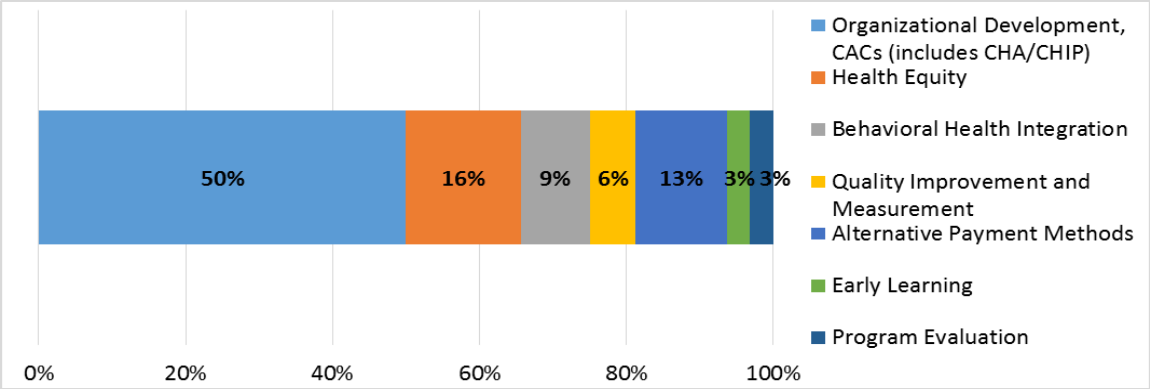
TA Bank projects August 2014 – March 2016:

CCO	Topic	Hours requested
1. Willamette Valley Community Health	Health equity	4
2. InterCommunity Health Network	Measurement	11
3. FamilyCare	CAC development, CHIP implementation	16
4. PacificSource Central Oregon	Measurement	25
5. Eastern Oregon CCO	CAC member engagement	5
6. AllCare	CAC member engagement	32
7. PrimaryHealth Josephine County	CAC member engagement	11
8. PrimaryHealth Josephine County, Jackson Care Connect, AllCare	Health literacy	10.5
9. Jackson Care Connect	CAC development, CHIP implementation	8.5
10. Trillium Community Health Plan	Health program evaluation	7
11. Western Oregon Advanced Health	CHIP development	15
12. InterCommunity Health Network	Alternative payment method training	9.5
13. Columbia Pacific CCO	CHIP implementation	19
14. Cascade Health Alliance	CAC member engagement	10.5
15. Health Share	Health equity	25
16. Willamette Valley Community Health	CAC member engagement	16
17. Trillium	Community Health Assessment	7
18. Eastern Oregon CCO	CHIP implementation	30
19. Willamette Valley Community Health	Alternative payment methods	11
20. PacificSource Central Oregon	CHIP development	13
21. InterCommunity Health Network	Early Learning	14
22. Jackson Care Connect	Strategic planning to address opioid issues (statewide performance improvement project)	18
23. Jackson Care Connect	Project management to address opioid issues (statewide performance improvement project)	Canceled
24. Jackson Care Connect	Behavioral health integration	On hold
25. Primary Health of Josephine County	CHIP implementation	22.5
26. Willamette Valley Community Health	Health equity training	8
27. PacificSource Columbia Gorge	CHIP implementation	9
28. Columbia Pacific CCO	Alternative payment methods	35
29. InterCommunity Health Network	Organizational development and strategic planning	9
30. Eastern Oregon CCO	Organizational development and behavioral health integration	14
31. InterCommunity Health Network	Alternative payment methods and risk stratification	TBD
32. Columbia Pacific CCO	Health literacy	On hold
33. Jackson Care Connect	CHIP implementation and CAC member engagement	10
Total Anticipated Hours:		505

Note:

- On hold = The CCO is deciding whether to move forward with the request.
- TBD (to be determined) = A request was submitted, and the number of hours is still being decided.

TA Bank projects by topic:



More information about the Technical Assistance Bank is available at transformationcenter.org/tabank.

Incentive metrics targeted technical assistance

The Transformation Center is planning targeted technical assistance for the following CCO incentive metrics:

- Childhood immunization rates
- Smoking cessation
- Adolescent well-care visits
- Colorectal cancer screening

Based on interviews and needs assessment conference calls with CCO representatives, input from the Public Health Division and consultants, and resources available, the Transformation Center plans to offer the following:

- **Childhood immunization rates** – Root cause analysis (pilot and potential spread); community convenings on immunization challenges and opportunities for improvement
- **Smoking cessation** – Provider-level trainings on tobacco cessation counseling and CCO-level quality improvement
- **Adolescent well-care visits** – Webinar series with follow-up consultation calls and educational materials for parents through the Oregon Pediatric Improvement Partnership; in-person, youth-led training through the Oregon School-Based Health Alliance focused on youth-centered care
- **Colorectal cancer screening** – Webinar series, individual follow-up consultation calls and potential individualized support from consultants through the Oregon Rural Practice-based Research Network and the Kaiser Permanente Center for Health Research

Table 6 - Innovator Agents – Summary of promising practices

Innovator Agent learning experiences

Summary of activities	The Innovator Agents convene a monthly in-person meeting to share information and learn from others in OHA as well as outside experts. This quarter, the IAs met three out of the three months and the meetings included updated information about behavioral health integration, strategic planning with the Transformation Center around technical assistance for community advisory councils, quality improvement discussions, and information about the Women, Infants and Children's program from Public Health. In addition, the Innovator Agents met with the new Director of Health Services Division to plan strategically about the IA role as the agency has reorganized.

Promising practices identified	The monthly meetings allow Innovator Agents to build and sustain relationships with executive leadership across OHA and other State divisions, which in turn facilitates the relationships with CCOs. Innovator Agents are able to share information gained from trainings and collaboratives with CCOs, the CACs, and the communities they support to promote health transformation across the state. It is also an opportunity to network and gain knowledge about cutting edge practices from other participants.
Participating CCOs	16
Participating IAs	7

Learning collaborative activities

Summary of activities	The Innovator Agents participate in monthly peer-to-peer collaborative learning opportunities that are attended by CCOs and OHA. These collaboratives offer an opportunity to share best practices or gain up-to-date information about health trends within the state and nation. During this quarter, peer-to-peer collaborative topics included behavioral health integration and transgender health.
Promising practices identified	Innovator Agent engagement with learning collaboratives and statewide trainings are a key strategy to ensure that innovations are identified and shared across CCOs. Because IAs generally support more than one CCO, the broad wealth of information gleaned from a wide array of training helps the IAs support each CCO's specific needs. In addition, IAs regularly connect CCOs to share innovative practices and promote innovation.
Participating CCOs	16
Participating IAs	7

Assisting and supporting CCOs with Transformation Plans

Summary of activities	During this quarter, IAs continued to support their CCOs' Transformation Plans by reviewing them periodically with the CCOs and connecting them to the expertise and resources that help them obtain their transformation plan goals. This was achieved with technical assistance, connections to expertise within OHA, or through information gained through learnings and collaboratives.
Promising practices identified	Transformation across all CCOs continues as each CCO incorporates the ongoing information and insights they have through training and collaboration. During this quarter three CCOs received technical assistance around alternative payment methods and plans for behavioral health integration technical assistance were developed with most of the CCOs.
Participating CCOs	16
Participating IAs	7

Assist CCOs with target areas of local focus for improvement

Summary of activities	As health transformation continues, CCOs are continually stretching to address all areas of health. Innovator Agents keep a finger on the pulse of how CCOs can improve their delivery of health services and connect them to the resources that can assist them. In addition, the IAs act as a connection between the CCOs and the local community which facilitates better relationships and integration of health services.
Promising practices identified	Behavioral health integration: All CCOs were given 30 hours of technical assistance around behavioral health integration. The IAs have assisted CCOs in developing a plan around how they can best use the technical assistance.
Participating CCOs	16
Participating IAs	7

Oregon Health Authority

Communications with OHA

Summary of activities	Innovator Agents meet regularly with leaders across OHA to strategize on how to collaborate and stay informed about OHA programs and policies. For example, this quarter IAs met with a contracted technical assistance provider about behavioral health integration. In addition, the IAs meet regularly with Quality Improvement and receive updates on Metrics and Scoring so they can better assist the CCOs in those areas. Additionally, Innovator Agents communicate routinely with Health Systems Division staff on specific issues and concerns. IAs attend a weekly meeting when possible for update and problem solving around the new eligibility system.
Promising practices identified	Regular and frequent communication with the Health Systems Division staff helps the Innovator Agents support continuous quality improvement efforts within OHA related to Oregon's health system transformation implementation. Innovator Agents have recently moved their monthly meeting place so they can be closer to Health Services Division staff and increase collaboration.
Participating CCOs	16
Participating IAs	7

Communications among Innovator Agents

Summary of activities	Regular meetings by phone and monthly in-person meetings have provided a critical link between Innovator Agents and have also helped keep them align with the Transformation Center and OHA. Since each Innovator Agent is located within their region and do not (in general) work out of a State office, these regular connections have provided direction and essential support.
Promising practices identified	In addition to their monthly meetings, IAs huddle once a week and then have regularly scheduled phone conferences where they invite other experts within and outside OHA. During this quarter, the IAs have phone conferenced with the Office of Equity and Inclusion, Office of Rural Health, the Child and Behavioral Health Program, and regularly with the Transformation Center.
Participating CCOs	16
Participating IAs	7

Community advisory council activities

Summary of activities	Innovator Agents continue to provide a key link between community advisory councils and OHA. All Innovator Agents regularly attend CAC meetings and most CAC meetings have time on the agenda for OHA updates from the Innovator Agents. Innovator Agents are able to continue to clarify the CAC's role within health transformation. Recently, CAC member engagement has been at the forefront. Innovator Agents have assisted CACs as they implement initiatives toward this goal.
Promising practices identified	As community advisory councils become more empowered within health care transformation, they are understanding better how to implement and refine their community health improvement plans and maintain them as a live, working document. Many CACs are also actively working toward becoming more inclusive and diverse and have used technical assistance from the Transformation Center to help them recruit and maintain members. Innovator Agents are central to connecting the partnerships, identifying common data sources and linking with the CCOs CHIP and CAC.
Participating CCOs	16
Participating IAs	All 7 Innovator Agents attend the CAC meetings associated with their CCO(s).

Rapid-cycle stakeholder feedback (to identify and solve barriers; assist with adapting innovations; simplify and/or improve rate of adoption; and increase stakeholder engagement)

Summary of activities	At the direction of their CCO, each Innovator Agent pursues specific issues related to challenges and barriers to health system transformation. Topics raised this quarter ranged from specific operational issues (such as billing codes) to reporting challenges (such as duplicate or unclear reporting requirements) to policy or rule making questions. In this area, the Innovator Agent role functions primarily as the bridge between the CCO perspective and the OHA perspective, and endeavors to facilitate an efficient and effective solution if possible. Innovator Agents have also participated in weekly meetings with other Health System Division staff to help resolve issues as they arise with the new eligibility system.
Promising practices identified	The role of the Innovator Agent to assist with integration of new services and adopting innovations can be an effective tool to increase stakeholder engagement and movement toward change. Many communities and Innovator Agents have been working with housing integrators around the issue of safe and affordable housing for members.
Participating CCOs	16
Participating IAs	7

Database implementation (tracking of CCO questions, issues and resolutions to identify systemic issues)

Summary of activities	The Issue Tracker is being revised to capture additional information about Innovator Agent presentations.
Promising practices identified	The Issue Tracker continues to be helpful for documenting issues and steps toward resolution.
Participating CCOs	16
Participating IAs	7

Information sharing with public

Summary of activities	Innovator Agents continue to play an active part in their communities. They serve on numerous boards, attend community meetings and provide ongoing information about health transformation
Promising practices identified	Communicating with community advisory councils and community health improvement plan work groups is a good way to more broadly disseminate information to community members about health care transformation.
Participating CCOs	16
Participating IAs	7

Table 7 - Innovator Agents – Measures of effectiveness

Measure 1: Surveys rating IA performance

Data published for current quarter? Type?	Innovator Agents designed a survey to capture feedback about the original intent of the Innovator Agent program, its successes, challenges and possibilities for the future. The survey was distributed to a wide range of people representing coordinated care organizations, including CCO staff, community organizations and advisory council members. The survey was vetted by Oregon Health Authority leadership, with distribution in October 2015. Results of the survey have been shared with OHA leadership and will be used in future discussions about the role of Innovator Agents and how they can best be used within OHA, CCOs and the communities they represent.
Web link to Innovator	-

Agent quality data	

Measure 2: Data elements (questions, meetings, events) tracked

Data published for current quarter? Type?	Examples of meetings and events attended by Innovator Agents during this quarter: ■ Weekly phone calls with Innovator Agents ■ Weekly phone call with Transformation Center, OHA ■ Monthly in-person meeting ■ Representation at the monthly CCO work group meetings ■ Representation on numerous OHA committees ■ Community forum on housing – Jackson County ■ CCO Contract meeting ■ Seeing Color: Conversations on Race – Jackson and Josephine counties ■ Legacy Health Literacy Conference ■ Governor's Transportation Vision Panel – White City ■ Poverty Forum – Klamath Falls
Web link to Innovator Agent quality data	-

Measure 3: Innovations adopted

Data published for current quarter? Type?	CCOs continue to implement innovative practices including trauma-informed care, telehealth and behavioral health integration.
Web link to Innovator Agent quality data	Learning collaboratives website: http://www.oregon.gov/oha/Transformation-Center/Pages/CCO-Learning-Collaborative.aspx

Measure 4: Progress in adopting innovations[5]

Data published for current quarter? Type?	CCOs have sought technical assistance through the Transformation Center and are taking action to implement the learnings, including evaluating the impact of programs that target social determinant issues, engaging members, integrating behavioral health and designing and implementing alternative payment methods.
Web link to Innovator Agent quality data	Technical assistance projects are described in a separate section of this report.

Measure 5: Progress in making improvement based on innovations[1]

Data published for current quarter? Type?	Incentive payments for 2014 performance were distributed during this quarter, resulting in a heightened focus on 2015 performance targets and improvement. Clinical advisory panels and boards of directors, along with CCO quality improvement staff, are highly engaged in identifying interventions to improve performance.
Web link to Innovator Agent quality data	Oregon's Health System Transformation 2015 Mid-Year Report is available at: http://www.oregon.gov/oha/Metrics/Documents/2015%20Mid-Year%20Report%20-%20Jan%202016.pdf

Measure 6: CCO Transformation Plan implementation

Data published for	As CCOs mature, the Transformation Plans are becoming more integrated

[5] This item will be reported in a qualitative, narrative fashion based on quality, access and cost data and other progress reports submitted by CCOs and reviewed for statewide impact.

current quarter? Type?	into the CCO administration and structure. Increasingly, CCOs are organizing their strategic planning efforts to incorporate the Transformation Plan domains. Innovator Agents are assisting their CCOs in determining their areas of need for technical assistance for this year.
Web link to Innovator Agent quality data	Transformation Plan Reports available online: http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/Oregon-CCO-Transformation-Plans.aspx

Measure 7: Learning collaborative effectiveness

Data published for current quarter? Type?	More stakeholders participated in the Transformation Center's Statewide CCO Learning Collaborative, with an average of 80 attendees at the two sessions in 2016 (compared to an average of 72 participants in 2015, 70 participants in 2014 and 61 participants in 2013). Participant evaluations for Q1 2016 indicate a continued high percentage of participants who found sessions valuable or very valuable (93% in Q1 2016; 92% in 2015; and 90% in 2014) while over half of participants planned to take action based on the learning collaborative (53% in Q1 2016; 50% in 2015; and 52% in 2014).
Web link to Innovator Agent quality data	-

Measure 8: Performance on Metrics and Scoring Committee metrics

Data published for current quarter? Type?	Innovator Agents work closely with CCOs and providers to support development of strategies toward the new incentive metrics added in 2015 including dental sealants and effective contraceptive use.
Web link to Innovator Agent quality data	Oregon's Health Systems Transformation: CCO Metrics 2015 Mid-Year Update is located here: http://www.oregon.gov/oha/Metrics/Documents/2015%20Mid-Year%20Report%20-%20Jan%202016.pdf

Other evaluation results from Transformation Center learning collaborative can be found in Section V, Table 9.

H. Legislative activities

OHA's 2016 Legislative Highlights summarizes activities during the quarter.

I. Litigation status

Nothing to report this quarter.

J. Two-percent trend data

See Appendix C.

K. DSHP terms and status

See Appendix D.

IV. Status of Corrective Action Plans (CAPs)

Table 8 – Status of CAPs

Entity (CCO or MCO)	Columbia Pacific CCO
Purpose and type of CAP	To ensure the children's fidelity wraparound requirements are being met
Start date of CAP	3/3/2016
Action sought	Get CCO in line with contract requirements(Exhibit B, part 2, sections m and n
Progress during current quarter	OHA currently monitoring the CCO's CAP and have updates scheduled until CAP is completed
End date of CAP	To be determined
Comments	

V. Evaluation activities and interim findings

In this quarter, OHA reviewed a proposal and selected a contractor for the summative evaluation of Oregon's Medicaid waiver. OHA also contracted with Oregon Health & Science University's Center for Health Systems Effectiveness (CHSE) for an evaluation of the Hospital Transformation Performance Program (HTPP) and worked with the contractor to finalize a survey of hospitals for the evaluation. CHSE and Providence Center for Outcomes Research and Education (CORE) continued work on the State Innovation Model (SIM) Grant evaluation, including a second round of surveys and interviews to assess adoption of Oregon's coordinated care model among CCOs and other health care organizations. Contracted evaluations of OHA's PCPCH Program, Behavioral Health Home Learning Collaborative (BHHLC), Sustainable Relationships for Community Health (SRCH) Program, and Transformation Center also continued.

Table 9 - Evaluation activities and interim findings

In the narrative below, relevant OHA and CCO activities to date are reported by the "levers" for transformation identified in the waiver agreement and Accountability Plan.

Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on primary care through patient-centered primary care homes (PCPCH)

Evaluation activities:

As part of its evaluation effort, the PCPCH Program is looking in-depth at 20 recognized clinics considered top-performing or exemplary practices. This will help determine which aspects of the PCPCH model are most important to successful practice transformation. By the end of 2015, key staff from all exemplary practices had been interviewed on-site. In this quarter, analysis from the interviews was compiled and an interim report was presented to OHA staff.

Interim findings:

As of March 30, 2016, there were 610 recognized clinics in the state (surpassing Oregon's goal of 500 clinics by 2015). This represents 61% of the estimated number of primary care clinics in Oregon.

PCPCH enrollment is a CCO inventive metric. The statewide baseline (for 2012) for this measure is 51.8%.

- Updated CCO performance metrics (see Appendix E) show that the proportion of CCO members enrolled in a PCPCH has continued to increase from the baseline of 51.8% to 87.5% as of the December 2014 – November 2015 reporting period, ranging from 73.5% to 99.9% among CCOs.
- It is notable that CCOs have sustained this increase despite the significant growth in Medicaid enrollment due to the Affordable Care Act.

Improvement activities:

Oregon's Patient-Centered Primary Care Institute (PCPCI) provides technical support and transformation resources to practices statewide, including learning collaborative opportunities. The current contract with PCPCI was closed out in 2015 and a new contract was executed for 2016. In the coming year, PCPCI will:

- Expand its role as a resource hub. PCPCI will provide web-based and in-person learning events, convene communities and identify gaps and barriers to inform policy, and develop new programming to support primary care transformation.
- Design and pilot a regional primary care extension program. PCPCI will facilitate planning, testing, and implementation of a regionally-based infrastructure to accelerate ongoing development of comprehensive primary care.
- Facilitate communication and coordinate collaboration among related initiatives, including the Million Hearts® initiative, payment reform, metrics alignment, and OHA activities led by the Transformation Center, PCPCH program, and others.

Lever 2: Implementing alternative payment methodologies (APMs) to focus on value and pay for improved outcomes

Evaluation activities:

In this quarter, OHA continued reporting on the 2015 CCO and state performance measures, continued validating measures, and finalized planning for 2016 measurement. In addition, OHA continued conversations with CMS regarding the request to extend the hospital transformation performance program (HTPP) for an additional year. See Appendix E for details.

Also in this quarter, OHA contracted for an independent, third-party evaluation of the HTPP, worked with the contractor to prepare an evaluation plan, and finalized a survey for the evaluation. The evaluation will:

- Compare change in specific quality measures among hospitals participating in the HTPP before and after the program began, and compare performance and quality measures with hospitals not participating in the program.
- Identify specific activities hospitals used to improve performance on HTPP quality measures, and determine the extent to which specific activities were associated with performance improvements.
- Identify changes in hospital practices made as a result of the HTPP, and identify investments hospitals made as a result of receiving HTPP payments.
- Identify policy changes that OHA and CCOs are considering as a result of lessons learned from the HTPP.

OHA contracted with CHSE to carry out the evaluation. CHSE is collaborating with CORE to conduct interviews and surveys for the evaluation. In this quarter, CHSE and CORE interviewed representatives from a small number of hospitals to inform development of a survey that will be used to collect information about hospitals' HTPP activities and worked with OHA to finalize the survey. Evaluation findings will be delivered to OHA in June 2016.

Interim findings:

CCO financial reports for October – December 2015, which are needed to calculate percentage of CCO payments to providers that are not fee-for-service (FFS) will not be due until March 31, and some CCOs

have requested extensions. As a result, Q4 2015 data are not available for this report. Internal analysis of the most recent financial reports available (for July – September 2015) shows that 52.8% of all plan payments are non-fee-for-service (FFS). This is an decrease of 2.8% from the previous quarter, in which 55.6% of plan payments were non-FFS.

Improvement activities:

OHA continued to contract with Oregon Health & Science University's Center for Evidence-based Policy (CEbP) to provide CCOs with technical assistance for developing and implementing APMs. Assistance from CEbP consisted of focused work with three CCOs: Cascade Health Alliance, Health Share of Oregon, and PacificSource Community Solutions – Columbia Gorge. In this quarter, CEbP held kick-off meetings with the three CCOs and their partners to discuss the kinds of technical assistance CEbP could provide. After these meetings, it became clear that the CEbP's offerings did not match the needs of two CCOs. PacificSource Community Solutions decided to discontinue work with CEbP and to pursue APM technical assistance through other resources offered by the Transformation Center's Technical Assistance Bank. CEbP decided to discontinue working with Health Share of Oregon, and the Transformation Center is following up to offer Health Share APM technical assistance through the TA Bank. CEbP will continue working with Cascade Health Alliance as planned. At the request of OHA, CEbP is writing a proposal to convene a half-day meeting to share emerging best practices on APMs with all 16 CCOs.

Also in this quarter, one CCO received technical assistance with APMs from OHA's Technical Assistance Bank. Columbia Pacific CCO submitted a TA Bank request in October to work with Bailit Health. Bailit Health is holding a series of telephone conferences with Columbia Pacific to provide feedback on Columbia Pacific's risk-sharing APM proposals, which consider complex factors related to hospital reimbursement and the Rural Health Reform Initiative.

As required through Senate Bill 231 (2015), the Transformation Center is convening a new Primary Care Payment Reform Collaborative. The purpose of this collaborative is to convene payers to share best practices on APMs for primary care and initiative alignment. The first meeting is scheduled for April 15, 2016. In this quarter, the planning committee identified and interviewed stakeholders who will participate in the Collaborative.

Lever 3: Integrating physical, behavioral, and oral health care structurally and in the model of care

Evaluation activities:

The Behavioral Health Home Learning Collaborative (BHHLC) is supported by Oregon's Adult Medicaid Quality Grant and assists organizations with integrating primary care into behavioral health settings. Under a no-cost extension, the BHHLC will continue through December 2016. In this quarter, Oregon Health & Science University's Oregon Rural Practice-based Research Network (ORPRN) engaged quantitative and qualitative data for its evaluation of the BHHLC. ORPRN analyzed three sets of the Behavioral Health Integration Capacity Assessment (BHICA) data for each participating site to track changes in patient profiles and organizational capacities over the course of the BHHLC. All sites were asked to report four adult core measures, but only a minority have the capacity to produce reliable data. The exercise helped to clarify each site's specific capacities and barriers, and has informed the plan for technical assistance going forward. Data collection and reporting on these measures is a focus for the BHHLC this year. Qualitative data for the evaluation include transcripts of kick-off meetings, focus group discussions, and exit interviews. Analysis of these data proved more difficult and time-consuming than anticipated, delaying completion of the evaluation. Much of the qualitative and quantitative analysis was included in the annual report on the Adult Medicaid Quality Grant submitted to CMS in March 2016. OHA anticipates that the full evaluation report on activities from 2014 to 2015 will be submitted to OHA by the end of April 2016. In this quarter, OHA developed a

plan to extend the evaluation to cover BHHLC activities through 2016. In March 2016, another round of kick-off meetings for participating sites began.

ORPRN staff, OHA staff, and two participating sites presented preliminary findings to the CCO Learning Collaborative in January 2016. The OHA project manager for the CCO Learning Collaborative serves on the Steering Committee that is developing the model for the Certified Community Behavioral Health Clinics Program.

Interim findings:

Five of the CCO incentive measures relate to physical and behavioral health care integration. Measure specifications for three measures (SBIRT, Follow-Up After Hospitalization for Mental Illness, and Mental, Physical, and Dental Health Assessment Within 60 Days for Children in DHS Custody) changed in 2015. As a result, performance on these measures in CY 2014 and subsequent reporting periods is not comparable to performance in prior reporting periods. The narrative below compares performance on these measures between CY 2014 and December 2014 – November 2015, the most recent reporting period.

- Alcohol or Other Substance Misuse (SBIRT) increased from the 6.3% in CY 2014 to 11.0% in December 2014 – November 2015. The measure was below the 2015 benchmark target of 12%. SBIRT ranged from 2.1% to 22.7% among CCOs in December 2014 – November 2015. Beginning in the CY 2014 reporting period, the measure included adolescents ages 12 to 17.
- Follow-Up After Hospitalization for Mental Illness increased from the 71.8% in CY 2014 to 74.1% in December 2014 – November 2015. The measure exceeded the 2015 benchmark target of 70.0%. The measure ranged from 50.0% to 88.9% among CCOs in December 2014 – November 2015. Beginning in the CY 2014 reporting period, the measure included follow-up services occuring on the same day of discharge.
- Mental, Physical, and Dental Health Assessment Within 60 Days for Children in DHS Custody was 27.9% in CY 2014. The measure was below the 2015 benchmark target of 90%. The measure ranged from 11.8% to 49.3% among CCOs in CY 2014. Beginning in the CY 2014 reporting period, the measure included dental assessments. Data for periods beyond CY 2014 will be available in a future report.
- Screening for Clinical Depression and Follow-Up Plan was 27.9% in CY 2014. The measure was below the target of 25.0% for 2015. The measure ranged from 3.3% to 68.1% across CCOs in CY 2014, with some of the variation likely due to challenges capturing data from electronic health records. The measure is updated annually, and is not available for December 2014 – November 2015.
- Follow-Up Care for Children Initially Prescribed ADHD Medications increased from 52.3% in 2011 to 57.7% in CY 2014 and 60.9% in December 2014 – November 2015 for initiation phase, and decreased slightly from 61.0% in 2011 to 60.8% in CY 2014 for continuation and maintenance phase (an update for continuation and maintenance phase is not available for the December 2014 – November 2015 reporting period and will be available in a future report). In December 2014 – November 2015, the measure ranged from 54.2% to 74.3% across CCOs for initiation phase. Please note that this measure has been removed from the incentive measure set for 2015 given strong CCO performance (above the 90th percentile nationally), but OHA continues to monitor and report on the measure as part of the quality and access test.

Improvement activities:

The Behavioral Health Home Learning Collaborative (BHHLC) assists organizations with integrating primary care into behavioral health settings. Under a no-cost extension, the BHHLC will continue through December 2016. In this quarter, OHA asked sites wishing to continue participating in the BHHLC to submit an application that identified their focus for quality improvement activities in Year 3. All ten sites that participated in Year 2 opted to continue, and one site that had participated in Year 1 asked to rejoin, meaning

Oregon Health Authority

OHA is currently working with eleven sites. Practice coaching resumed in February and typically occurs twice per month. Kick off meetings with each site's full team, including CCO representatives, began in early March. Planning for the next all-day, in-person learning session also began in this quarter.

Lever 4: Increased efficiency in providing care through administrative simplification and a more effective model of care that incorporates community-based and public health resources

Evaluation activities:

Evaluating Oregon's Medicaid waiver

In this quarter, OHA reviewed a proposal and selected a contractor for the summative evaluation of Oregon's Medicaid waiver. The summative evaluation will improve on the waiver midpoint evaluation and other preliminary efforts to assess the implementation and impacts of Oregon's Medicaid waiver: It will include data from all five years of the demonstration (with allowances for lag associated with some types of data). In addition, OHA expects the contractor will use Medicaid members from another state and "weighted" Oregon commercial plan members as comparison groups, enabling the contractor to rigorously estimate the effect of the waiver on health care spending, quality, access, and other key outcomes. The contractor will also synthesize findings about OHA's and CCOs' transformation activities from existing evaluations, and provide actionable recommendations for advancing Medicaid transformation beyond the current waiver period.

In addition to selecting a contractor for the summative evaluation, OHA worked with the contractor to revise its evaluation plan and made tentative plans for a series of meetings with the contractor to address methodology details. OHA expects to execute a contract for the summative evaluation in Q2 2016. The contractor will deliver evaluation findings to CMS and OHA by the end of 2017.

Assessing the spread of coordinated care in Oregon

In February 2016, CORE began administering a second round of surveys and interviews to assess spread of the coordinated care model among CCOs, commercial health plans, hospitals, and other provider organizations. The surveys assess the extent of transformation in 11 domains identified by OHA, CORE, and CHSE:

- Cross-sector partnerships
- Community involvement in governance
- Integrated and shared health care data
- Using data for population health management
- Integrated physical, behavioral, and dental care
- Better coordination (right care in the right place)
- Prevention and social-determinants-of-health-informed care
- Workforce transformation and diversification
- Ownership of risk
- Integrated risk
- Aligning incentives and value

CORE administered surveys to 103 organizations, including 12 CCOs, that participated in the first round of surveys and interviews conducted February – April 2015.

In addition to surveying payer and provider organizations, CORE will conduct in-depth interviews with representatives at a small number of organizations that respond to the survey. The interviews will provide

context for survey results and enable CORE to answer questions about the organizations' motivation and mechanisms for transformation:

- What kinds of factors motivated organizations to adopt specific elements of the coordinated care model? Factors may include direction from governing bodies, pressure from community organizations and other external stakeholders, competition in one or more market segments, and transformation in other states.
- What kinds of mechanisms did organizations use to implement specific elements of the coordinated care model? Mechanisms may include outreach and education, financial incentives, or mandates for staff and contractors; investment in new staff, systems, or technologies; or other mechanisms.

In March 2016, CORE and OHA identified organizations that would be invited to participate in interviews from among those that had responded to the survey as of mod-March. CORE and OHA targeted organizations that exhibited substantial changes in the extent of transformation within specific domains; that exhibited transformation in a large number of domains; and that exhibited transformation in domains of special interest, including use of APMs, collection and use of population health data, and workforce transformation. CORE will conduct interviews with 10 payer organizations and 10 provider organizations, as well as a single round of surveys and interviews among employers that offer health care coverage. Surveys and interviews will continue through April 2015. Findings will be included in a State Innovation Model (SIM) Grant evaluation report from CHSE and CORE to be delivered September 2016.

Tracking "spillover" from Medicaid's coordinated care model

CHSE continued its analysis of health care claims and encounters data to determine whether the effects of Medicaid transformation may have "spilled over" to non-CCO patients. Spillover may occur if clinics that are working to improve care management and coordination for Medicaid patients also adopt these improvements for other patients. In this quarter, CHSE analyzed the association between the percentage of a clinic's patients that are covered by Medicaid and the clinic's score on a variety of health care quality measures. In the next step of the analysis, CHSE will analyze the association between changes in quality for Medicaid and non-Medicaid patients over time. Findings from spillover analysis will be included in the SIM Grant evaluation report from CHSE and CORE to be delivered September 2016.

Sustainable Relationships for Community Health (SRCH) Program

In this quarter, a formal process evaluation was completed for the SRCH Program (see Interim Findings below for results).

Interim findings:

Measures of efficient and effective care collected by OHA

From calendar year 2014 to December 2014 – November 2015, the following measures of efficient and effective care for which data were available improved (see Appendix E for details):

- Emergency department visits per 1,000 member months decreased by 1.7% (from 47.3 per 1,000 member months to 46.5 per 1,000 member months).
- Potentially avoidable hospital admissions per 1,000 member months decreased for the following conditions: chronic obstructive pulmonary disease (13.3%), adult asthma (9.6%), and diabetes short-term complications (4.6%). However, potentially avoidable hospital admissions per 1,000 member months for congestive heart failure increased by 10.3%.
- Developmental Screening in the First 36 Months of Life increased from 42.6% to 54.0%. In addition, Adolescent Well-Care Visits increased from 32.0% to 36.8%.

Please note that hospital readmissions and rates of screenings that serve as measures of efficient and effective care not listed above are not available from the period December 2014 – November 2015 and will be available in a future report.

SRCH program evaluation

Key findings from process evaluation of the SRCH Program include:

- Consortia teams should identify and work with the right partners from the beginning in order to make high-level decisions about systems change across organizations.
- Expectations about the SRCH process should be clearly defined from the beginning of the initiative's funding period.
- Careful planning and flexibility must be balanced when leading and participating in cross-sector collaboration.

The process evaluation concluded that the SRCH Program afforded participants the ability to gain a larger, more comprehensive understanding of the roles, responsibilities, and complexities of collaborating in order to plan and make decisions to build sustainable community health programs.

Improvement activities:

Sustainable Relationships for Community Health (SRCH) Program

From February 2015 through March 2016, OHA's Public Health Division awarded five grants to local consortia consisting of coordinated care organizations (CCOs), local public health authorities, clinics and chronic disease self-management program providers. Grantees participated in a series of three institutes to help them improve health outcomes for pre-diabetes, diabetes, and hypertension. Grantees created and implemented quality improvement plans for closed-loop referrals, payments or reimbursements for self-management programs, and using tools and best practices for provider engagement and data collection. Grantees improved efforts around data collection and measurement concepts; identified relevant performance measures; and identified tools for developing data collection and measurement plans. New processes for data sharing across organizations were developed and a shared vision for commitment was defined. Grantees created joint agreements and coordinated key performance indicators to implement the work related to pre-diabetes, diabetes, and hypertension moving forward.

Summary of Health Information Technology (HIT) initiatives

OHA's Office of Health Information Technology (OHIT) continues to make progress on state HIT initiatives and ensure OHA's efforts align with and support CCO needs through various activities that include stakeholder support and programmatic activities. Major HIT activities in January – March 2016 include:

- Bringing real-time hospital event notifications to CCOs and care teams.
- Engaging CCOs in the development of technical assistance for Medicaid practices related to their EHRs and meaningful use.
- Implementing telehealth pilots in five communities.

OHA recently increased adoption of PreManage, a tool that brings real-time hospital notifications to CCOs and care coordinators. OHA is pleased to be a co-sponsor of this effort and is responsible for coordinating CCO use of the tool. All 59 Oregon hospitals are now contributing admit, discharge, and transfer (ADT) data (both emergency department and inpatient data) to the Emergency Department Information Exchange (EDIE), which serves as the data infrastructure for PreManage. CCOs, health plans, and providers can subscribe to PreManage to access the hospital event data and better manage their populations who are high utilizers of hospital services. Currently, several commercial health plans and eleven of the CCOs are using (or in process of launching) a PreManage subscription, and nearly 100 clinics in Oregon are subscribers. The

EDIE Utility Governing Committee (of which OHA is a member) is considering ways to assess the impact of these tools and report on progress.

OHIT convenes the Health Information Technology Advisory Group (HITAG) comprised of CCO representatives to guide HIT activities that support CCOs. OHIT held a HITAG meeting in January 2016. In addition, OHIT convenes the Health Information Technology Oversight Council (HITOC) that is tasked with setting goals and developing a strategic HIT plan for the state, overseeing implementation of the HIT plan, and monitoring progress with HIT goals. OHIT held a HITOCH meeting in February 2016.

In December 2015, OHA executed a contract with OCHIN to provide technical assistance to CCO priority practices to meaningfully use their Electronic Health Records (EHRs). The technical assistance will help providers capture Clinical Quality Measures (CQM) data in a format that can be submitted electronically to OHA and better position CCOs to meet electronic health record adoption benchmarks.

In 2015, the Office of the National Coordinator for Health Information Technology awarded OHA and our program collaborator, Jefferson Health Information Exchange, a $1.6 million grant to advance the adoption and expansion of health information technology infrastructure and interoperability. A primary goal of the grant is to overcome barriers to information sharing and care coordination across care settings and integrate behavioral and physical health data for more robust health information exchange. Five CCOs are participating, which will allow them to access their patients' information from other providers, including data on behavioral health, controlled substance prescriptions, hospital event notifications, ambulatory care, and notifications on significant life events.

CCO metrics "dashboards"

OHA continues to release quality metric progress reports for CCOs using the automated metric reporting tool ("dashboard") developed by CORE. In March 2016, OHA released a dashboard for the period covering December 2014 – November 2015. Measures were updated to include ICD10 codes. The dashboards will continue to be expanded to include additional measures, filters, and capabilities.

Lever 5: Implementation of health-related flexible services aimed at improving care delivery, enrollee health, and lowering costs

Evaluation activities:

The revised evaluation plan delivered by OHA's prospective contractor for the waiver summative evaluation (see Lever 5, Evaluation Activities, above) includes a proposal to evaluate the impact of flexible services on health care spending and other key outcomes. As a first step, OHA will meet with the contractor's evaluation team to inform the contractor about data available on flexible services. The contractor will then formulate a more detailed proposal for evaluating flexible services, which may include qualitative analysis of member experience with flexible services, quantitative analysis of data from select CCOs as available, and other methods.

Interim findings:

OHA's evaluation contractor will include findings about the effectiveness of flexible services in its final evaluation report, which will be delivered to CMS and OHA by the end of 2017 (see Lever 5, Evaluation Activities, above). In addition, the contractor will provide recommendations for evaluating flexible services following the end of the 2012 – 2017 demonstration period.

Improvement activities:

In this quarter, the Transformation Center convened a meeting of internal stakeholders to discuss OHA's recent posting of revised Oregon Administrative Rules for flexible services. It was decided that the OARs

will need to be revisited later in 2016 in the event of any changes in flexible services as a result of Oregon's CMS 1115 waiver renewal. In the meantime, OHA will address any questions about the OARs on a case-by-case basis.

Lever 6: Testing, accelerating and spreading effective delivery system and payment innovations through peer-to-peer learning, the spread of best practices, and innovation through the Transformation Center

Evaluation activities:

The Transformation Center revised its evaluation plan to align with new strategic plan initiatives for 2016. The Center is working in collaboration with OHSU to implement this evaluation plan. Most of the Center's new strategic plan initiatives, including targeted technical assistance for selected CCO incentive metrics, behavioral health integration consultations with CCOs, and grants to support Community Health Improvement Plan implementation, are launching in the first and second quarters of 2016, so data will not be available until later in the year.

Findings from the Transformation Center's ongoing, internal process for rapidly evaluating the effectiveness of its learning collaboratives are below.

Interim findings/ Improvement activities:

In this quarter, the Transformation Center continued work on its seven external learning collaboratives. From January through March 2016, two of the learning collaboratives met at five sessions. On average, 44 people attended each session.

- Across all sessions, the roles of attendees were: 27% clinical, 12% administrative or operational lead, 17% quality improvement or quality assurance, and 44% in other roles.
- Sessions included two webinars and three in-person sessions.
- Session topics included transgender health and behavioral and physical health integration for people with serious behavioral health conditions.

Across all sessions, 93% of respondents found the session valuable or very valuable to their work and 60% of all respondents said they would take action at their organization as a result of attending the learning collaborative session.

The evaluation forms asked attendees to identify the most helpful aspects of each learning collaborative. Among the most helpful aspects from learning collaboratives this quarter, participants identified: hearing how other CCOs are integrating behavioral and physical health care for people with serious behavioral health conditions and hearing from experienced presenters.

In this quarter, the Clinical Innovation Fellows submitted midyear progress reports. All 15 fellows indicated the CCI program is valuable in supporting their work (10 very valuable; 5 valuable), and find it valuable in their growth as a leader (10 very valuable, 5 valuable). The fellows reported that the topics on which they have learned the most so far include leadership skills and project management.

VI. Public forums

Public comments received

Medicaid Advisory Committee

No report this quarter.

Oregon Health Policy Board

No report this quarter.

VII. Transition Plan, related to implementation of the Affordable Care Act

No updates to the Transition Plan.

VIII. Appendices

Appendix A. Quarterly enrollment reports

1. SEDS reports

Attached separately.

2. State reported enrollment tables

Enrollment	January 2016	February 2016	March 2016
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	1,063,848	1,084,765	1,094,899
Title XXI funded State Plan	60,993	62,175	62,664
Title XIX funded Expansion Populations 9, 10, 11, 17, 18	NA	NA	NA
Title XXI funded Expansion Populations 16, 20	NA	NA	NA
DSH Funded Expansion	NA	NA	NA
Other Expansion	NA	NA	NA
Pharmacy Only	NA	NA	NA
Family Planning Only	NA	NA	NA

Enrollment current as of	January 31, 2016	February 29, 2016	March 31, 2016

3. Actual and unduplicated enrollment

Ever-enrolled report

POPULATION			Total Number of Clients	Member Months	% Change from Previous Quarter	% Change from Previous Year
Expansion	**Title 19**	PLM Children FPL > 170%	74	206	-160.81%	-1237.84%
		Pregnant Women FPL > 170%	28	71	-639.29%	-2296.43%
	Title 21	SCHIP FPL > 170	21,101	59,194	4.49%	10.10%

POPULATION			Total Number of Clients	Member Months	% Change from Previous Quarter	% Change from Previous Year
Optional	**Title 19**	PLM Women FPL 133-170%	678	1,802	-479.06%	-1528.76%
	Title 21	SCHIP FPL < 170%	70,710	197,940	-4.16%	18.19%
Mandatory	**Title 19**	Other OHP Plus	168,388	476,055	-11.40%	-68.31%
		MAGI Adults/Children	835,013	2,384,992	-0.11%	10.47%
		MAGI Pregnant Women	20,063	53,800	-2.11%	39.88%
		QUARTER TOTALS	1,116,055			

** Due to retroactive eligibility changes, the numbers should be considered preliminary.*

OHP eligibles and managed care enrollment

OHP Eligibles*		Coordinated Care				Dental Care	Mental Health
		CCOA**	CCOB**	CCOE**	CCOG**	DCO	MHO
July	1,045,836	911,396	1,081	928	35,299	54,090	3,781
August	1,066,977	927,738	1,542	1,044	35,437	55,494	3,839
September	1,076,833	941,854	1,190	975	36,011	56,771	3,825
Qtr Average	1,063,215	926,996	1,271	982	35,582	55,452	3,815
		87.19%	0.12%	0.09%	3.35%	5.22%	0.36%

**Total OHP Eligibles include: TANF, GA, PLM-Adults, PLM-Children, MAGI Adults/ Children, MAGI Pregnant Women, OAA, ABAD, CHIP, FC and SAC. Due to retroactive eligibility changes, the numbers should be considered preliminary.*
***CCOA: Physical, Dental and Mental Health; CCOB: Physical and Mental Health; CCOE: Mental Health only; CCOG: Mental and Dental*

Appendix B. Neutrality reports

1. Budget monitoring spreadsheet

Attached separately.

2. CHIP allotment neutrality monitoring spreadsheet

Attached separately.

Appendix C. Two-percent trend reduction tracking

Attached separately.

Appendix D. DSHP tracking

Attached separately.

Appendix E. Oregon Measures Matrix

Attached separately. In this period, OHA continued reporting on the 2015 coordinated care organization and state performance measures, finalized planning for 2016 measurement, and continued validating measures.

This quarterly report continues to include the final 2013 and 2014 results for the 17 CCO incentive measures and 33 quality and access test measures, and provides data for a new rolling 12-month window (December 2014 – November 2015) for a subset of measures for which data are available.

In this reporting period, OHA continued conversations with CMS regarding the request to extend the hospital transformation performance program (HTPP) for an additional year and launched an evaluation of the first two years of HTPP. Preliminary Year 2 HTPP Data were reported last quarter, and final year 2 HTPP data (covering October 2014 – September 2015) will be available next quarter.CCO Incentive Metrics

CCO incentive metrics

CCO reporting updates

In January, OHA published the CCO Metrics 2015 Mid-Year Update, which includes results on the CCO incentive, quality and access test, and core performance measures. This report lays out the progress of Oregon's CCOs on quality measures from July 1, 2014 through June 30, 2015 and is available online at: www.oregon.gov/oha/metrics. This is the first report to also show a subset of measures reported for Oregon Health Plan members with disability, and with severe and persistent mental illness (SPMI) or broader mental health conditions.

During this reporting period, OHA continued to provide updated metrics to CCOs utilizing the automated metric reporting tool ("dashboard").

Measure validation updates

OHA contracted with the Oregon Health Care Quality Corporation (Q Corp) to independently calculate and conduct a multi-directional validation process on the 33 quality and access test measures. This has been an ongoing process, with Q Corp calculating and validating the 2011 baseline, calendar years 2013 and 2014, the "dry run" period (July 2012 – June 2013), and the first and second years of the test (DY 2 and 3).

The status of validation of the 22 measures that are computed using administrative claims data is shown below for each measurement period.

Time period	Baseline	Dry run	CY 2013	Year One test	CY 2014	Year Two test
Measures signed off (as of 9/30/15)	22	22	22	22	21	TBD
Measures signed off (as of 12/31/15)	22	22	22	22	22	13
Measures signed off (as of 3/31/15)	22	22	22	22	22	21*
Total measures	22	22	22	22	22	22

**OHA specifications for Plan All-Cause Readmission (NQF 1768) did not conform to HEDIS 2015. OHA agreed to update specifications for the CY 2015 measurement period, but elected not to rerun and validate for the Year 2 Test Period.*

Hospital metrics update

Discussions with CMS regarding Year 3 of HTPP

OHA and CMS continued conversations about OHA's extension amendment request to extend the HTPP for an additional year. CMS provided verbal approval for a one-year extension of the program with no significant changes from the first two years of the program, however Year 3 benchmarks are still pending CMS review.

HTPP evaluation

In this quarter, OHA contracted for an independent, third-party evaluation of the Hospital Transformation Performance Program. Oregon Health & Science University's Center for Health Systems Effectiveness

(OHSU, CHSE) will conduct the evaluation – focusing on both qualitative and quantitative impacts of the first two years of the program. Results will be available in June 2016.

Hospital reporting

In this reporting period, OHA continued to provide claims data to hospitals for validation of the follow-up after hospitalization for mental illness measure. Discharges covering the entire Year 2 were shared with hospitals in February 2016, and OHA worked with hospitals throughout March 2016 to validate these data.

Progress report data for the other hospital measures are self-reported by the hospitals to OHA via the Oregon Association of Hospitals and Health Systems (OAHHS) each quarter. Official submissions of data covering the entire second year of the program were submitted to OHA on March 31, 2016 and Year 2 data will be reported to CMS next quarter.

Committee and workgroup updates

The **CCO Metrics & Scoring Committee** met twice during this period.

- In January, the Committee reviewed results of the 2015 Mid-Year Report and began discussions on its long-term vision, and framework and mechanics for the CCO incentive metrics program under Oregon's next Medicaid 1115 waiver.
- In February, the Committee continued its discussion from January, and discussed possible future options for the quality pool structure. The Committee also heard a presentation from OHA's Public Health Department on public health modernization and the State Health Improvement Plan.

Meeting materials are available online at:
www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx

The **CCO Metrics Technical Advisory Workgroup (CCO TAG)** met three times this quarter. Meetings included presentations on technical assistance opportunities and measure-specific Q&A; and continued discussions on food insecurity screening and a Health Equity Index.

Meeting materials are available online at: www.oregon.gov/oha/analytics/Pages/Metrics-Technical-Advisory-Group.aspx.

The **Hospital Performance Metrics Advisory Committee** met twice during this reporting period.

- In January, the Committee made recommendations for a revised Year 3 program structure, including three additional measures: 1) Reducing cesarean sections; 2) Reducing prescription opioid use; and 3) C-difficile.
- In February, having learned that CMS approved HTTP Year 3 with no changes, the Committee discussed next steps for Year 4 and beyond. The Committee will move forward with the model they had recommended for Year 3 as a starting point for their Year 4 proposal. The Committee will consider any shifts to this recommendation after the formal evaluation results are available in June 2016.
- Additionally, applications for Committee membership were accepted during February and March. Six of the current eight members' initial two-year terms will end in July 2016. There was also one vacancy. Members serve an initial two-year term, and are eligible to apply for two additional one-year terms. Appointments will be made in June 2016.

Meeting materials are available online here: www.oregon.gov/oha/analytics/Pages/Hospital-Performance-Metrics.aspx.

The **Hospital Metrics Technical Advisory Workgroup (Hospital TAG)** met three times in this reporting period. Meetings focused on reviewing draft Year 3 measure specifications, development of an Opioid reduction measure, and Year 2 data submission processes.

Meeting materials are available online here: www.oregon.gov/oha/analytics/Pages/Hospital-Metrics-Technical-Advisory-Group.aspx

Core Performance Measure Matrix

Core performance measures will be reported next quarter. Some core measures are included in the Measures Matrix.

HTPP Measures Matrix

This matrix is available in the Measures and Benchmarks Table online at: http://www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx.

Appendix F: Uncompensated Care Program

Nothing to report this quarter. OHA is currently implementing system updates to support collection of UCCP claim data.