

**Oregon's State Innovation Model Project  
Implementation Period  
Final Report  
12/24/13**

# Table of Contents

- Overview** ..... 5
- SIM Context** ..... 7
  - Update on governance, management structure and decision making authority ..... 7
    - Governor’s leadership..... 7
    - 2013 legislative update ..... 8
    - Oregon health policy board (OHPB) ..... 9
    - Oregon SIM oversight and operations coordination ..... 10
- Accomplishments: Model Intervention, Implementation and delivery Governor’s leadership** ..... 10
  - Spreading of the coordinated care model ..... 10
    - Oregon health policy board (OHPB) ..... 11
    - Public employees benefit board (PEBB) ..... 11
  - Accelerating innovation ..... 11
    - Transformation center ..... 12
    - Long-term care innovator agents ..... 16
    - Regional health equity coalitions..... 16
- Innovation in delivery ..... 17
  - Patient-centered primary care home (PCPCH) ..... 17
  - Health evidence review commission (HERC) ..... 19
  - Oregon health information technology ..... 19
  - Developing equity leadership through training and action training project (DELTA) ..... 20
  - Health care interpreter project..... 21
  - Community health ..... 22
  - Housing with services ..... 23
  - Long-term care alignment ..... 24
  - Linking health to education: early learning council work..... 25
- Payment reform ..... 25
  - Primary care multi-payer strategy workgroup ..... 25
  - Other multi-payer payment reform..... 26
  - CCO incentive payments ..... 27

Analysis and evaluation .....	27
Performance measurement.....	27
Analytic tools and capacity .....	28
Self-evaluation .....	28
<b>Planned activities for next quarter .....</b>	<b>29</b>
Accelerate innovation .....	29
Transformation Center .....	29
Long-term care.....	29
Regional equity coalitions (RHEC).....	30
Innovation in delivery .....	30
Patient-centered primary care homes.....	30
Health information technology.....	30
Community health .....	30
Health evidence review commission (HERC) .....	30
Housing with services .....	31
Long-term care.....	31
Early learning councils .....	31
Payment reform.....	32
Multi-payer strategic workgroup.....	32
Spread of the model to Public Employees Benefit Board (PEBB) .....	32
Analytics and evaluation .....	32
<b>Likelihood of achieving next quarter’s objective .....</b>	<b>32</b>
<b>Substantive findings .....</b>	<b>32</b>
<b>Lessons learned .....</b>	<b>33</b>
<b>Suggestions/recommendations for current/future SIM states .....</b>	<b>33</b>
<b>Suggestions/recommendations for CMMI SIM team .....</b>	<b>33</b>
<b>Findings from self-evaluation .....</b>	<b>34</b>
<b>Problems encountered/anticipated and implemented or planned solutions .....</b>	<b>34</b>
<b>Work breakdown structure.....</b>	<b>36</b>
<b>Points of contact.....</b>	<b>36</b>

**Appendix A** ..... 37  
**Appendix B**..... 38

## Overview

In April of this year, the Center for Medicare & Medicaid Innovation began providing generous resources to Oregon through the State Innovation Model award. This funding supports Oregon's work to transform the health system to bring better health, better care and lower costs. With transformation's focus on prevention, coordination, and paying for better health, preliminary data already point toward a successful model of coordinated care — one that will spread innovation further, faster, because of these resources.

Principles of the coordinated care model include:

- Best practices to manage and coordinate care;
- Sharing responsibility for health;
- Measuring performance;
- Paying for outcomes and health;
- Providing information;
- Achieving and maintaining a sustainable rate of growth in costs.

State Innovation Model (SIM) funding allows Oregon to accelerate health system transformation in our state, fueling the spread of the coordinated care model from the Medicaid population to other payers and populations more quickly and effectively. During this implementation period, Oregon achieved all the key goals and objectives as outlined in our operations plan and set the stage for the exciting work beginning in the demonstration period. Oregon's transformation work is on the move.

Some notable accomplishments from the first six months that were possible thanks to this funding include:

- The Transformation Center is operational, having quickly hired key staff, created an operational infrastructure, and began work to support and spread the coordinated care model, health care innovations, promising practices, and lessons learned. The Transformation Center's team and its website acts as a hub of accurate, timely information on metrics, learning opportunities, and resources.
- The release of the Public Employees' Benefit Board request for proposals for health insurance reflecting elements of the coordinated care model for the 2015 benefit year. The Board is hoping to see innovative models of care, similar to the work underway by communities with Medicaid CCOs.
- A multi-payer consensus was finalized amidst almost all of Oregon's major public and private payers with a signed agreement to support alternative payment strategies for Patient-Centered Primary Care Homes across the state. This was particularly important since the Affordable Care Act Section 2703 Medicaid "Health Home" funding expired in September.
- Initial performance reports showing a decline in hospital and emergency department visits and more investment in primary care as Oregon implements the coordinated care organization (CCO) model via CCOs in the Medicaid context. These results signal that

the state is on the right track with the coordinated care model. Oregon's transformation progress reports are online at [www.Oregon.gov/OHA/metrics](http://www.Oregon.gov/OHA/metrics).

- A significant step toward a statewide Health Information Exchange was accomplished, as all of Oregon's hospitals have agreed to join the state to support an Emergency Department Information Exchange (EDIE). In addition, the [OHA Health Information Technology Task Force](#) convened in this period and engaged stakeholders in developing recommendations for a multi-year business plan for health information exchange across Oregon ("Phase 2.0") including: long-term financial sustainability, governance and other elements to be implemented in 2015 and beyond.
- The State is making progress in adopting a culture of innovation in the Oregon Health Authority. The Institute on Health Care Improvement delivered training on the science of health care improvement and provided practical, hands-on skills to guide improvement projects for innovator agents, account representatives and quality assurance managers and other Oregon Health Authority staff.

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

#### Creating Learning Communities:

- During this period, the Transformation Center launched a statewide learning collaborative for Medicaid CCO medical directors and quality improvement managers. This learning collaborative meets monthly and examines each of the 17 CCO incentive metrics.
- By statute, each CCO has a Community Advisory Council (CAC) with consumers representing 51 percent of council membership. Many of these individuals have not served in an advisory capacity before. The Transformation Center surveyed CAC members to identify their organizational and leadership development needs and has launched a learning collaborative to support the success of consumer input to improve service delivery. Additional foundation funding will support a customized leadership development program for CAC members.
- Multiple payers came together to sponsor a learning collaborative with their provider networks around the Screening, Brief Intervention and Referral tool (SBIRT) for substance abuse, prompted by the Medicaid CCO incentive metrics. Provider education sessions took place in several large cities including Portland, Salem and Eugene.
- Planning for the complex care learning collaborative began during the implementation period, for a launch in November 2013.

#### Tools and resources to support innovation:

- SIM resources support a robust analytical capacity that improves our ability to provide timely, accurate, actionable data to CCOs. Two Health System Transformation (HST) Progress reports were issued and are viewable at: [www.oregon.gov/oha/Metrics/Pages/index.aspx](http://www.oregon.gov/oha/Metrics/Pages/index.aspx)
- Oregon's Patient-Centered Primary Care Institute (PCPCI) is able to continue, thanks to SIM funding, to support primary care practices across the state with technical assistance

emphasizing preventive, primary care under the coordinated care model. The Institute brings experts through webinars and consulting services to aid practices across the state with care transformation.

Bringing payers and providers together for alternative payments efforts:

- Multi-payer consensus on primary care completed, planning underway with delivery system stakeholders on next steps for alternative payment efforts in other areas.
- OHA's chief financial officer, in collaboration with Oregon Health Care Quality Corporation, one of Oregon's multi-stakeholder entities and a Robert Wood Johnson Foundation Aligning Forces for Quality grantee, convened an initial meeting of several commercial payers to discuss payment reform technical assistance needs.

Integrating systems and developing partnerships:

- The housing with services pilot project, using the Vermont model that incorporates housing and social services to improve health outcomes for older adults and people with disabilities, is moving forward. Services will begin in the next reporting period.
- Taking steps to integrate community health and health care, the Oregon Health Authority (OHA) launched a funding opportunity for collaborative partnerships between CCOs and local public health authorities to tackle population health and clinical care challenges.
- With leadership from the state's Early Learning Council, early learning hubs are being developed across the state to pull together resources focused on children and families in defined service areas. The hubs will focus on outcomes for children and their families and work closely with CCOs. SIM resources support coordination efforts focused on kindergarten readiness.

## **SIM Context**

### **Update on governance, management structure and decision-making authority**

#### **Governor's leadership**

Oregon is in the unique position of being a national leader in health care reform, which provides substantial momentum and support for SIM activities, with strong leadership from the Governor. On July 3, 2013, Governor John Kitzhaber sent a letter to HHS Secretary Kathleen Sebelius and CMS Administrator Marilyn Tavenner to invite collaboration with CMS, CMMI and other state governors to develop multi-payer strategies and develop common core principles on fiscal sustainability and changing the way care is organized. Specifically, Governor Kitzhaber invites collaboration on:

- Reducing the per capita rate of growth: A state commitment to achieve a reduction in the per capita growth rate of Medicaid spending, without reducing eligibility, benefits, quality, health outcomes or access.
- Federal investment: Depending on the particular circumstances and needs of the state, there will be a negotiated budget-neutral federal investment so long as the state demonstrates a significant return on investment over 10 years.

- Payment for outcomes: Payment systems and/or provider payment structures that shift from payment for procedures or encounters to a system of balanced incentives that reward improvements in health outcomes and promote transparency and accountability.
- Accountability: A commitment to quality measures is a key aspect of health system transformation and common transparent metrics must be used to provide both intra- and interstate comparisons.
- Flexibility: Allowing local and regional flexibility to pursue delivery system changes that achieve the desired outcomes, provided that eligibility benefits and quality are not reduced and State Plan requirements that have not been waived are met.
- Coordinated and integrated care: Delivering higher quality, coordinated care through integration of benefits with a strong focus on primary care and home and community-based care delivery.
- Multi-payer\_strategy: A commitment to pushing health care reform efforts beyond Medicaid and into the commercial market.

Oregon will share its accomplishments and experience in health care reform, and support national, state and local efforts to transform the health care delivery system into one that produces better health, better care and lower costs.

### **2013 legislative update**

The six-month SIM implementation period included the close of Oregon's 2013 legislative session. Several bills supportive of Oregon's SIM goals were passed:

- HB 2118 creates a workgroup just getting underway to recommend aligned metrics among Cover Oregon, Medicaid, the Public Employees' Benefit Board (PEBB) and the Oregon Educators Benefit Board (OEBB). Aligned metrics will foster spread of the model to populations beyond Medicaid.
- HB 2279 allows local governments to join PEBB. This expands the pool of potential lives covered by elements of the coordinated care model in the PEBB 2015 benefit year.
- SB 436 directs Medicaid CCOs to coordinate with the Governor's new Early Learning Council (ELC) on community health assessments and directs integration and cooperation between health care, population health and early learning systems.
- SB 604 specifies that a common statewide credentialing database should be created, to reduce administrative burdens to both providers and credentialing entities. This legislation will facilitate expanding opportunities for telemedicine, including those activities supported by SIM in subsequent periods. A multi-stakeholder advisory group was underway as of fall 2013 to make recommendations for an efficient credentialing solution.
- SB 724 directs the Health Authority to develop an accounting system for flexible (innovative, nontraditional) health services provided by Medicaid CCOs in an effort to coordinate care or avoid costlier services at a later date. OHA has developed guidance for CCOs that becomes effective January 1, 2014.
- HB 2859 calls for strategies to meaningfully engage Medicaid patients in their care. A workgroup staffed by the Transformation Center's Director of Systems Innovation and was able to rapidly accomplish the task of providing recommendations to the Legislature in November 2013. More details will be available in the next progress report.

- The Oregon Health Authority budget was passed; it included additional funding to support the Medicaid CCOs' innovative work through a \$30 million Transformation Fund grant program. SIM resources will support a learning collaborative beginning in March 2014 for the CCOs to share innovations, lessons learned, and opportunities for improvement gleaned from transformation fund projects.

### **Oregon Health Policy Board (OHPB)**

In a June 3, 2013 letter to the Oregon Health Policy Board, Governor John Kitzhaber directed the board to identify possible statutory and regulatory changes necessary to ensure that the state capitalizes on the opportunity to extend the coordinated care model into the commercial marketplace. The letter specifically asks OHPB to identify recommendations for the Legislature and the Governor by the end of 2013, including, but not limited to:

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

This work explicitly supports Oregon's SIM goals of spreading the coordinated care model and accelerating health system transformation. The three areas of focus and a brief summary of the work are described below.

#### *Transparency, accountability, cost shift*

After reviewing previous recommendations from OHPB's predecessor body, the Oregon Health Fund Board, OHPB has focused on a discussion of a framework for transparency and accountability across the markets and elements of the delivery system, addressing the impact of transformation and the federal ACA. Key partners include the Oregon Insurance Division, CoverOregon, Oregon's Health Insurance Exchange and key health care delivery system stakeholders including the Oregon Health Leadership Council (OHLC)<sup>1</sup>. Detailed recommendations for this work will be included in Oregon's next quarterly report but will include a statewide scorecard effort for ongoing monitoring across markets.

#### *Coordinated care model alignment group*

This group is focused on aligning state purchasers' contracting with the coordinated care model and includes representatives from the Public Employees' Benefit Board (PEBB), Oregon Educators Benefit Board (OEBB), and Cover Oregon (Oregon's health insurance exchange). The group presented its findings to the Oregon Health Policy Board in December, aiming to embed coordinated care model principles in PEBB and OEBB purchasing strategies and incorporate those principles in individual and small group commercial plans sold in Oregon.

---

<sup>1</sup> The OHLC is a collaborative organization working to develop approaches to reduce the rate of increase in health care costs and premiums so health care and insurance are more affordable. Formed in 2008 at the request of the Oregon business community, the council brings together health plans, hospitals and physicians to identify and act on cost-saving solutions that maximize efficiencies and quality. Please see Appendix A for a member list.

### *Rate review*

In considering how the rate review process might be used to advance transformation, OHPB invited testimony from health plans, small business representatives, consumers and consumer advocates and received public testimony at five board meetings. Manatt Health Solutions and Georgetown University provided expert consultation. Potential strategies considered included:

- Fostering system-wide transparency and accountability through a robust measurement framework, including a public-facing health system dashboard, tracking the effects of ACA implementation and Oregon's health system reforms;
- Using a small set of focused metrics from the dashboard or measurement framework above for informal inclusion in 2015 rate filings;
- Having the Oregon Insurance Division identify opportunities for administrative simplification in the rate review process; and
- Developing meaningful communication outreach strategies that work for consumers and health plans during the rate review process.

This work sets the stage for spreading the coordinated care model beyond Medicaid as we enter Testing Year 1. While this report is intended to summarize Oregon's activities through September 2013, the December final recommendations of the Policy Board to the Governor are available [online](#). Further detail will be provided in Oregon's next quarterly [report](#).

### **Oregon SIM oversight and operations coordination**

A SIM Operations Committee has been established, with representatives from across the Oregon Health Authority and our sister agency, the Department of Human Services, Aging and People with Disabilities program. This group convenes biweekly to coordinate SIM-funded activities and identify barriers and potential solutions. The committee communicates with members of the SIM Steering Committee to ensure SIM work is always within the context of the efforts of the Governor, Legislature, and key health care system leaders and other stakeholders. The SIM program area leads are drawn from across the Oregon Health Authority and the Department of Human Services, Aging and People with Disabilities program. This group monitors progress on personnel, budgeting and contracting. Additionally, committee members have provided information for the SIM Operational Plan and SIM Project Management Tool, and the committee supports collaboration and coordination of health care transformation activities across state government.

Oregon's SIM Steering Committee, comprised of the leadership team for the SIM grant, led a process to review the Oregon SIM Operational Plan and refocused the SIM grant activities and budget to align with SIM funding allocations with proposed activities. Additionally, this steering committee reviewed the continuation budget and quarterly report.

## **Accomplishments: Model intervention, implementation and delivery**

### **Spreading the coordinated care model**

Oregon's SIM grant funding allows the state to rapidly spread the coordinated care model beyond Medicaid. SIM funding in the implementation period has provided the support to begin this work. Oregon's next steps for extending the coordinated care model include contracting for

coordinated care in the Public Employees' Benefit Board and the Oregon Educators Benefit Board via request for proposals (described below), and in the next contracting cycle for Qualified Health Plans (QHPs) in Oregon's new health insurance exchange, CoverOregon. This will continue the spread of the model across both public and private markets. Efforts by the Transformation Center and Patient-Centered Primary Care Home program, described in more detail below, will support and sustain model innovation across provider networks.

### **Oregon Health Policy Board (OHPB)**

Guiding the strategies that will expand the coordinated care model across Oregon, the Oregon Health Policy Board has been setting the groundwork as we move into Test Year 1. As described in the Governance section of this report, Governor Kitzhaber directed OHPB to identify possible statutory and regulatory changes necessary to ensure that the state capitalizes on the opportunity to extend the coordinated care model into the commercial marketplace. The letter specifically asks OHPB to identify recommendations for the Legislature and the Governor by the end of 2013, which is being completed and is available [online](#).

### **Public Employees' Benefit Board (PEBB)**

Anticipating work of the Public Employees' Benefit Board to incorporate key elements of the coordinated care model into the 2015 contracts and the need for better communications with state employees, PEBB worked through a series of consultant-identified recommendations not only about messages but about how, when and where to communicate with members. How decisions are made about health care and by who is not well understood by PEBB membership, creating skepticism and cynicism. To begin the conversation with members, and partnering with labor, this spring PEBB Board members held a series of eight local meetings in seven cities across the state with PEBB members, along with a live webinar, and an online survey. More than 1,100 people participated. Another round of 60 member engagement events occurred in September during open enrollment to communicate with members about initial enhancements to 2014 benefits that align with the coordinated care model. For example, members would have reduced co-pays if they seek primary care in a patient-centered home and engage in wellness opportunities. These meetings included additional discussions of the coordinated care model and the new request for proposals (RFP) for partners to spread the model across the state for state employees in 2015.

With technical assistance provided by CMMI and their SIM consultants, the request for proposals (RFP) was posted for the 2015 PEBB benefit year to continue the spread of the coordinated care model into health care for a public employee population of 130,000 covered lives. The RFP closes in December 2013 with the board working through the vendor applicants for decisions by spring 2014. The Board is hoping to see innovative models of care, similar to the work underway by communities with Medicaid CCOs in the responses.

### **Accelerating innovation**

Early in the implementation period, some of the OHA's leadership team, which included the SIM principal investigator/OHA Chief Medical Officer, the director of the Transformation Center, the director of Health Analytics, the director of Quality and Measurement, and the state Health Information Technology coordinator spent several weeks conducting a series of listening

sessions with 14 of the sixteen<sup>2</sup> coordinated care organizations. The purpose of the listening sessions was to gather initial CCO stakeholder feedback to assist in the development of strategies to support and accelerate innovation, including the Transformation Center and integrated planning related to metrics, data analysis needs and health information technology. Feedback from those sessions has guided planning and contracting to provide the right mix of expertise and skills in health care transformation to meet the needs of Oregon stakeholders. Discussions with key commercial insurance and broader health care system stakeholders will follow to shape the blueprint for the Transformation Center's efforts to spread the coordinated care model into the commercial marketplace.

As described below, Oregon has three major strategies supported by SIM to accelerate innovation and build a culture of innovation and improvement across the health delivery and social support systems: 1) the Transformation Center acts as a convener of stakeholders and partners, instigates innovation, and spreads system improvements across populations and payers; 2) the long-term care innovator agents will help bridge systems and institute care coordination mechanisms between CCOs and long-term care services and supports partners; and 3) the OHA's Office of Equity and Inclusion is building capacity and leadership for health equity as a key strategy to accelerate innovation and reduce health disparities.

## **Transformation Center**

### *Infrastructure for improvement and innovation*

SIM investments in the Transformation Center have provided the necessary resources to establish a robust center that supports coordinated care organizations, the Community Advisory Councils and clinical innovation efforts across the state. The Transformation Center acts as a central hub and convener of internal and external partners fostering clear communications and reducing or eliminating barriers and administrative burden. Supporting the success of CCOs is critical to spreading the coordinated care model. An estimated 80 percent of Oregon's health care providers see Medicaid enrollees, and more than 92 percent of all Medicaid clients are enrolled in CCOs. CCOs' success with their provider networks will set the stage for the changes needed across the health care delivery system.

One of the key first steps for the Transformation Center was developing its high-level strategic plan for its first year of operations. The center's staff recruitment strategy has attracted top talent in the areas of health policy, clinical innovation, partnerships, rapid-cycle learning and knowledge dissemination and management expertise. The center has begun developing its guiding principles, policies and procedures to clarify the roles, responsibilities and lines of communication of staff members with our internal and external partners. The center is both a physical and virtual workplace connecting staff that are stationed across the state providing support locally to CCOs in their own communities. SIM investments in technology have developed a training room within the center that is capable of hosting small- and medium-sized classes or meetings both in person and/or using distance bridging technology, such as video conferencing, live video streaming, webinars and telephone conferencing. This space can

---

<sup>2</sup> There are currently 16 CCOs. At the time of these listening sessions, only 14 existed. One new CCO began operations in fall 2013; another existing CCO with two distinct service regions will operate under two separate contracts beginning January 2014, for a total of 16 CCOs.

accommodate Oregon Health Policy Board meetings, which will facilitate and expose more stakeholders to the Transformation Center, its mission and resources and link innovator agents and others to the Board’s strategic work. This space is used to support the weekly innovator agent staff meetings with agents calling in from their bases across the state and connecting with their other service team members from across the Oregon Health Authority, especially the Division of Medical Assistance Programs (DMAP), the Public Health Division or other partners.

This implementation period has also allowed the Transformation Center initially to focus on improving OHA internal processes and opportunities for innovation, as well as support and technical assistance to the CCOs. An important SIM-funded learning experience in April was a three-day Science of Improvement training facilitated by the Institute for Healthcare Improvement. The training brought together OHA innovator agents, service representatives and quality improvement coordinators, along with management, to learn the science of improvement and acquire the tools for fostering a culture of improvement within OHA and extending to our CCO partners. The lessons learned will aid other states on the best practices and cultural shifts necessary for state health agencies to support innovation in the delivery system.

Spreading innovation means helping people make changes. SIM funding supports a consulting contract with Neil Baker, M.D., who has more than 30 years’ experience facilitating change. This includes many years in leadership and quality improvement. The Transformation Center has engaged Dr. Baker to support the learning collaboratives, as well as provide consultation in person and in telephone conference calls with the innovator agents and Transformation Center staff to support coaching CCOs and stakeholders on the relational issues that arise as people work together towards change. Dr. Baker describes, “High performance, sustained over time, is not just about setting direction and getting to results. It is also about resilience and the ability to innovate and change. These factors depend on the ways people work together and how leadership is expressed—people issues, not technical issues.”

Finally, a CCO-OHA issues tracker system is in beta testing. The purpose of the issues tracker is to allow DMAP innovator agents and account representatives to record the various questions asked by their CCOs and track the status of answers. Once it is fully functional, the issues tracker will identify trends in CCO issues, which will contribute to system-level solutions.

#### *Supporting delivery system transformation*

The Transformation Center has coordinated efforts to distribute new, non-competitive Transformation Funds to the CCOs provided by the Oregon Legislature in July 2013. The \$30 million in state General Fund moneys is intended to support CCO-proposed projects that are innovative, scalable, transferable and related to CCO transformation plans including, but not limited to, the following focus areas:

- Information technology systems and CCO infrastructure, including additional investment in electronic medical records (EMR) and claims processing systems;
- Population health management, case management, disease management, and achieving quality metrics;

- Provider panel and clinic enhancements to provide extended primary care services to high-risk Oregon Health Plan members; and
- Projects designed to improve patient engagement and patient accountability

The Transformation Center posted the request for grant proposals, has evaluated and negotiated with CCOs and is currently in the process of executing grant contracts to disburse funds to CCOs as quickly as possible to gain the greatest value for this investment. Those CCO's who submitted during the first funding phase are being distributed and proposals received in the second phase of the Transformation Fund application process are currently under review and funding will be released by Dec. 15. SIM resources will support a learning collaborative beginning in March 2014 that will promote the application of the science of improvement tools and resources in the implementation of these transformation projects through our collaboration with the Institute for Healthcare Improvement.

As part of the rapid cycle learning supported by the SIM grant, the Transformation Center has launched a learning collaborative to support the Community Advisory Councils (CAC). Each CCO is required to have a council and 51 percent of each advisory group must be composed of CCO consumers. Many CAC members have never served on an advisory council. The CAC collaborative is designed to support leadership and organizational development needs so that councils are best positioned to meet their statutory obligation to deliver a community health assessment and community health improvement plan for each CCO by June 2014, and actively participate in efforts to spread the coordinated care model in their communities.

Another accomplishment during the implementation period was the development of recommendations regarding patient engagement in transformed models of care. The Transformation Center's Director of Systems Innovation, Chris DeMars, M.P.H., staffed a legislatively appointed Individual Responsibility and Health Engagement Task Force (HB 2859, 2013). The task force made recommendations to the Oregon Legislature to establish mechanisms to meaningfully engage Oregon Health Plan (OHP) members in their own health, disease prevention and wellness activities. Many of the final recommendations will be implemented through the Transformation Center.

The Transformation Center director has started discussions on partnership opportunities with a variety of organizations including Oregon Health & Science University; Oregon Health Care Quality Corporation (QCorp) and its Patient-Centered Primary Care Institute; a number of social service organizations; and health and consumer advocates. These conversations will lead to the Transformation Center linking the CCOs with organizations that can help them achieve their innovation goals. It also will fuel additional linkages to spread innovation.

#### *Fostering clinical innovation*

SIM funding supports the work of the Transformation Center's Director of Clinical Innovation; Ron Stock, M.D. Dr. Stock brings more than 25 years of practice experience to his role as director, including leading his clinic to team-based care through extensive innovation. During the implementation period, Dr. Stock initiated a well-received learning collaborative with the

medical directors and quality improvement managers of CCOs to identify best practices for meeting performance expectations for the 17 CCO incentive metrics.

Additional planning and outreach with medical directors is underway to develop a learning collaborative on providing complex care that will include several CCO staff as well as providers, community health workers and care coordinators from their networks to share on-the-ground best practices. In September, Dr. Stock and Learning Collaboratives Manager, Emilee Coulter-Thompson, M.S.W., conducted 14 interviews with 19 medical directors and leaders of community-based clinics to assess current work on complex care and inform the development of a meeting agenda for the initial day-long collaborative. A key lead in pulling this collaborative together has been David Labby, M.D., Ph.D., the chief medical officer for Health Share, a Portland-area CCO. Dr. Labby also acts as principal investigator on a CMMI Community Innovation “Health Commons” grant (via Providence Health System).

The Health Commons project will integrate care delivery for Medicaid and dually eligible Medicare/Medicaid beneficiaries through cooperation among traditional health care competitors in the tri-county metropolitan area. The program will include a registry with real-time alerts that will enable the coordination of care across all service sites, standardize discharge and transition processes from hospitals to primary care, emergency room navigation services to divert non-urgent cases to primary care, and intensive patient support services through community-based and cross-disciplinary care teams. The Health Commons project should result in reduced use of emergency rooms, fewer avoidable hospital readmissions and improved access to more appropriate and cost-effective levels of health care services, resulting in better care for those served. Over time, improving the health of the population is anticipated to save \$32.5 million. The new statewide complex care collaborative starting through the Transformation Center will build on sharing information about lessons learned from the CMMI-supported project, including their efforts to date with community health workers, or “Health Resilience Specialists,” and trauma-informed care. More than 100 providers and other stakeholders came to the initial discussion with ongoing interactions planned during the next several months.

Ron Stock, M.D., and OHA Chief Medical Officer Jeanene Smith, M.D., have been working with OHA and Transformation Center leadership to plan the structure and the recruiting of the Council of Clinical Innovators. This SIM-supported project will recruit a cadre of 10 to 12 providers who will serve as champions of change and support implementation of the coordinated care model through provider-to-provider conversations. The “Transformation Academy” will provide extensive sharing of best practices and leadership skills to the clinical innovators who will carry these tools back to their local communities to foster the spread and adoption of coordinated care model principles across many practice areas. Dr. Stock talked with CMMI staff about their experience with a similar model of change. Further input from CCOs, health plans and health system leaders will be sought with the recruitment of champions of clinical change expected to be conducted in March–April 2014.

#### *Transformation Center facilitates communications*

Director of Communications for the Transformation Center Alissa Robbins works closely with the OHA Director of Communications, OHA leadership, other OHA communications staff, as well as communications staff in other agencies, such as the Department of Human Services,

Cover Oregon, and the Oregon Insurance Division to coordinate messages and provide access to critical information regarding the coordinated care model. She develops the communications strategy for spreading the coordinated care model to other payers, including writing the master communications plan for the Transformation Center. The communications director also worked internally on an assessment of communications to CCOs and has worked on a number of internal communications projects to streamline how we do business; this work will continue into the next quarter.

Supported by SIM investments, the Transformation Center website aggregates information CCO staff are looking for in a central, easy-to-navigate website, which includes OHA resources; contacts; links to funding and grant opportunities; learning collaborative schedules and resources; metrics resources, and more. The website aims to further information about the value of the coordinated care model to other payers, and to Oregonians the model serves: [www.oregonhealthstories.com](http://www.oregonhealthstories.com). The website will continue to develop with the purpose of supporting CCOs and other partners achieve success through the coordinated care model, and to support the spread of the model beyond Medicaid. The website is viewable at: <http://transformationcenter.org/>. This website has been adopted as a platform for linking the work of the Early Learning Council and the health transformation learning collaborations.

### **Long-term care innovator agents**

Another example of how Oregon is accelerating innovation is the development of innovator agents focused on linking medical care with the systems that coordinate and deliver long-term services and supports. Inspired by the innovator agent model in the Transformation Center, Oregon has leveraged SIM funds and state General Fund moneys provided in the 2013 Oregon legislative session to support a total of seven long-term care innovator (LTC) agent positions. SIM funding supports three of those positions — these will be state employees — and the state general funding supports an additional four positions, which will be contracted out to local Area Agencies on Aging (AAA). Working in conjunction with Transformation Center innovator agents, the long-term care innovator agents will address consumer and systems issues to facilitate better outcomes, lower costs, and avoid cost shift between social and medical systems. High cost, heavy utilizers who are dually eligible (Medicare/Medicaid) or triply eligible (eligible for Medicare, Medicaid and long-term services) will be a priority for intervention.

Four larger AAAs have been selected as the contractors for the out-stationed LTC innovator agents, since they also administer the Medicaid program and services for older adults and people with disabilities in their geographic regions. These four agencies serve the bulk of the Medicaid-enrolled older adults and people with disabilities in Oregon and are the most logical method of establishing the positions given the absence of Adults and People with Disabilities state offices in those regions. The LTC innovator agent positions were in recruitment during the implementation phase and will be in place during demonstration phase to focus on improving coordination between the long-term care system and CCOs.

### **Regional Health Equity Coalitions**

SIM funding supports expanding Oregon's network of Regional Health Equity Coalitions (RHECs). RHECs operate as advisors to CCO's Community Advisory Councils and community partners on culturally relevant and specific strategies to reduce health disparities and provide

technical assistance and support to agencies and community leaders to act as change agents to improve equity and the representation of the interests of marginalized communities in health transformation efforts. This is a key strategy aimed at improving the social determinants of health. SIM resources support the development of three additional coalitions. The Office of Equity and Inclusion (OEI) convened an advisory committee that met three times in this period to provide guidance on the development of a request for proposals (RFPs) for the new RHECs. This will support health equity efforts as Oregon grows the coordinated care model. The committee consisted of representatives of existing RHECs, coordinated care organizations, the Public Health Division, Transformation Center innovator agents, private foundations, and interested stakeholders. The committee reviewed data and solicited input on the proposed funding model, activities and achievements, challenges and outcomes to date.

Discussion of key questions for new RHECs included the following:

- How should the RHEC model both engage in health system transformation to eliminate disparities in health care (access, health care quality, health outcomes) and maintain a focus on the social determinants of health?
- How do we ensure a focus on health equity and the needs of communities of color?
- What are the minimum standards for coalition work?
- How should the RHEC model engage partnerships with private and public funders? What principles of partnership should steer the ways funders engage with, and commit to, the RHEC model?

The RHEC RFP has been developed and posted. SIM resources support the Regional Health Equity Coalition coordinator position. This position is responsible for providing technical assistance to these new coalitions and monitoring the coalitions to share best practices and spread innovation in improving health equity and reducing health disparities. The position has been posted, application review is underway and hiring will be complete in early December.

### **Innovation in delivery**

With SIM support, Oregon has several initiatives underway to improve health care delivery systems to achieve the improved care component of the triple aim. The Patient-Centered Primary Care Home Program continues to grow, encompassing more practices and shaping new care models experienced by consumers. Oregon continues to lead in the area of adopting and promoting evidence-based best practices for clinicians. Planning for continued health information technology made significant progress in this period. Oregon's emphasis on improving health equity and reducing disparities continues in the area of health care interpreting and training to develop leadership that fosters a transformative culture addressing the needs of historically underserved populations and improving health outcomes for everyone. Exciting work between CCOs, local public health departments and community-based partners is underway as they develop or grow their consortia in preparation for the release of the request for proposals for the population-focused prevention grants.

### **Patient-Centered Primary Care Home (PCPCH) Program**

The state's PCPCH Program is preparing to launch [the 2014 PCPCH recognition criteria](#). The new criteria are based on the most recent evidence in the literature, provider experience with the

2011 PCPCH criteria, and broad stakeholder input. They will be in effect for clinics seeking recognition or renewing their recognition status starting in January 2014. Currently the state's program has 465 clinical practice sites recognized as primary care homes based on current (2011) criteria. The new standards for recognition provide a comprehensive roadmap for primary care transformation, further enhancing the adoption of evidence-based practices as a core element of Oregon's coordinated care model.

*Provider technical assistance offered from April 1, 2013 – Sept. 30, 2013*

Due to the SIM grant's support, continued technical assistance to clinics is being provided through the [Patient-Centered Primary Care Institute](#), housed within our multi-stakeholder partner, the Oregon Health Care Quality Corporation.

Although SIM funds were not used during this entire period to support all of the activities listed in this section, they will allow the PCPCH program to continue its robust site visit system and technical assistance offerings, both of which are critical to program success and model spread. Technical assistance topics have included:

- Partnering with Patients: Engaging Patients in Quality Improvement;
- Screening Brief Intervention and Referral to Treatment (SBIRT): Behavioral Health Screenings and Patient-Centered Care;
- Primary Care Behavioral Health Services: A Road Map for Success;
- Using Data in Quality Improvement;
- START: Implementing Standardized Developmental Screening in the Patient and Family-Centered Medical Home;
- Approaches to Patient-Centered Interactions: Creating a Truly Patient-Centered Primary Care Home;
- The 2014 PCPCH Recognition Criteria;
- Care Setting Transitions and the Primary Care Home;
- Measuring and Improving the Patient Experience of Care: Surveys, Tools and Approaches.

Slides and audio recordings of each presentation are available at:

[www.pcpci.org/resources/webinars](http://www.pcpci.org/resources/webinars). Six webinars were presented (also available to the public online at [www.pcpci.org](http://www.pcpci.org)).

- [Partnering with Patients: Engaging Patients in Quality Improvement Initiatives](#) (7/9)
- [SBIRT: Behavioral Health Screenings and Patient-Centered Care](#) (7/24)
- [Primary Care Behavioral Health Services: A Road Map for Success](#) (8/13 and 8/21)
- [Using Data in Quality Improvement](#) (8/20)
- [START: Implementing Standardized Developmental Screening in the Patient and Family-Centered Medical Home](#) (9/10)
- [Approaches to Patient-Centered Interactions: Creating a Truly Patient-Centered Primary Care Home](#) (9/17)

Planning and contract negotiation are also underway for the next phase of technical assistance through the Patient-Centered Primary Care Institute for primary care practices across Oregon. A draft scope of work has been developed and we anticipate executing a contract in January 2014.

### *Primary care payment strategy*

Please see the Payment Reform section below for details about the Multi-Payer Primary Care Payment Strategy Workgroup that was convened and facilitated by Oregon Health & Science University's Evidence-based Practice Center. This workgroup met four times and, through a consensus process, reached a pioneering agreement across public and private payers to coordinate their efforts to support primary care homes in Oregon.

### *Site visits*

During this reporting period, 20 site visits were conducted to recognized primary care homes. Thanks to the SIM support, the PCPCH Program is working to expand and improve this process and provide additional technical assistance to clinics. The PCPCH Program is conducting an innovative pilot project to include a community-based clinical consultant at all site visits. The purpose of the clinical consultant is to act as a mentor and connect the primary care home with technical assistance tools and resources. In collaboration, the consultant and clinic will develop short-term and long-term goals for practice transformation. The consultant will stay engaged with the clinic during a six- to 12-month period to help the clinic achieve their stated goals. The PCPCH program has already contracted with five community-based consultants across Oregon.

### *PCHCP outreach and recruitment*

The program continues to work on its communications strategy to ensure alignment across all health system transformation activities. Analyzing those practices that have not yet sought recognition and their challenges, the program has increased efforts to focus on independent practices, particularly those in rural and frontier Oregon. Efforts are underway to increase engagement with rural providers, and conducting two community forums in Eastern Oregon in October 2013.

### **Health Evidence Review Commission (HERC)**

SIM funding supported the OHSU Evidence-based Policy Center to conduct initial planning for improving the Health Evidence Review Commission's clinical evidence synthesis and translation work to aid the spread of the coordinated care model. A process improvement strategy was developed and is underway including: enhanced planning for clinical and health technology topic selection for HERC, and gaining stakeholder input via interviews/meetings to understand how best to connect CCOs, their clinical advisory panels, as well as other payers, plans, providers and health system stakeholders with the HERC's evidence synthesis work. This collaboration with the Center will address best practices for dissemination and translation of HERC guidelines through the efforts of the Transformation Center, in alignment with national efforts such as "Choosing Wisely" to guide providers and their patients to evidence-based care.

### **Oregon Health Information Technology**

During this period, the state coordinator for Health Information Technology and a SIM-funded consultant (Patricia MacTaggart of George Washington University) have conducted listening sessions and met with 15 of the sixteen coordinated care organizations (CCOs) as part of the OHA's initial listening tour. They also met with other health systems, plans, advocates, providers, the Health Information Technology Oversight Committee (HITOC), counties, and internal state leadership.

### *Listening sessions and strategic planning*

The information gathered from listening sessions was used to identify key needs across both public and private delivery systems in Oregon. OHA has unanimous support from the CCOs on HIT/HIE “Phase 1.5,” the near-term HIT/HIE development strategy to support health system transformation. As this work advances, OHA will seek support from additional private partners. To be developed in the 2013–2015 timeframe, Phase 1.5 includes six elements:

- A state-level provider directory;
- Statewide hospital notifications;
- Incremental development of a patient-provider attribution service;
- Statewide Direct secure messaging;
- A state clinical quality metrics registry; and
- Expanded technical assistance for Medicaid providers for EHR adoption and meaningful use. This phase of HIT/HIE services will build a foundation for future statewide interoperability and HIE, while supporting immediate coordination between providers seeking to exchange patient information and the incremental use of aggregated clinical data to improve the delivery of care. SIM funds were a key support for building stakeholder consensus around the services and approach to Phase 1.5.

### *Health information technology task force*

Further SIM-supported stakeholder work during this reporting period was underway with the [OHA HIT Task Force](#). The task force includes a diversity of stakeholders, including (but not limited to) major payers, health systems, hospitals, providers, local HIE efforts, public sector, and advocates/consumers. The role of the task force is to recommend key components of a multi-year business plan framework (“Phase 2.0”), including long-term financial sustainability, governance and other elements to be implemented in 2015 and beyond.

### *Emergency department information exchange*

OHA has partnered with the Oregon Health Leadership Council (OHLHC) to support the availability of Emergency Department Information Exchange (EDIE) in hospitals across Oregon. EDIE is a solution developed by Collective Medical Technologies (CMT) to exchange information among EDs to identify frequent users and share care plans with ED teams to help those frequent ED utilizers to determine if there is another care setting that is more appropriate. SIM funds are being used for a grant that will be combined with funding from OHLHC, its members and the state’s hospitals to procure and implement the EDIE solution.

### **Developing Equity Leadership through Training and Action Training Project (DELTA)**

DELTA is a comprehensive health equity and inclusion leadership program that strategically provides training, coaching and consultation to key health, community and policy leaders in Oregon. It will 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, each cohort will act as

drivers of equity and inclusion within Oregon’s health promoting systems. During the implementation period, the following tasks have been completed:

- Three DELTA educational sessions (for a cohort already underway) were held that focused on the following topics: Power and Privilege and Community Engagement Best Practices; Data Collection and Analysis, Culturally and Linguistically Appropriate Services (CLAS) Standards and Cultural Competence in Health Care Delivery; and Best Practices for Developing a Diverse Workforce and Implicit Bias/Implicit Association Test.
- The DELTA Advisory Committee met twice during this quarter. The following objectives were met: finalized DELTA Evaluation Plan (summarized below); designed the structure for future cohorts; developed recruitment plan for future cohorts.
- The content design and layout for the DELTA program section of the OEI website has been completed. The content will include the following components of the program: description; 2013 cohort biographies; 2013 training calendar; nomination/application process; frequently asked questions; contact information; and logos for DELTA and Kaiser. The go-live date for the website is pending.

These activities were are not supported by SIM funding but when leveraged along with SIM investments in equity, are an essential component to our success in addressing health equity in all aspects of health system transformation, and are provided as a precursor to the SIM support work that will be underway in the SIM Demonstration Period 1. SIM support to the DELTA project will support the development of effective leadership within the communities across Oregon that can break down barriers to health equity as we transform the delivery system.

### **Health care interpreter project**

Health care interpretation is critical today in the face of rapidly shifting U.S. demographics and the rising number of Americans with limited English proficiency. According to a 2011 American Community Survey, more than 58 million U.S. residents speak a language other than English at home and more than 26 million residents speak English “less than very well” and may be considered to have Limited English Proficiency (LEP).<sup>3</sup>

Similar demographic shifts in Oregon emulate national trends. The makeup of the state’s population is rapidly changing as a result of immigration, economics, gentrification, and other factors. In 2011, nearly 378,000 or 9.8 percent of Oregon’s population was foreign-born and 541,345 individuals spoke a language other than English at home. Oregon’s Limited English Proficiency population nearly tripled from fewer than 50,000 in 1990 to 228,891 in 2011.<sup>4</sup> In Multnomah County alone, 10.4 percent of the county’s population speaks English “less than very well.” Stakeholders are increasingly recognizing that language access is an issue that must be addressed in the context of the demography of patient populations of today.

Language service providers estimate that there are approximately 3,500 practicing health care interpreters in Oregon. However, very few of these interpreters are qualified or certified, meeting

---

<sup>3</sup> Selected Characteristics of the Native and Foreign-born Populations. 2011 American Community Survey 1-Year Estimates. U.S. Census Bureau

<sup>4</sup> Language Spoken at Home. 2011 American Community Survey 1-Year Estimates. U.S. Census Bureau

national level standards of medical terminology, standards of practice, ethics and language proficiency. Currently, the National Board for Certification of Medical Interpreters counts only 33 Oregon health care interpreters who have met training requirements and passed validated testing to become certified. Over-reliance on unqualified interpreters and family members creates significant risks for patients and providers alike, increases potential costs due to misdiagnoses or lack of adherence to medical directions and treatments, and reduces quality of care and patient satisfaction.

### *Certifying interpreters*

In alignment with our application and operations plan, the Oregon Health Authority's Office of Equity and Inclusion developed and disseminated applications for the Health Care Interpreter Program. Oregon is in negotiation with CMMI about how to address the budget issues that have emerged related to these opportunities to spread best practices for health care interpreting. More information will be available in the next reporting period. During the implementation period:

- OEI convened a subcommittee of the Oregon Health Care Interpreter Council (statutory advisory committee that guides the development of the state program). The subcommittee established the criteria and process for participation.
- The contracting mechanism to distribute the funding was finalized.
- The steering committee met and conducted outreach to encourage applications.
- The application materials were posted and 72 applications have been received.

### **Community health**

Oregon is striving to integrate population health and the health care delivery system. SIM supports several strategies that capitalize on the principles, practices and community relationships that are the strong leading edge of the public health system to build and strengthen relationships and systems coordination with the health care delivery system.

### *Community prevention program*

The Community Prevention Program, supported by SIM funding, is designed to implement evidence-based strategies that address the leading causes of death and disability and leading drivers of health care costs in Oregon. The opportunity is directed to consortia consisting of at least one local public health department and at least one CCO is to implement evidence-based population health interventions in both the health system setting and the community. The aim is broader than just Medicaid, but to ensure optimal health is supported where Oregonians live, work, play, learn and receive services. The work undertaken in funded projects will be used as a model for other local health departments, CCOs and other health plans, as funded entities will be required to disseminate their work and lessons learned with others. In addition, funded entities must develop a plan for how their work will be sustained after the SIM grant ends, with a particular emphasis placed on the engagement of other public and private payers to support evidence-based population health interventions. The request for grant applications (RFGA) for the community prevention program was released Sept. 19. The revised RFGA closes Dec. 10, 2013, and notices of intent to award will be sent Dec. 20. These will be invaluable resources to Oregon's communities as we spread the model in Testing Year 1.

### *Coordinating data and analytical capability*

An advisory committee consisting of staff from the OHA Office of Health Analytics and the Public Health Division has been meeting in order to coordinate all population health surveillance-related activities funded by SIM. This group is continuing work on the design and protocol development of a Medicaid Behavioral Risk Factor Surveillance System (BRFSS) survey to be fielded in mid-2014. The Public Health Division began methodological and logistical planning for a race/ethnicity oversample of the ongoing annual Behavioral Risk Factor Surveillance System survey as well. This work will enable Oregon to monitor and track efforts of transformation as we move into the testing years of SIM.

### *Public health indicators by race/ ethnicity and by CCO region*

Staff from Program Design and Evaluation Services, working under a SIM-funded subcontract, have been continuing work on the analysis of 31 public health indicators by race/ ethnicity and by CCO region. The intent is that this information will assist CCOs in the development of their required Community Health Assessments and Community Health Improvement Plans and will give CCOs a better understanding of the health risk behaviors of their service areas. Multiple health indicators will be included<sup>5</sup>. Once complete in March 2014, the public health indicators analyzed by CCO region will be shared with CCOs; consultants are working with the Office of Equity and Inclusion and the Office of Health Analytics to determine the most appropriate data display and publication method. This information goes beyond what is available for CCOs in their claims data and can assist CCOs with identifying areas for further quality improvement, particularly around the prevention of disease and disability. This will also be useful for evaluation and monitoring of transformation efforts across the state.

### *Oregon Public Health Assessment Tool*

With support from SIM funding, a mortality data module was added to the Oregon Public Health Assessment Tool (OPHAT) in August 2013 and released with version 1.1. In September 2013, the following OPHAT datasets were updated to include 2012 data: birth risk factors, fertility, population estimates, communicable disease and pregnancy/abortion. Work continues on updating the mortality data, redesigning the user interface and other functional enhancements that will be released with version 2.0. The OPHAT tool will serve as a resource to local public health authorities, CCOs, hospitals and other local organizations, particularly as they develop Community Health Assessments and Community Health Improvement Plans. OPHAT will allow local communities to monitor the change in health status indicators over time and create simple queries of population health data with convenience.

## **Housing with Services**

SIM funding supports a community-based Congregate Housing with Services pilot project, based on a model used in Vermont. In this model, partnerships between health plans, housing providers, and long-term supports and services providers are used to achieve positive health

---

<sup>5</sup> Indicators to be included: leading causes of death, years of potential life lost, suicide deaths, opioid-related overdose deaths, motor vehicle crash deaths, health status, poor physical or mental health limiting daily activities, positive youth development, lung cancer incidence, heart attack hospitalizations, diabetes, hypertension, breast cancer by stage, pertussis, salmonella, chlamydia, HIV diagnosis, fall hospitalizations, overweight/obesity prevalence in adults and eighth-graders, alcohol-related deaths, binge drinking in teens and adults, cigarette smoking in adults and eighth-graders, low birth weight births, prenatal care in first trimester, teen pregnancy, teen births, and adequate immunization

outcomes, address social determinants of health, increase member engagement, reduce health disparities, and save costs in communities or in Section 8 housing that serves mostly low-income, aged, and people with disabilities. A contract has been executed with Cedar Sinai, a major housing partner in Oregon, to launch this project. OHA and our partners are developing relationships with coordinated care organizations and a broad spectrum of health and social service providers that will participate in the pilot program. Identification of subcontractors for project management, health care economist/program evaluation, and administrative support services has been completed. Construction of the Wellness Center has also commenced (funded through other sources but essential for the program launch). Subcommittees to develop proposals for the service package design as well as tenant involvement activities are also being convened. This work during the implementation period readies Oregon's efforts to proceed as we enter Test Year 1.

### **Long-term Care Alignment**

Long-term care services and supports were excluded in the legislation that authorized the development of the coordinated care model in Medicaid and its related global budget. As a result, there is an energetic effort underway to bridge the coordination within the health care delivery and long-term care systems. Several approaches are underway.

#### *Barriers and opportunities for integration*

An Oregon model of long-term services and supports integrated with CCOs has been developed by the Centers for Medicare and Medicaid/Long Term Care/Coordinated Care Organization (CMS/LTC/CCO) study group and is described in a report that will be sent to CMS in December 2013. This report, mandated by CMS in the Medicaid waiver Accountability Plan, asked OHA to convene a stakeholder group to study barriers and opportunities for the integration of long-term care into CCO global budgets and include an implementation plan and timeline in the final report of the study group.

The study group included 20 members selected by OHA and the Department of Human Services (DHS, which is the parent agency for Adults and People with Disabilities) from a pool of 120 applicants representing a broad array of stakeholders from across medical and social services including CCOs, medical providers, the Program of All Inclusive Care for the Elderly (PACE), provider advocacy organizations such as the Oregon Health Care Alliance, Area Agency on Aging representatives, Service Employees International Union (SEIU), American Association of Retired People (AARP), consumer representatives and others. For more information about the study group and the shared accountability subcommittee and their work, please see [www.oregon.gov/DHS/cms/pages/index.aspx](http://www.oregon.gov/DHS/cms/pages/index.aspx).

The full study group received monthly updates and accepted the work of the subcommittee on shared accountability. In September 2013, the subcommittee completed a recommendation on sub-population reporting of CCO incentive metrics by populations using long-term services and supports. Criteria and priorities for long-term services and supports metrics were identified and work began on a recommendation for metrics that focus on outcomes resulting from areas of shared accountability. The subcommittee has recommended a work plan for further stakeholder input on metrics, review of the metrics by OHA and DHS leadership and the Metrics and Scoring Committee and agreed to continue being active in future shared accountability work subsequent

to the completion of full study group work. The work of the subcommittee on shared accountability can be viewed at: [www.oregon.gov/dhs/cms/Pages/SharedAccountability.aspx](http://www.oregon.gov/dhs/cms/Pages/SharedAccountability.aspx). The latest version of the draft report is available at: [www.oregon.gov/dhs/cms/Meeting%20files/Draft%20Report%2011%2014%2013%20Final%20Proposed%20--Web%20Posting.pdf](http://www.oregon.gov/dhs/cms/Meeting%20files/Draft%20Report%2011%2014%2013%20Final%20Proposed%20--Web%20Posting.pdf).

#### *Memoranda of understanding*

First-year Memoranda of Understanding between local Aging and People with Disabilities or Area Agency on Aging offices are set to expire in the fall of 2013. These agreements are contractual obligations in the CCO contracts with OHA and have five required and eight optional domains in which the parties state how they will work together in each domain and how they will hold each other accountable. There are 33 MOUs between CCOs and local offices because CCO and local office boundaries do not coincide. Information about, and copies of, MOUs may be found at: [www.oregon.gov/DHS/Pages/hst/apd-cco-info.aspx](http://www.oregon.gov/DHS/Pages/hst/apd-cco-info.aspx). Renewal of these MOUs will be a focus in fall 2013 through spring 2014 as the long-term care innovator agent positions are hired and new staff can focus on evaluating the effectiveness of the past MOUs and building consensus for the next agreements.

#### **Linking Health to Education: Early Learning Council Work**

The Joint Early Learning Council and Health Policy Board Subcommittee met a total of seven times in 2013 and completed its straw proposal and recommendations for aligning health and early learning system transformation. Both parent policy bodies endorsed the straw proposal and implementation is now underway.

OHA's director of Child Health has continued to serve as the liaison between the Oregon Health Authority and Oregon's Early Learning Council, which has just approved the first six regional Early Learning Hubs that will oversee local coordination of early learning services. Up to 16 hubs will be certified by July 2014, after which cross-system learning collaboratives are expected to begin. The community hubs intent is strong coordination efforts with local CCOs with the ability to share data and innovative efforts across the education and health sectors. A draft proposal has been developed that outlines how Oregon's HIT/HIE services can be used to share child information across health and early learning systems, such as developmental screening results. Implementation is expected in the next year for data sharing, and further updates on the progress of the hubs will be included in future quarterly reports.

#### **Payment reform**

Oregon, now with a year of alternative payment with its Medicaid CCOs and their global budgets, has continued to strive to move the plan to provider payments away from fee for services to outcomes based alternative payments as well. The state has experienced some exciting work advancing payment reform in this reporting period.

#### **Primary care multi-payer strategy workgroup**

With the support of the SIM grant, a Multi-Payer Primary care Payment Strategy Workgroup was convened and facilitated by Oregon Health & Science University's Evidence-based Practice Center. This workgroup met four times, and included all the major commercial insurers in the

state, representatives of the new Medicaid CCOs, primary care provider organizations and the state. Through a consensus process, they produced recommendations for strategies for public and private payers to support primary care homes in Oregon. The end result is that nearly all commercial and public payers in Oregon (excluding Medicare FFS) will offer structured payments, using Oregon's Patient-Centered Primary Care Home recognition to support patient-centered primary care homes. Payers will establish the amount, the type of payment and timeline for implementation with the providers in their networks. As purchasers, PEBB, OEBC and Medicaid are also aligning with this agreement through their contracting processes.

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

The state's Patient-Centered Primary Care Home Program will continue to work with the plans and payers to develop communications and a set of metrics to monitor the impact of the collaborative efforts to support primary care. The agreement's timing is important as Oregon's Medicaid "Health Home" incentive payments have ended as the state moves into the demonstration period. Consensus and multi-payer cooperation to incent adoption of Oregon's Patient-Centered Primary Care model is critical.

### **Other multi-payer payment reform**

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

On April 25, OHA's chief financial officer, in collaboration with Oregon Health Care Quality Corporation, one of Oregon's multi-stakeholder entities and a Robert Wood Johnson Foundation Aligning Forces for Quality grantee, convened an initial meeting of several of the commercial payers to discuss payment reform technical assistance needs. This meeting was facilitated by payment reform expert Harold Miller and included discussion of potential strategies for ensuring coordinated care organization success; opportunities for reducing costs while promoting transforming care; identifying barriers to achieving cost savings; designing and implementing successful payment reforms; identifying which opportunities overlap between Medicaid, private payers and Medicare; provider education needs; sequencing payment reforms; and development of appropriate roles among stakeholders. Results of this discussion, the Quality Corporation's upcoming total cost of care work, and other efforts in collaboration with Oregon's multi-stakeholder Health Leadership Council will inform planning for next steps in payment reform.

Additional work in this area included:

- Ongoing consultation with payment reform experts to inform and advise the state and stakeholders on payment approaches;
- Continued monitoring of the new FQHC Alternative Payment Pilots in four clinics for potential spread more widely across Oregon;
- Continued work with the Oregon Association of Hospitals and Health Systems (OAHHS) Small and Rural Health Committee to prepare Oregon's smaller (Type A & B) hospitals for transformational changes brought on by health reforms and market changes, in collaboration with federal and state leaders to develop solutions not only in support of the financial sustainability of small rural hospitals but also of the coordinated care model.

### **CCO incentive payments**

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

### **Analysis and evaluation**

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

### **Performance measurement**

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

The November 2013 quarterly report compiles nine months of utilization and cost data based on claims made for payments from the coordinated care organizations in 2013. This report also shows six months' worth of several statewide performance metrics. In the months to come, analysis on more metrics will be completed and published. Also, for the first time, this report shows baseline race and ethnicity data for performance measures. This critical information will help highlight areas of greatest disparity and potential improvement.

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

A similar statewide, multi-payer quarterly dashboard is planned for first release in March 2014. Recent Oregon Health Policy Board meetings have included public discussion of potential data elements for this dashboard and board members provided input on priority information for monitoring health system transformation and ACA implementation statewide.

Supported by SIM resources, Oregon Health Care Quality Corporation (QCorp) is working to provide an objective check on the initial CCO metrics. QCorp has also partnered with Oregon's Health Insurance Exchange, Cover Oregon, for its initial qualified health plan metrics, and will be working with the OHA Office of Health Analytics on PEBB and OEGB metrics.

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

### **Analytic tools and capacity**

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

- The Milliman Health Care Cost Guideline grouper software was purchased to allow use of a common grouping tool between our All-Payer All-Claims database and our internal Medicaid data.
- A contract with AUS Marketing Research Systems, Inc., d.b.a. Social Science Research Solutions, has been executed to support data collection and analysis for the Oregon Health Insurance Survey. This survey will allow Oregon to monitor ACA implementation with the 2014 Medicaid expansion and the new health insurance exchange, as well as the spread of the coordinated care model.
- The contract to select the vendor to conduct the Consumer Assessment of Health Care Providers and Services (CAHPS) survey and data analysis has been executed and work begins in January 2014.

### **Self-Evaluation**

With input from CMMI and contracted SIM technical assistance staff, Oregon released a SIM-funded RFP during the implementation period for a "midpoint" evaluation of how the Coordinated Care Model (CCM) is being implemented in Medicaid and how it is impacting

quality and experience of care. The contract was awarded to Mathematica Policy Research in December. Assessing the success of the CCM is the first of Oregon's three evaluation objectives for the SIM grant; results from this evaluation will inform efforts to spread the model to other payers and populations. Oregon is also working with CMMI contractors from the Urban Institute and NASHP on their plans for national-level evaluation of the SIM test states. The contractors are planning a site visit to Oregon in early March and will conduct several focus groups as part of that visit.

## **Planned Activities for Next Quarter**

Below is a summary of our key activities scheduled for the next quarter, Oct. 1 through Dec. 31, 2013, by subject area within the Oregon SIM project. We are on target with expected activities that are detailed in our operational plan and appendices. The SIM Operations Team meets regularly to check in on progress, identify barriers and resolve problems. At this time, we do not perceive any barriers to accomplishing the work described below.

### **Accelerate innovation**

#### **Transformation Center**

- Plan and execute the first annual Transformation Summit for CCOs.
- Plan and execute the initial meeting for providers regarding complex care, leading to the establishment of our next learning collaborative.
- Continue planning and hosting the Community Advisory Council Learning Collaborative, focused on organizational and leadership development.
- Continue planning and hosting the QHOC Learning Collaborative, focused on CCO incentive metrics.
- Continue beta testing and improvements to the online issue tracking tool.
- Complete hiring for the transformation analysts positions.
- Further refine the Institute for Healthcare Improvement contract to add work that supports the learning collaboratives and building quality improvement capacity at OHA and within CCOs.
- Present recommendations to the Legislature and the Oregon Health Policy Board from the legislatively appointed committee on Individual Responsibility and Health Engagement Task Force.
- Complete development of the master communications plan and begin implementation.
- Maintain and significantly expand the Transformation Center website, while also making ongoing updates as needed.
- Complete development of the Council of Clinical Innovators business plan, begin implementation.

#### **Long-term care**

- Complete hiring of seven long term care innovator agents. Commence monthly long-term care innovator agent meetings that will include education on the aims of the coordinated care model, and the critical liaison role they will be playing.

- Long-term care innovator agents will receive an orientation to the work of the Transformation Center and begin exploring shared activities with their counterpart Medicaid CCO innovator agents.
- Contracts for the two out-stationed long-term care innovator agents will be completed with those community entities.

### **Regional Health Equity Coalitions (RHEC)**

- Evaluate and select proposals for three new RHECs; execute contracts.
- Begin conducting RHEC site visits.

### **Innovation in delivery**

#### **Patient-Centered Primary Care Homes**

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

#### **Health information technology**

- Continue work on Phase 1.5 services, including convening a Health Information Technical Advisory Group to help define the scope of work (including major technology requirements) and applying for federal funding for Medicaid's share of the development.
- Work with the OHA HIT Task Force to complete the business plan framework for Phase 2.0.
- Spread awareness about HIT and how it can be used in various settings to advance the triple aim.
- Participate in the steering committee for the EDIE solution, and proceed with implementation of the exchange of information between Oregon's hospitals emergency rooms.

#### **Community health**

- Evaluate and select proposals for community health pilot projects. Execute contracts.

#### **Health Evidence Review Commission (HERC)**

- Continue work with Oregon Health & Science University Evidence-based Practice Center to review evidence for clinical decision making.

- Continue process improvement assessment to increase the efficiency of HERC’s process, deliverables and translation to evidence-based clinical decision tools.

**Housing with services (deliverables described below are conducted by contractor)**

- Rate plan development and initiation of CCO contract negotiation.
- Hold kickoff meeting.
- Review and approve subcontract for evaluation period.
- Form a committee of stakeholders and begin meetings to provide consulting as part of identifying system needs, specifications and design work.
- Complete hiring or contracting for information technology planning consultant for data and communication systems.
- Health care economist, program staff and stakeholders will complete research, and develop per-member per-month rate that CCOs or other payers will pay for each member receiving services from Housing with Services; the rate methodology will be documented in a report to OHA.

**Long-term care**

- Continued work with the CMS/LTC/CCO Study Group and Shared Accountability Subcommittee to complete study group charge, develop a plan for implementation of the group’s recommendations approved by leadership, including shared accountability follow up. Planning for this group will begin in early 2014 with work expected to continue in future quarters.
- Continued work with OHA health analytics unit on CCO and long-term care services and supports metrics.
- Develop and initiate second-year MOUs between the CCOs and DHS, and set up a monitoring plan for MOU-related activities.
- An information technology specialist will assist Housing with Services and innovator agents and policy analyst with data pulls and analysis as needed to support transformation work.
- Staff will continue to support as needed for the 16th CCO which just launched. Staff will monitor and assist if needed to facilitate communication or activities between Adults and People with Disabilities local office and the new CCO or area providers.
- Shared accountability work will continue both through an internal workgroup following up on CMS/LTC/CCO Study Group recommendations (as mentioned above) and through the Long-Term Care 3.0 Initiative carrying out the health care transformation work referenced in Senate Bill 21 from the Oregon 2013 legislative session.

**Early Learning Councils**

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

## **Payment reform**

### **Multi-Payer Strategic Workgroup**

- Continue meetings and developing common agreement for action steps for next phase of multi-payer collaboration on payment reform beyond recent primary care strategies.
- Continue to monitor primary care consensus efforts across the multi-payers with the primary care providers, with the PCPCH program assessing metrics and coordinating alignment with the Comprehensive Primary Care Initiative efforts in Oregon.

### **Spread of coordinated care model to Public Employees' Benefit Board (PEBB)**

- RFP for 2015 closes in December 2013 and the PEBB Board will evaluate proposals aiming to select vendor(s) by spring 2014.
- Monitor 2014 benefit to further PCPCH use and wellness efforts for state employees.
- Prepare for next round of member engagement meetings for spring 2014 to further discuss coordinated care model efforts with state employees.
- Continue discussions with the Oregon Educators Benefit Board on their next benefit RFPs and inclusion of coordinated care elements, based on work to date in PEBB.

### **Analytics and evaluation**

- The upcoming November CCO Health System Transformation quarterly report will be expanded to include preliminary January-June data on a subset of measures and baseline data for a subset broken out by race and ethnicity. Another quarter of financial utilization data will be added as well.
- Continue work with the vendor for the midpoint evaluation of the coordinated care model implementation and impact in Medicaid, refining the evaluation plans for spread of the model.
- With input from the Oregon Health Policy Board, the Governor's Office, and a technical advisory group, continue work to initiate by March an initial multi-payer dashboard, including measures of coverage trends and access to care, quality of care, utilization and expenditures.
- Continued testing of both the initial metric database and the grouper software will occur.

## **Likelihood of Achieving Next Quarter's Objectives**

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

## **Substantive Findings**

Initial progress to date has been outlined in this report, summarizing the first six months of SIM funding that was primarily focused on implementation. We noted above some very early initial

findings on lowering hospital and emergency room use, while increased investment in primary care in our first months of CCOs operating in Medicaid. As we enter into the demonstration period, we will continue to update CMMI with our progress to fully implement the coordinated care model in Medicaid and spread of the model across other markets and populations in Oregon.

## **Lessons Learned**

Investment of time and resources into the statewide tour of listening sessions early in the implementation period paid dividends in understanding the environment and context that CCOs have been operating within during their first year. These site visit sessions in the home communities built strong bonds for collaboration and sent important signals to OHA about the type of assistance most needed in Oregon's communities to move the health care delivery system forward as we fully implement Medicaid CCOs and spread the transformation model into other markets in Oregon. This rich understanding of need and desired delivery modalities will inform our work including the Transformation Center strategic planning, activities and resource allocation. Similarly, the offices of Analytics, Quality and Measurement, and Health Information and Technology, along with the Patient-Centered Primary Care Home (PCPCH) Program and the state's PCPCH Institute will use these experiences to craft resources and support more in tune with the needs of the local health care delivery system, especially in our more rural and frontier areas. CMMI's investment in Oregon's analytical infrastructure will augment understanding and provide rapid feedback for the local providers and systems to shape and improve their innovations.

Communications and stakeholder engagement are critical, with a definite need to bring groups together face-to-face to successfully negotiate consensus, share implementation experiences and build learning community networks. CMMI's investment in travel and tools to share learning are invaluable to achieve this.

## **Suggestions/Recommendations for Current/Future SIM States**

None to report at this time.

## **Suggestions/Recommendations for CMMI SIM Team**

- Information about topics and dates for SIM-sponsored webinars lags and it becomes challenging for getting the members of Oregon's teams to be able to participate, and have interactive opportunities to ask questions. It would be good to understand what is planned going forward during our demonstration year so we can share the schedule with our project leads and their multiple teams across Oregon.
- Oregon appreciates CMMI recognizing the need of the states to receive additional time to summarize our first six months of efforts, as we were finalizing the operational plan and readiness documents for the demonstration phase. The additional time allowed us to reflect on the work completed to date and how it moves Oregon forward for spread of the

coordinated care model, which wasn't possible earlier while also finalizing our Operational Plans and budgets.

- We would like to work with CMMI to review the expectations for required detailed narrative reporting with specific due dates for the entirety of Demonstration Year 1, including expected format and any necessary supporting documentation. This would be for any expected quarterly reports, and also detailed descriptions of what narrative will be expected at the end of the demonstration year as well. This will allow the grants management team and the operational teams to anticipate needs far in advance and to collect any needed “artifacts” as the year progresses, rather than having to scramble to collect at the end of the year. We want to ensure we provide CMMI with needed information but also allow our multiple projects leads maximum time to focus on implementing and working with stakeholders for all of Oregon's activities necessary to spread the coordinated care model.
- We want to work closely with CMMI regarding the federal evaluation efforts as they are finalized and resultant expectations for the state. Initial discussions with the evaluators directly have been helpful and are proceeding, and Oregon wants to be sure the evaluators, the state and CMMI review any updates or refinements in a timely manner to ensure we can to respond to data, information sharing or other requests that will support the federal effort.

## Findings from Self-Evaluation

No findings to report at this time, except as noted above regarding initial performance reporting of the Medicaid CCOs.

## Problems Encountered/Anticipated and Implemented Or Planned Solutions

**Disallowed costs issues:** The CMMI disallowed the costs for health equity interpreter learning opportunities we had termed “scholarships for training to support health equity leadership development.” This critical aspect of workforce development was outlined in our initial applications, revised budgets upon selection as a test state, and thoroughly discussed in our operational plan and with our project director. Health equity is an important part of our coordinated care model and providing a learning environment to share best practices with this portion of our workforce, to allow for full certification will improve quality of care, decrease costs and improve health. Workforce development in this area is a critical aspect of delivery system reform. We are reviewing with our state workforce collaboratives to find an acceptable approach to develop community partnerships, including the new Medicaid CCOs and others to further the necessary sharing of best practices and learnings for this portion of Oregon's delivery system workforce. OHA looks forward to working with CMMI on a solution that will support our joint interests in transformative innovation that achieves the triple aim and provides quality health care to all Oregonians.

**Release of funding issues:** CMMI’s assistance in meeting tight timelines, especially related to coordination of complex funding streams, would be greatly appreciated. Additionally, requests for extensive budget follow up related to our continuation application led to a delay in the release of our funds for the demonstration period until mid-December. The requests for detailed follow up with short turnaround times measured in 24–48 hour increments are difficult to satisfy. While we appreciate the need for our federal partners to have additional information to satisfy new requirements, anticipating those needs in advance would prevent the requested required extensive rework. We hope that we are providing the expected requirements from the onset now that we have completed the implementation phase, and that the demonstration phase will go more smoothly.

**Multiple and unanticipated requests for documents, some with delayed guidance:** With clear and prompt guidance from CMMI, expectations and specific requirements could be better met and also prevent delays in getting initiative-related work started. Moving into Demonstration Year 1, a full-year schedule of narrative reports with details on expected format and required documentation (or “artifacts”) worked out as soon as possible across the test states will allow us to promptly prepare our multiple teams with timelines and expectations beyond what we have in our detailed project management plan.

### **Some challenges in Oregon we are monitoring**

#### *Delays due to implementation of the ACA*

- Due to the launch of Oregon’s Health Insurance Exchange in October and planning for Medicaid expansion in January 2014, OHA has deferred establishing a Transformation Center Steering Committee comprised of representatives from all payers until the second quarter of 2014 to ensure our partners are able to fully engage with the Transformation Center.
- The execution of a contract for a website plan and development is delayed. The website will support communicating about the coordinated care model to external audiences and multiple payers was delayed due to the priorities and staffing levels in the Office of Information Services, largely due to staffing needed to prioritize system activation for the Health Insurance Exchange and planning for Medicaid expansion. The Transformation Center plans to move forward in the next quarter with this project.

#### *Statewide distribution of long-term care innovator agents*

Seven long-term care innovator agents will cover the state and would benefit from learning and working together; however, the geographic distance may be an obstacle. Technology such as laptops, Skype, iPhones and other tools and technology that support long-distance communications will be explored.

#### *Coordination of long-term care and CCO agreements*

Hiring timeline and CCO current activities and responsibilities may challenge our ability to have second-year MOUs for long-term care with the Department of Human Services, especially ones that are enhanced from the initial year, completed by Nov. 1. Possible solutions may be a short extension of the first-year agreements allowing for more in-depth discussions around

strengthening, and enhanced agreements aided by newly in place long-term care innovator agents.

## **Work Breakdown Structure**

Please see Attachment 1.

## **Points of Contact**

Jeanene Smith, M.P.H., M.D., Principal Investigator

[Jeanene.smith@state.or.us](mailto:Jeanene.smith@state.or.us)

503-373-1625

Beth Crane, EMPA, SIM Project Director

[Elizabeth.crane@state.or.us](mailto:Elizabeth.crane@state.or.us) □

971-673-2833

## Appendix A

### **Oregon Health Leadership Council members**

George Brown, M.D., Legacy Health, *Co-Chair*  
Don Antonucci, Regence Blue Cross Blue Shield of Oregon, *Co-Chair*  
Pat Curran, CareOregon  
Andy Davidson, Oregon Association of Hospitals and Health Systems  
Jim Diegel, St. Charles Health System  
Majd El-Azma, LifeWise Health Plan of Oregon  
Chris Ellertson, Health Net  
Craig Fausel, M.D., The Oregon Clinic  
Jim Fitzpatrick, CIGNA  
Robert Gluckman, M.D., Providence Health & Services  
Bruce Goldberg, M.D., Oregon Health Authority  
Howard Graman, M.D., PeaceHealth  
Norm Gruber, Salem Health  
Ken Hamm, First Choice Health  
John Hill, PeaceHealth  
William Johnson, M.D., Moda Health  
Chuck Kilo, M.D., OHSU  
Doug Koekkoek, M.D., Providence Health & Services  
Andrew McCulloch, Kaiser Permanente  
Melinda Muller, M.D., Legacy Health  
Roger Muller, M.D., UnitedHealthcare  
Larry Mullins, Samaritan Health Services  
Ken Provencher, PacificSource Health Plans  
Joe Robertson, M.D., OHSU  
Tom Russell, Adventist Health  
Micah Thorp, D.O., Northwest Permanente  
David Underriner, Providence Health & Services  
Roy Vinyard, Asante Health System  
John Wagner, Aetna

# Multipayer Strategy to Support Primary Care Homes

---

*November 5, 2013*

## Background

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

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

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

## Goal

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

## Objectives

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

## Actions

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

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

Payers will also work with providers to review implementation strategies.

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

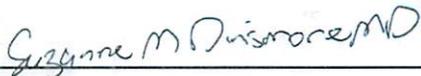
### Participating Organizations Agreeing to these Goals, Objectives and Actions



John Wagner  
Aetna



Pat Curran  
CareOregon



Suzanne Dinsmore  
Childhood Health Associates of Salem



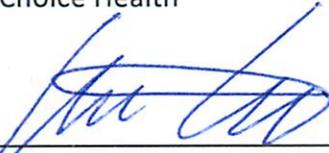
John Sobek  
CIGNA



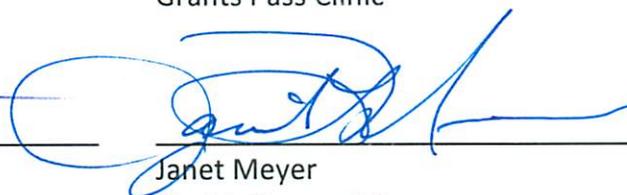
Paul Barner  
First Choice Health



Christi Siedlecki  
Grants Pass Clinic



Chris Ellertson  
Health Net of Oregon



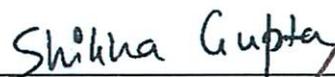
Janet Meyer  
Health Share of Oregon



Bess Jacobo  
Kaiser Permanente



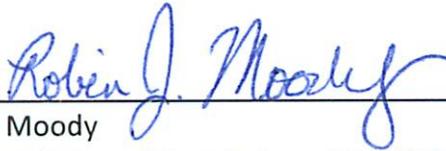
Majd El-Azma  
LifeWise Health Plan of Oregon



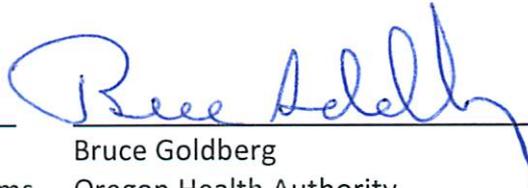
Shikha Gupta  
Moda Health



Evan Saulino  
Oregon Academy of Family Physicians



Robin Moody  
OR Association of Hospitals and Health Systems



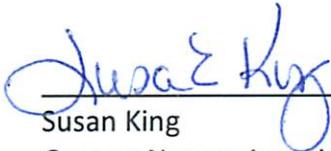
Bruce Goldberg  
Oregon Health Authority



Don Antonucci  
Oregon Health Leadership Council



Jo Bryson  
Oregon Medical Association



Susan King  
Oregon Nurses Association



Ken Carlson  
Oregon Pediatric Society



Ken Provencher  
PacificSource Health Plans



Dave Underiner  
Providence Health & Services



Don Antonucci  
Regence Blue Cross Blue Shield of Oregon



Chris Senz  
Tuality Health Alliance



Valerie Gordon  
Umpqua Health Alliance





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

Oregon Health Authority  
Last Updated August 19, 2013

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

Please refer to the following definitions when using this document:

**Unchanged:** The measure was part of the 2011 criteria.

**New:** This optional measure was added to the 2014 criteria.

**(D):** Data submission required.

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

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

### **Important Note:**

Any clinic applying for PCPCH recognition must review the technical specifications prior to submitting an application. The technical specifications describe each measure in more detail, including what documentation the clinic must have to support their attestation. Clinics must have all services, processes, and policies they attest to in place at the time the PCPCH application is submitted.

The technical specifications for the 2014 criteria will be available mid-September 2013.

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

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

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

<sup>1</sup> The intent of this measure has not changed, but the language has been clarified.

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

<sup>2</sup> The intent of this measure has not changed, but the language has been clarified.

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

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

<sup>3</sup> The intent of this measure has not changed, but the language has been clarified.

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

<sup>5</sup> The intent of this measure has not changed, but the language has been clarified.

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

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

<sup>7</sup> The intent of this measure has not changed, but the language has been clarified.

<sup>8</sup> The intent of this measure has not changed, but the language has been clarified.

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

<sup>9</sup> The intent of this measure has not changed, but the language has been clarified.

<sup>10</sup> The intent of this measure has not changed, but the language has been clarified.