InterCommunity Health Network CCO

Benchmark report

June 2015

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Transformation Plan Benchmark Report
IHN Coordinated Care Organization

Transformation Area 1: Integration of Care

Benchmark 1	**Hospital to Home (H2H) Care Transition Pilot:** Evaluate Member needs for mental health and chemical dependency services, with an emphasis on services for Members with serious and persistent mental illness, as well as physical health related needs upon discharge. Data reports support that H2H, mental health and alcohol and drug intervention as a package provide a more comprehensive intervention and reduce hospital readmission rates for the same diagnosis in a 30 day period.
How Benchmark will be measured (Baseline to July 1, 2015)	• Number of Members assessed. • Care coordination of additional services through Linn County. • Develop and report on readmission data.
Milestone(s) to be achieved as of July 1, 2014	• Contractor ensures that policy, procedure, data systems and coordination operational for all aspects of the H2H Care Transition Pilot. • Contractor ensures that 40% of eligible Members participate in H2H Care Transition Pilot; of those Members, 75% will not readmit to inpatient for the same diagnosis within 30 days.
Benchmark to be achieved as of July 1, 2015	• Contractor attains 8% increase over Baseline in Member participation in H2H Care Transition Pilot. Baseline and method of calculation to be determined and mutually agreed upon between Contractor and Oregon Health Authority (OHA). • Contractor attains 10% decrease from Baseline in H2H Care Transition Pilot Members' readmission rates to inpatient for same diagnosis within 30 days. Baseline and method of calculation to be determined and mutually agreed upon between Contractor and OHA.

1. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Activity *(Action taken or being taken to achieve milestones or benchmarks)*	Outcome to Date	Process Improvements
1.	A contract was developed between Oregon Cascades West Council of Governments (OCWCOG) H2H and Linn County for the delivery of mental health and alcohol and drug assessment and treatment services for the Care Transitions Project in Linn County. It involved development of a referral process between the two agencies. This contract was the baseline for referral of H2H consumers to Mental Health and Addictions staff in Benton and Lincoln Counties.	The contract was officially for one year and ended June 30, 2014. Referrals continue to be made to all three county departments by H2H staff when appropriate.	Regular check-in with staff from all three county agencies and H2H would be beneficial in assuring there is a "closed loop" in proving service
2.	A small pilot was developed to serve consumers in Lincoln County at risk for hospital readmissions.	Total of 12 referrals received in Lincoln County from September 2014-June 2015.	The pilot with ADEO In-Home Care agency for ongoing service to Lincoln County will be continued on a fee for service basis until June 2016.
3.	Ongoing work to increase over-all referrals from all hospitals in the tri county area	Referrals from all hospitals are on the rise but the growth is slow.	Removed potential barriers to make the referral process as simple as possible for hospital staff. Widened referral criteria to "cast a bigger net" of people who can use the program. Gained access to EPIC Electronic Health Record (EHR) system and piloting with staff at GSRMC to update an antiquated fax referral system.
4.	A commitment was made for ongoing coordination between Samaritan Albany General Hospital (SAGH), Samaritan Lebanon Community Hospital (SLCH), Good Samaritan Regional Medical Center (GSRMC) and H2H staff.	We continue to meet quarterly and check process and triage concerns	Occasional check-in meetings are helpful to make sure that all teams are aware of commitment to provide ongoing referral.

1. b) Please note whether benchmark(s) were met with a "yes" or "no" for each benchmark.

Yes, the benchmarks identified were met. Currently 18% of persons participating in the H2H program are IHN-CCO members. This is a significant increase from the percentage of IHN-CCO members who were participating in H2H at the pilot's inceptions which was closer to 8%. In addition members who participate in the program continue to have a lower readmission rate (on average 13% across the counties) than members who do not participate in care transitions coaching.

The number of referrals to H2H from the hospitals, which has been an ongoing challenge, is increasing slowly and projected numbers for 2015 will be increased from 2014 numbers by 10%.

1. c) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

The number of referrals made to H2H by hospital staff is an ongoing issue and despite the growth this year we continue to consider ways we can increase the number of referrals. The most referrals to the program have come from SAGH in 2014 and the beginning of 2015. In 2014 that hospital made almost half of the total 233 referrals made to the program.

Traditionally H2H consumers have a home visit from an H2H coach within 24 hours of discharge from the hospital. Because of this many H2H consumers are extremely sick during that visit and are hesitant to want workers to come to their home. The primary diagnosis for admission to the hospital is the priority and the focus of the home visit and directs the conversation. Discussing other issues like ongoing mental health concerns or addictions falls down the triage list; sometimes this means they aren't addressed at that first meeting, but will be talked about in a follow up phone call.

1. d) Describe any strategies you have developed to overcome these barriers and identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

We are continuing outreach and marketing to the hospitals in our area and meeting quarterly with hospital staff to discuss the program and triage concerns. We have removed barriers to referrals in the form of complicated processes.

We have developed a protocol to try to address the concerns of mental health and substance abuse later in our work with the consumer after the more immediate and pressing health concerns have been addressed and consumers are more stable. This is addressed in a follow-up phone call. We still find that people are very private in sharing information and resistant to being referred to the county for assessment or follow up.

1. e) How was the Community Advisory Council involved in the activities for this transformation area?

Members of the Community Advisory Council (CAC) represent agencies involved in serving consumers on the H2H pilot including Senior and Disability Services, IHN-CCO, Physicians, and County Mental Health and Addictions office. They provided ongoing input and collaboration during the project. Additionally, members of the CAC are involved in the Delivery System Transformation Steering Committee (DST) and received regular reports back from H2H staff about how the program was progressing.

1. f) How was the CAC informed of the outcomes for activities in this transformation area?

H2H staff regularly report progress to the DST. Many of those DST members are on the CAC and share this information. In addition Senior and Disability Services Advisory Council members are on the CAC and have provided input on the H2H program throughout the process.

Transformation Area 2: PCPCH

Benchmark 2.1	**Patient Assignment and Engagement Pilot – Phase 1** Use pilot sites panel of Members as a focus group to assess Emergency Department (ED) utilization and identify opportunities to enhance appropriateness of ED utilization.
How Benchmark will be measured (Baseline to July 1, 2015)	• Through analysis of claims data, demonstrated decrease in inappropriate utilization of ED.
Milestone to be achieved as of July 1, 2014	• Contractor develops data reports identifying Members who have utilized the ED more than six times in the prior year or for non-emergency purposes.
Benchmark to be achieved as of July 1, 2015	• Contractor ensures that Members will be redirected to the PCPCH; Contractor attains a reduction in ER usage by this group of Members by a measurement factor of 20%

2. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	An online portal was created and is accessible by clinic site staff. Technical and data infrastructure: Implemented the infrastructure for storing, sorting, and analyzing Primary Care Provider (PCP) assignment data, with a defined approach for addressing discrepancies. Defined a process for practice and member notification of PCP changes. Increased provider/practice understanding of the assignment process. Discussion occurred regarding readiness to open the portal to other PCP sites.	The Delivery System Transformation Steering Committee has closed this component of the pilot. IHN-CCO is in process of identifying a long-term strategy for implementing the functionality currently available only through the portal.	Overall the functionality is good. There have been on-going improvements in the type of data available through the portal. There was improvement in matching the clinic's list of patients on their PCP panels with the IHN-CCO PCP assignment list. It was decided to open the portal to a limited number of additional sites. This work has been internalized operationally within IHN-CCO.
2.	Member Engagement: Strategies for outreach and engagement were defined with responsibilities of IHN-CCO and practice sites defined.	Mapped desired process for assignment; identified key strategies for improvement, and desired outcomes and metrics.	Established and implemented criteria for initial assignment when the IHN-CCO member does **not** select a PCP. Criteria includes: • If a member was on Oregon Health Plan within the last three years, they would be reassigned to their previous PCP. • Match the member to the closest open PCP in their area of residence.
3.	Member Engagement: A list of high risk conditions were identified utilizing health assessment data with input	Established and tested an engagement strategy for	An Alternative Payment Methodology (APM) pilot was launched in January

	from the CAC and QA committee. Active outreach occurred for identified at risk groups. The engagement process was developed by a workgroup of RN Care Coordinators. The initial engagement visit was designed to include obtaining a health history, a brief risk assessment and screening, and an introduction to the medical home, including encouragement to call the PCP first for non-emergencies. An initial test of the strategy occurred over an eight week period in early 2014. Anecdotal results of one test week follows. • From a list of 142 names; 50% did not have a phone number available through the online portal so unable to call the member and 10% were already enrolled and being seen by the pilot site. • Of the 35 patients called; over 50% were not interested or confused with the suggestion to schedule an engagement visit, 15% stated they had a different PCP, and 2 scheduled and completed a visit. • Of the 2 patients receiving a visit that week, staff and patients felt it was helpful and 'patient-centered'. One of the pilot sites tested a group visit for new Oregon Health Plan (OHP) members. Invitations were mailed to members assigned but not yet seen by the clinic. Registration, a health history, and brief risk assessment were conducted. Three group engagement visits were scheduled, with 3 – 9 participants per session.	newly assigned IHN-CCO members.	2015. This work was transitioned to the APM pilot clinics. The APM pilots are currently using Affordable Care Act (ACA) eligible diagnosis to determine level of risk.

4.	Emergency Department (ED) Utilization: Reduce ED utilization for non-urgent diagnosis. Initial data collection to identify members who have utilized the Emergency Department more than six times in the prior year for non-emergency issues.	This information was difficult to retrieve from IHN-CCO (late 2013). Preliminary reviews of data suggested that a high percentage of those visiting the ED frequently had co-morbid, mental health, addiction, and chronic medical conditions.	
5.	Met with ED staff and pilot steering committee to discuss potential strategies for minimizing ED use for non-emergent issues.	Samaritan Health Services is participating in the EDIE project which will partially assist in identification of frequent ED utilizers.	Strategies in communicating with existing IHN-CCO members regarding ED utilization will be included within the APM pilot sites. Both proactive i.e. member communication about when to use the ED and reactive i.e. next day follow-up by the PCP when it is known a patient used the ED will be developed.

2. b) Please note whether benchmark(s) were met with a "yes" or "no" for each benchmark.

Although outcomes were unmeasurable at the time of report; great progress was made in new engagement strategies for member identification, member assignment, and member education.

2. c) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

Although the pilot was not needed to complete the work it started, it was instrumental in launching the effort by bringing people together from three different clinic systems to identify desired results, assist in development, and test the portal and engagement strategies. The principles identified for the assignment process were critical for progress in multiple areas of transformation.

The project stalled for a period of time due to the loss of a Project Manager that had been assigned at the beginning of the pilot. This was a critical position to coordinate discussion, work, and follow-up that was occurring across several entities. Although, the portal had established its value for PCP assignment management and was being picked up within IHN-CCO, without the Project Manger there was risk of losing the historical 'memory' of discussion, intent, and ideas. Fortunately this didn't happen; however a consideration for future pilots is to identify the

need for a Project Manager when involving multiple entities. Another area to watch for within pilot activities is how to engage and get buy-in from administration/systems leadership to assure that successful small scale pilots are able to spread to have larger system impact.

2. d) Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

There were no barriers identified to date that required intervention at the state level.

2. e) How was the Community Advisory Council involved in the activities for this transformation area?

The CAC Chair and the CAC Coordinator receive updates through the Delivery System Transformation Steering Committee (DST) meeting that they both attend.

2. f) How was the CAC informed of the outcomes for activities in this transformation area?

The CAC Chair and CAC Coordinator receive updates through the DST meeting that they both attend.

Benchmark 2.2	**Integration of Mental Health, Addictions and Primary Care Pilot – Phase 1** Improve access to Behavioral/Mental Health Services
How Benchmark will be measured (Baseline to July 1, 2015)	• Contractor will measure the length of time from identification of Member need for behavioral or mental health services to the time when the Member is seen for an appointment.
Milestone to be achieved as of July 1, 2014	• Contractor establishes a Baseline from the time the Member with a need for behavioral or mental health services or with severe and persistent mental illness is identified to the time of actual implementation of services. • Contractor develops mechanism to record and report monthly on pilot progress.
Benchmark to be achieved as of July 1, 2015	• Contractor achieves improved timelines to access services over the course of the pilot for Members with severe and persistent mental illness.

2. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	A new pilot contract has been executed and work is now in progress.	Samaritan Lincoln City Primary Care Clinics have agreed to participate in this pilot.	

2. b) Please note whether benchmark(s) were met with a "yes" or "no" for each benchmark.

No

2. c) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

The original pilot project was put on hold due to the pilot sponsor no longer being with the organization.

2. d) Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

It took some time, but a new pilot was developed that addressed this area of transformation. This new pilot has two clinics that have signed on to participate, and as of June 2015 the work is now in progress.

2. e) How was the Community Advisory Council involved in the activities for this transformation area?

The Community Advisory Council (CAC) Chair and CAC Coordinator receive updates through the Delivery System Transformation Steering Committee (DST) meeting that they both attend.

2. f) How was the CAC informed of the outcomes for activities in this transformation area?

The CAC Chair and CAC Coordinator receive updates through the DST meeting that they both attend.

Transformation Area 3: Alternative Payment Methodologies

Benchmark 3	Develop a performance based reimbursement model which pays Samaritan Health Services (SHS) Participating Providers a quality bonus for achieving or exceeding identified Benchmarks, and a model that reimburses SHS specialist Participating Providers through bundled payments for specific types of services rendered.
How Benchmark will be measured (Baseline to July 1, 2015)	• Contractor will use known and measured Health Plan Employer Data and Information Set (HEDIS) Benchmarks to establish a Baseline. • Contractor will measure claims data before and after implementation of the bundled payments.
Milestone to be achieved as of July 1, 2014	• Contractor implements the bundled payment software and begins bundling payment to a small set of SHS specialist Participating Providers.
Benchmark to be achieved as of July 1, 2015	• Contractor compares utilization data on related services from Participating Providers who are not included in the model to those that are being bundled. • Contractor begins working on non-SHS Participating Provider contracts to implement performance based reimbursement.

3. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	The APM Subcommittee is monitoring the three capitated clinics each month, and is continuing to promote the capitation based model throughout the Patient Centered Primary Care Home (PCPCH) community. We have several reports that we are sharing with each other including full transparency with financial data. We are discussing the tools, and making the infrastructural changes to the delivery model that need to be in place in order to move toward a shared risk agreement. The model includes financial, utilization,	An IHN-CCO wide project is in place around patient assignment reconciliation. All three clinics have hired a behaviorist when one wasn't already employed. Care Coordinators are being hired and the clinics are reporting "touches". Members are getting	We are finding it challenging to get leaders involved, but are finding that leaders have to be involved for smooth, successful transitions to a capitation based model. Need data available in a more timely fashion.

	access and clinic performance metrics that will be monitored to determine success.	access to care in two out of three of the clinics more timely. Clinics are putting workflows in place to target patterns. IHN-CCO is adding three more clinics onto the model by the end of 2015. We are discussing what services could be moved into the capitation, and are discussing the push to start using Pay for Performance (PFP) incentives on top of the capitation.	

3. b) Please note whether benchmark(s) were met with a "yes" or "no" for each benchmark.

Yes

3. c) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

Still need a better risk stratification model to support sustainability. Gaining buy-in from the provider clinics to accept the Per Member Per Month (PMPM) payment and trust in the new methodology is much too long of a process in some clinics. We need to have stronger provider leadership support.

3. d) Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

We have posed the idea and are working with Samaritan Health Services' Information Systems (IS) department to look at risk stratification tools as part of our Health Information Exchange (HIE). We used our OHA Technical Assistance funds to have a professional speak to our community on APM's and recommend models for our community. We are educating and spreading the word as much as possible.

3. e) How was the Community Advisory Council involved in the activities for this transformation area?

The Community Advisory Council (CAC) receives reports on an ongoing basis on the payment methodology being implemented and will continue to receive the outcomes of the performance being monitored.

3. f) How was the CAC informed of the outcomes for activities in this transformation area?

The CAC receives information from IHN-CCO on all transformation projects and goal achievements. The APM Subcommittee provides information for these reports on alternative payment outcomes for reporting to the CAC.

Transformation Area 4: Community Health Assessment and Community Health Improvement Plan

Benchmark 4	Collaboration with local public health and mental health authorities, professionally and culturally diverse community based organization, hospital system(s), the Contractor Community Advisory Council (CAC) and Community partners and stakeholders to prepare strategies for development of a shared health assessment and improvement plan that serves as a strategic population health and health care system service plan for the Communities served by Contractor
How Benchmark will be measured (Baseline to July 1, 2015)	• Use the information gathered from Community participants to determine the strategic issues that must be addressed in order to reach Contractor vision. • Specify goals, objectives, strategies, budget and leadership for the strategic issues identified. • Describe the scope of the activities, services and responsibilities that Contractor considers upon implementation of the shared health assessment and improvement plan.
Milestone to be achieved as of July 1, 2014	• Contractor completes Community Health Assessment Plan (CHIP).
Benchmark to be achieved as of July 1, 2015	• Contractor measures health improvement against the Baseline and reports the results of its health improvement efforts to the Community.

4. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	A data collection project to inform the Community Health Improvement Plan reporting period of July 1, 2014 – June 30, 2015.	Data collection was completed and a CHIP progress report was submitted to OHA at the end of June 2015.	The process used by the Community Advisory Council (CAC) and the CAC Coordinator to accomplish this deliverable produced a valuable report outlining the results of year one health improvement efforts.

4. b) Please note whether benchmark(s) were met with a “yes” or “no” for each benchmark.

Yes

4. c) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

The Oregon Office of Equity and Inclusion (OEI) has not made itself available for the collection of baseline data on health disparities. OEI offered training on health disparities related to race and ethnicity. The CAC is considering whether this training is a priority at this time. If OEI can assist IHN-CCO with developing meaningful baseline data on health disparities, the newly formed IHN-CCO Health Disparities Subcommittee will be highly interested in such collaboration.

4. d) Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

Health Disparities Subcommittee: The IHN-CCO Race and Ethnicity Subcommittee have been working on a language access Quality Improvement Project and a list of bilingual health providers. The committee is currently restructuring and has changed its name to the Health Disparities Subcommittee and will be broadening its membership and its focus. Linn-Benton Health Equity Alliance has been asked to participate in this subcommittee, as well as a request for additional community representatives.

Regional Health Assessment (RHA) Project Partnerships: To strengthen community partnerships, IHN-CCO funded a Regional Health Assessment project to support a coordinated population health data collection effort. The RHA is creating a regional health assessment template that meets core stakeholder needs, with the ability to extract data by county, OHP membership, age, sub-populations at risk of health

disparities, etc. This will ensure sustainability of the process with continuously updated data and partner involvement. Partners include IHN-CCO, County Health Services (including local mental health), and Federally Qualified Health Centers (FQHC) with school-based health providers, Dental Care Organizations, United Way, Linn-Benton Health Equity Alliance, hospitals, the Early Learning Hub, the State, and other organizations including community-based.

4. e) How was the Community Advisory Council involved in the activities for this transformation area?

The Community Advisory Council (CAC) gathers community information and needs from holding and hosting meetings along with providing and hosting trainings and presentations to create the annual strategic plan (CHIP). The CAC holds open public meetings for all the CAC meetings and the Local Advisory Committee meetings; the CAC hosts Community Conversations and provides an Issue Brief form for individuals to rise issues and concerns. The CAC has hosted *Roles, Responsibilities, and Strategic Planning and Leadership and Influence* training and has presented to IHN-CCO Board of Directors, Patient Centered Primary Care Homes, and Local Advisory Committees.

IHN-CCO sees the CHIP, especially the Health Impact Areas (HIAs), as a focus of transformational work as pilot project proposals are not only required to support one of the eight elements of the IHN-CCO Transformation Plan, but also one of the four CHIP HIA's created by the CAC.

4. f) How was the CAC informed of the outcomes for activities in this transformation area?

IHN-CCO hosts three annual public meetings with partnership of the Linn-Benton Health Equity Alliance to gather ideas on how to make these meetings more accessible with an increased attendance by IHN-CCO members. Some of the suggested changes have already been implemented and others may be tried over time. Meetings are typically well attended and robust discussions take place between the community and IHN-CCO leadership.

IHN-CCO created a matrix to highlight the HIAs each pilot project has the potential to improve. This matrix will be used by the IHN-CCO Delivery System Transformation Steering Committee to identify gaps and to evaluate how each pilot project proposal supports overall transformation efforts.

The CAC Chair sits on the IHN-CCO Board of Directors. The CAC Chair and CAC Coordinator attend and participate in different IHN-CCO meetings such as the Regional Planning Council, the Delivery System Transformation Steering Committee and many more. The CAC Coordinator also attends State meetings such as the OHA Health Equity Committee, the OHA CAC Learning Steering Collaborative, and the OHA CAC Steering Committee. All of these meetings help apprise the CAC of outcomes and future activities within transformation.

Transformation Area 5: EHR, HIE and meaningful use

Benchmark 5.1	Contractor agrees to participate in OHA's upcoming process to assess the next phase of statewide Health Information Exchange (HIE) development (including assessing the scope, financing, and governance of statewide HIE services). In particular, Contractor will make appropriate executive and staff resources available for an interview with an OHA consultant, and will participate in brief stakeholder workgroup meetings if requested by OHA. After the OHA process concludes and the next phase of statewide HIE services are defined, Contractor will update this HIE component of its transformation plan at the next update cycle.
How Benchmark will be measured (Baseline to July 1, 2015)	
Milestone to be achieved as of July 1, 2014	
Benchmark to be achieved as of July 1, 2015	
Benchmark 5.2	Development and implementation of Electronic Health Records structure, policy and workflows to support an electronically accessible Care Plan for all Participating Providers involved in a Members care.
How Benchmark will be measured (Baseline to July 1, 2015)	• Utilization of chosen Electronic Health Records structure by Participating Providers in the care of Members
Milestone to be achieved as of July 1, 2014	• Contractor develops roadmap for implementing Health Information Technology (HIT) in its Service Area. • Contractor gives access to case management staff to evaluate and educate Participating Providers. • Contractor pilots Epic Care Link usage between Contractor and a select Participating Provider panel.
Benchmark to be achieved as of July 1, 2015	• Contractor establishes a shared Electronic Health Record system for Participating Providers and partners to access in its Service Area, to enable a "community care plan".

5. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	IHN-CCO implemented a community wide Health Information Technology (HIT) Workgroup. Workgroup is now referred to as the Regional Health Information Collaborative Committee (RHIC).	The RHIC continues to meet every two weeks.	The RHIC has been able to maintain a collaborative partnership through weekly meetings in which decisions and direction are determined by representatives from partnered organizations.
2.	January 2015: • Established IHN-CCO data filters for Samaritan Health Services (SHS) EPIC data feed. • SHS EPIC data feeds promoted to EPIC Test. • Training plan developed. • HealthShare Patient Index (HSPI) ran for initial results and testing. • IHN-CCO eligibility file imported successfully. February 2015: • Imported Facets provider listing. • HSPI Tuning. • Initial testing of deduplication logic. • Live feeds of SHS EPIC data HL7v2 records established. March 2015: • SHS EPIC C-CDA interface test sample files sent and tested. • Single Sign-on functionality implementation initiated. • Edge Gateway established for OCHIN interface. • Lincoln County Health Services moved to future phase.	Created, tested and promoted Eligibility logic, Deduplication logic and IHN-CCO filters. HSPI tuning was initiated and fine-tuned for SHS EPIC and Facets datasets Initiated and tested the data feed for Medication and Allergy information from SHS EPIC. Benton County Health Services VPN setup and data transmission.	The RHIC has acquired claims data and encounter data from multiple partnered organizations. Medical, mental and pharmacy data have been merged as intended. We now have the opportunity to rollout the clinical viewer to a select pilot group of health care providers once the training, access and consent are configured.

	April 2015: • Deduplication logic promoted to HS Test. • Non-Clinical encounter GUI customization. May 2015: • Medication samples import. • Benton County kick-off. June 2015: • Facets, HSPI and EPIC promotion plans completed. • Training plan initiated.		

5. b) Please note whether benchmark(s) were met with a "yes" or "no" for each benchmark.

Yes

5. c) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

Establishing consent models that are applicable to all data sources and partners is an on-going conversation. As the data is interpreted and reviewed, additional questions are formulated concerning the sensitivity and general protections required by regulations and standards. Several partners have voiced concerns about their readiness to participate. Lincoln County Health Services recently switched Electronic Health Records (EHR's) for their mental health records and was unable to fully staff the RHIC project at this time. Linn County Health Services needs to complete their EHR upgrade in order to be able to use standard interfaces such as HL7v2 for transactions into RHIC. IHN-CCO has initiated conversations with other health care providers to understand their readiness to participate in RHIC.

5. d) Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

In March, IHN-CCO sent a representative to the InterSystem Global Summit. Education and experience were generated by attending hands-on learning sessions about the HealthShare product and working with HealthShare product experts. We also were able to participate in the HealthShare Users Group and were able to discuss challenges and received valuable recommendations. IHN-CCO also participated with OHA Health Information Oversight Council (HITOC) in an overview of the Share Nationwide Interoperability Roadmap and the recently created HIT/HIE Community and Organizational Panel (HCOP) panel for statewide discussions concerning HIE operations.

5. e) How was the Community Advisory Council involved in the activities for this transformation area?

The Community Advisory Council (CAC) Chair continues to attend RHIC Privacy Workgroup meetings. We presented a RHIC status and overview to the IHN-CCO Regional Planning Council in April 2015 and presented RHIC status and vision to the IHN-CCO CAC in May 2015.

5. f) How was the CAC informed of the outcomes for activities in this transformation area?

An overview and status of the Regional Health Information Collaborative was presented to members of the IHN-CCO CAC in May 2015.

Transformation Area 6: Communications, Outreach and Member Engagement

Benchmark 6	**Mental Wellness Literacy Campaign Pilot:** Increase awareness amongst Primary Care Providers (PCP), community and faith-based organizations, and local schools in Linn County, and the Contractor organization as a whole, of the ways all parties can take action to improve the wellness of people with mental health problems.
How Benchmark will be measured (Baseline to July 1, 2015)	• Focus groups comprised of community and faith-based organizations, educators, Contractor staff, and PCP's. • Member, stakeholder, and local resident surveys.
Milestone to be achieved as of July 1, 2014	• Contractor offers an online learning and resource center in multiple languages. • Contractor offers Community education campaign in culturally and linguistically appropriate ways. • Contractor targets an education campaign for community and faith-based organization, and local schools.
Benchmark to be achieved as of July 1, 2015	• Contractor ensures that 100% of Contractor staff and PCPs are aware of the online learning and resource center and have knowledge of its purpose. • Contractor ensures that participants in focus groups indicate awareness of the community education campaign and knowledge of its purpose through a measurement tool. • Contractor ensures that 35% of those surveyed indicate awareness of the

	community education campaign and knowledge of its purpose.

6. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	Creation of an online Learning and Resource Center. • Online training platform developed to provide ongoing access to mental health screening, training and practice tools for Primary Care Providers (PCPs). • Online training developed—*Understanding Mental Illness*—in partnership with Linn County Health Department. • Training available online for PCPs. • PCPs are required to complete training as part of their contractual obligations to IHN-CCO.	100% of IHN-CCO staff and PCPs aware of online resource. Over 300 PCPs in Benton, Lincoln and Linn Counties have participated in mental health awareness training developed. Completion of training for PCPs was documented through reporting for online training system. IHN-CCO staff was presented live training during staff meeting.	PCPs informed of training through Course Notifications delivered via email. Email reminders were sent until the training was completed.
2.	Educational Campaign: *Today I Am.* • Conducted community survey, including attitudes about mental illness. • Conducted focus group sessions, including attitudes about mental illness. • In response to data from above, developed media campaign	Linn County English version launched May 1, 2014, completed July 2014. *Today I Am* campaign post-survey completed August 2014 shows 51% familiarity with IHN-CCO, 65% familiarity with Wellness Campaign	Health literacy review of all online and printed materials conducted by Maximus Center for Health Literacy. Recommended changes (use of more white space in the design, simpler phrasing, shorter sentences and paragraphs, more use of images) were incorporated before materials were translated into Spanish ensuring health literacy standards were maintained.

	(*Today I Am*) focused on Eight Dimensions of Wellness, including mental wellness. • Media campaign included website, billboards, poster, flyers, display materials at community events and within community organizations, newspaper and mall ads, outside banners, online advertising, local magazine articles, interviews with local/regional newspapers, presentations at seminars. • Research firm conducted post-survey of members, stakeholders, and local residents (307 Linn County residents).	(exceeding target of 35%).	
	Latino Focus Groups: • Completed November 2014. • Used Spanish population research to adapt the English campaign to be culturally appropriate. • Developed marketing, public relations and media plan for Spanish campaign in Benton, Lincoln, and Linn Counties.	Regional (Benton, Lincoln, and Linn Counties) Latino community education campaign launched June 2015.	Presented adapted campaign materials to two Latino focus groups and used feedback to fine-tune the messaging. The feedback was largely positive and very helpful in finalizing the campaign imagery and tone. Developed campaign imagery, messaging, and public event schedule in consultation with Latino stakeholders and project team.
3.	Education Campaign: • Partnered with local coalitions and youth organizations to develop prevention and stigma reduction messages, in coordination with observance of Mental Health Awareness Month	Educational materials aimed at reducing the stigma of mental health were made available to more than 4,000 middle- and high-school students. Since 2013, 12 county-wide	The efforts of Linn County youth programs, shelters, and student organizations were supported by a coalition of local health educators from private, public, and non-profit organization. The coalition reviewed local data, prioritized target areas for improvement, and assessed resources and opportunities for partnership to maximize impact. The coalition then allocated pilot funding to

	2014 and 2015, Recovery Month 2014, and Mental Illness Awareness Week 2014. • Collaborative planning with Mental Health Advisory Board. • Hosted community youth suicide prevention training, *Taming the Epidemic of Youthanasia,* with Dr. Dennis Embry on May 14, 2014 (attendance 233). • Provided both Adult and Youth Mental Health First Aid community training, and facilitated sustainable funding. • STAND (Students Taking Action Not Drinking) youth council developed school-based mental health awareness campaign in seven local school districts. Activities included dissemination of student developed posters (in English and Spanish), video and other promotional incentives (lanyards, activity cards, etc.) bringing awareness to the eight dimensions of wellness. • City Proclamations. • Provided both Adult and Youth Mental Health First Aid community training. • Community and business distribution of table tents and posters illustrating Myths/Facts about mental illness, and local	events and 4 school-based events promoting mental health awareness have been conducted. These events have created partnerships amongst community, health-care and faith-based organizations, and local schools to support ongoing public awareness through participation in multiple, annual events such as observation of Mental Health Awareness Month (May) and Mental Illness Awareness Week (October). 100% of respondents in evaluation of Embry training rated quality of information presented as excellent or good.	provide evidence-based prevention curricula through LifeSkills Training, a universal prevention curriculum, in 4th and 6th grades in seven school districts; and through Girls Circle/Boys Council, a curriculum for at-risk students in middle and high schools in multiple districts.

	resources.		
4.	Coalition of Local Health Educators: • Coordination with Regional Healthy Communities Steering Committee for Mental Health Promotion and Prevention (MHPP) Grant, with common Linn County Steering Committee. • Key partners identified and gathered for orientation meeting June 23, 2014. • Gathered and reviewed local data, assessed gaps and needs, determined focus on prevention strategies with grades K-14. Solicited proposals and awarded funding to: ○ *Botvin's LifeSkills Training* universal prevention curriculum in additional 4th and 6th grades throughout county (Linn Co. A&D), serving total of 1,823 students in Year 1 and 1,487 students in Year 2. ○ *Girls Circle / Boys Council* prevention curriculum for identified at-risk youth in rural middle and high schools (Jackson Street Youth Shelter), serving 136 students in Year 2.	*Life Skills Training*: 91% of 4th graders and 81% of 6th graders in 2013-14, and 91% of 4th graders and 84% of 6th graders in 2014-15, reported increase in decision-making skills. *Girls Circle/Boys Council*: Provided Girls Circle to 52 females and Boys Council to 84 males in Linn County. Identified 12 youth with suicidal ideation and referred for services.	The coalition is now part of the Regional Healthy Communities Steering Committee, which oversees grant projects for IHN-CCO. Additional educational material was developed by STAND, the Linn Youth Council, aimed at reducing stigma and promoting the Eight Dimensions of Wellness, and was distributed in middle and high schools in seven school districts.

6. b) Please note whether benchmark(s) were met with a "yes" or "no" for each benchmark.

Yes.

6. c) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

It was challenging to find Spanish translation resources that provide both appropriate education level and dialect. It was challenging to determine the best way to deliver educational campaign in culturally appropriate way for Spanish speakers in the service area, which represent several different dialects widely dispersed across large rural areas. Latino focus groups helped to determine messaging and most relevant media for campaign. There appears to be very limited availability of practical online training for sale or on free websites that focus on reducing the stigma of mental illness or welcoming patients with mental illness into your medical practice.

6. d) Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

Project team has worked through IHN-CCO's Innovator Agent to connect with the Oregon Office of Equity and Inclusion to better understand best practices, standards and resources for addressing language and cultural barriers. The project team collaborated with the Linn County Hispanic Advisory Committee and the Linn-Benton Regional Health Equity Coalition to address language and cultural barriers.

6. e) How was the Community Advisory Council involved in the activities for this transformation area?

Community Advisory Council (CAC) members participated in the focus groups that helped form the messages and strategies for the education campaign. Quarterly updates were presented to the IHN-CCO Delivery System Transformation Steering Committee and Regional Healthy Communities Steering Committee, attended by the CAC Coordinator and Chairperson.

6. f) How was the CAC informed of the outcomes for activities in this transformation area?

Updates and drafts of the elements of the education campaign and online learning resource were presented for review and comment during the CAC's public meetings.

Transformation Area 7: Meeting the culturally diverse needs of Members

Benchmark 7	Contractor staff and Participating Providers receive annual trainings that focus on but are not limited to health equity, health literacy, cultural competence, cross-cultural communication, working with non-traditional health care workers in clinical teams, diversity, and cultivating a diverse workforce.
How Benchmark will be measured (Baseline to July 1, 2015)	• Training process is developed. • New employees receiving trainings within 6 months of hire. • All employees receiving trainings on an annual basis.
Milestone to be achieved as of July 1, 2014	• Contractor develops a process for delivery and documentation of training. • Contractor ensures that identified staff and Participating Providers have received trainings focused on topics identified in this Benchmark.
Benchmark to be achieved as of July 1, 2015	• Contractor ensures that 100% of Contractor employees and Participating Providers have completed annual trainings that assist in assuring that the culturally diverse needs of Members are met.

7. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	Training Process has been developed and Providers received training on an annual basis. New Providers were added as they were contracted and receive the training for that year and each year after.	Completed for 2014	2015 - Increase database to reach providers in Behavioral Health, Clinic Managers and their Staff. (*Completed*)
2.	Reports were created in the Cornerstone Learning Management System that allows IHN-CCO to track the Users' progress and completion of all trainings.	Completed for 2014	

7. b) Please note whether benchmark(s) were met with a "yes" or "no" for each benchmark.

IHN-CCO works to ensure that 100% of participating providers and employees are given the opportunity to complete trainings.

7. c) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

Getting 100% of participating providers to complete the annual trainings. In 2014 IHN-CCO launched the new training portal, Cornerstone Learning Management System (LMS), and Providers were not familiar with the new system. During the second annual training, there was a learning process of understanding by Providers as to why they needed to complete the trainings.

7. d) Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

Summer 2015: IHN-CCO Provider Engagement staff will work with Clinic Managers on the Cornerstone LMS. This will allow Clinic Managers to obtain the knowledge and skills to help the Providers in their clinics navigate the training system. The 2015 Annual Training will launch in October, which will give Providers three months to complete the training.

7. e) How was the Community Advisory Council involved in the activities for this transformation area?

A demonstration of the Cornerstone Learning Management System was presented to the Delivery System Transformation Steering Committee (DST); both the Community Advisory Council (CAC) Chair and CAC Coordinator attend the DST.

7. f) How was the CAC informed of the outcomes for activities in this transformation area?

The CAC Chair and CAC Coordinator receive updates through the DST meeting that they both attend.

Transformation Area 8: Eliminating racial, ethnic and linguistic disparities

Benchmark 8	Contractor will document the ethnicity data of its Members and will identify if there are any disparities in access based on ethnicity.
How Benchmark will be measured (Baseline to July 1, 2015)	• Baseline – No data to date. • Contractor researches and documents the ethnicity of its Members.
Milestone to be achieved as of July 1, 2014	• Contractor gathers Member ethnicity data either from state data or by contacting its Members.
Benchmark to be achieved as of July 1, 2015	• Contractor identifies any disparity in access based on ethnicity.

8. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	Improve IHN-CCO website to include language inventory of providers.	This information is available within the two provider directories located on our website.	Website is now consistently updated. In addition to English and Spanish, additional languages have been added to the "Other Languages" column.
2.	Developed a clinic assessment tool: *Latino/Spanish Access Assessment Tool*	Given to pilot clinic.	
3.	Developed recommendations for clinic manager related to access for the Hispanic/Latino population at the clinic The subcommittee recommendations: 1. <u>Phone Messages/Phone Queue</u>: Phone tree to be available in Spanish including after hours. 2. <u>Hours of Operation in Spanish</u>: Spanish language for days open and hours of operation on entry doors. 3. <u>Member Materials in Spanish</u>: Make Spanish materials more readily available (check-in/ check-out) in the office. 4. <u>New Patient Education</u>: Include after hours and hours of operation in new patient orientation (if not already provided). 5. <u>New Patient Education</u>: Add definitions of urgent/emergent, routine care, and preventative services in the new patient materials (if not already included). 6. <u>Referral Requests</u>: Indicate on referral forms when patients are non-English speaking for example – only speak Spanish.	Final recommendations of the subcommittee to the pilot clinic manager.	

	7. <u>Satisfaction Survey</u>: Learn more about the clinic patient satisfaction survey and the results to determine areas for improvement.		

8. b) Please note whether benchmark(s) were met with a "yes" or "no" for each benchmark.

Yes

8. c) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

Data collection, subcommittee member's schedules, and subcommittee member turnover

8. d) Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

Even with the barriers, subcommittee was able to drill data down to a particular clinic, particular ethnicity and make recommendations to the clinic for improving access.

8. e) How was the Community Advisory Council involved in the activities for this transformation area?

The Community Advisory Council (CAC) Coordinator was a member of the subcommittee working on this area.

8. f) How was the CAC informed of the outcomes for activities in this transformation area?

The CAC Chair and CAC Coordinator receive updates through the Delivery System Transformation Steering Committee meeting that they both attend.