CHCCO PARTNERSHIP IN BUILDING A BETTER FUTURE
CHC of Benton & Linn County

Community Health Centers of Benton and Linn Counties

- 7 clinics
- 2 counties
- 13 providers
- 10,000+ patients
- 6,000 visits/month

6 Primary Care clinics
   Corvallis (2), Alsea, Monroe, Lebanon, Sweet Home

Additional Services
   Family Planning
   School-based Health Centers (2)
   Pharmacy
   Behavioral Health
   Oral Health Services

Target populations
   Latino/Hispanic
   Veterans & Seniors
   Complex health needs

For more information: bentonlinnhealthcenters.org
The Social-Ecological Framework

- Policy
- Community
- Organizational
- Interpersonal
- Individual
ORGANIZATIONAL INTENT
MEANINGFULLY CHANGE DESIGN & DELIVERY OF SERVICES

- Promote full continuum of services from person centered to population based

- Patient/Community Centered
  - Understand community needs & interests
  - Active outreach to targeted populations

- Redesigned management structure to support integration

- Created ‘bridges’ between services

- Integrated QI and strategic planning across Health Services with a focus on reports & use of data
Benton County Health Services

Engaged communities and blended services achieving better health

Person-Centered Services
- Behavioral Health Care
- Addictions Services
- Oral Health
- Family Planning
- Primary Care
  - Alsea
  - Benton
  - East-Linn
  - Lincoln
  - Monroe
  - Sweet Home

Crisis Mental Health
- Developmental Diversity
- Women Infants Children
- Nurse Home Visiting
- Communicable Disease
- Immunization
- Epidemiology
- Healthy Communities
- Emergency Preparedness
- Water, Septic & Solid Waste
- Food Safety
- Health Policy

Promotion
- Health Policy & Prevention Management Team

Platform
- QI & Business Support

Protection
- Regulatory Health & Population Service Management Team

Provision
- Person-Centered Management Team

Person-Centered Services

Population-Centered Services

Health Center Director

Health Department Director

"ENGAGED COMMUNITIES AND BLENDED SERVICES ACHIEVING BETTER HEALTH"

June 2016
InterCommunity Health Network CCO (Coordinated Care Organization) was formed in 2012 by local public, private, and non-profit partners to unify health services and systems for Oregon Health Plan (Medicaid) members in Benton, Lincoln, and Linn Counties.

As IHN-CCO, we are committed to improving the health of our communities while lowering or containing the cost of care. We will accomplish this by coordinating health initiatives, seeking efficiencies through blending of services and infrastructure, and engaging all stakeholders to increase the quality, reliability, and availability of care.
IHN-CCO’S APPROACH

- Collaborate starting with Regional Planning Council (RPC)
- “Keep the lights on”
- Adjust and adapt – “Building the plane while flying”
- We are all the Coordinated Care Organization (CCO)
AGENCIES IN RPC

- Benton County
- Samaritan Health Plans
- Capital Dental
- CAC Chair
- CAC Coordinator
- Linn County
- Lincoln County
- Advantage Dental
- Early Learning Hub
- The Corvallis Clinic
- Samaritan Health Services
- Cascades West Council of Governments
- Moda
- State Innovator Agent
- DHS
- Willamette Dental
InterCommunity Health Network CCO (Coordinated Care Organization) was formed in 2012 by local public, private, and non-profit partners to unify health services and systems for Oregon Health Plan (Medicaid) members in Benton, Lincoln, and Linn Counties. As IHN-CCO, we are committed to improving the health of our communities and providing better care while lowering or containing the cost of care.

**IHN-CCO BOARD OF DIRECTORS**
Sets the goals, policies and directives of the CCO.

**SAMARITAN HEALTH PLAN OPERATIONS**
Works with community partners to coordinate care of members.

**IHNC-CCO REGIONAL PLANNING COUNCIL**
Develops strategies to transform and integrate the system of care.

**IHNC-CCO COMMUNITY ADVISORY COUNCIL**
Supports community and member involvement and input into CCO operations and mission.

**MEMBERS & PROVIDERS**

[Map showing locations of Benton, Lincoln, and Linn Counties]
“Collaboration is working with each other to do a task and to achieve shared goals. It is a process where organizations work together to realize shared goals. Structured methods of collaboration encourage introspection of behavior and communication. These methods specifically aim to increase the success of teams as they engage in collaborative problem solving.” — Wikipedia Definition
KEY ASSUMPTIONS OF COLLABORATION

- Must value **diverse** membership and ideas
- Each member has **expertise**
- Must have a **common** purpose
- Members need to **trust** one another
- Trust allows members to **share** in decision-making and responsibility
IHN-CCO AND COMMUNITY PARTNERS EMBRACED COLLABORATION MODEL CALLED “COLLECTIVE IMPACT”
IHN-CCO HAS TAKEN THE POSITION OF THE BACKBONE ORGANIZATION

Activities of Backbone Organizations

1. Guide vision and strategy
2. Support aligned activities
3. Establish shared measurement
4. Build public will
5. Advance policy
6. Mobilize funding
There are Five Conditions to Collective Impact Success

<table>
<thead>
<tr>
<th>Condition</th>
<th>Requirement</th>
</tr>
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<tbody>
<tr>
<td>Common Agenda</td>
<td>All participants have a <strong>shared vision for change</strong> including a common understanding of the problem and a joint approach to solving it through agreed upon actions</td>
</tr>
<tr>
<td>Shared Measurement</td>
<td><strong>Collecting data and measuring results consistently</strong> across all participants ensures efforts remain aligned and participants hold each other accountable</td>
</tr>
<tr>
<td>Mutually Reinforcing Activities</td>
<td>Participant activities must be <strong>differentiated while still being coordinated</strong> through a mutually reinforcing plan of action</td>
</tr>
<tr>
<td>Continuous Communication</td>
<td><strong>Consistent and open communication</strong> is needed across the many players to build trust, assure mutual objectives, and appreciate common motivation</td>
</tr>
<tr>
<td>Backbone Support</td>
<td>Creating and managing collective impact requires a separate organization(s) with staff and a specific set of skills to <strong>serve as the backbone for the entire initiative and coordinate participating organizations and agencies</strong></td>
</tr>
</tbody>
</table>
COMMON AGENDA
THE ANSWER LIES IN THE TRIPLE AIM

Oregon’s Solution = Coordinated Care Organizations
ORIGINAL EIGHT KEY ELEMENTS OF TRANSFORMATION

1. Physical and mental health care integration
2. **Patient-Centered Primary Care Homes (PCPCH)**
3. **Alternative payment methods**
4. Community health assessments
5. Electronic health records
6. Culturally-appropriate and health-literate communications
7. Services/staffing that reflect diversity and address disparities
8. Quality improvement plans
Strategic Focus: 2018

Access
- Assure growth at Alsea & Sweet Home
- Dental expansion
- Rotations for residents, PA, and NP

Cost
- Impact of Public Employees Retirement System (PERS)
- Contingency plan
- Assess Board 501(c)(3) non-profit status
- Impact study further analysis

Equity
- Patient and community engagement
- Implement Social Determinants of Health (SoDH) pilot
- Board training on Trauma Informed Care

Quality
- Facility remodel
- Patient Centered Primary Care Home (PCPCH) 5-Star Status
- Operational plan
- 4 of 7 clinical outcome measures

Board Development
Board recruitment & orientation
Gaining input to support long-range planning strategy
SHARED MEASUREMENT
Regional Coordination of Community Health Assessments
## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>Community Health Assessment</td>
<td>CHA</td>
</tr>
<tr>
<td>Community Health Improvement Plan</td>
<td>CHIP</td>
</tr>
<tr>
<td>Intercommunity Health Network Coordinated Care Organization</td>
<td>IHN-CCO</td>
</tr>
<tr>
<td>Community Health Needs Assessment</td>
<td>CHNA</td>
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<tr>
<td>Regional Health Assessment</td>
<td>RHA</td>
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</table>
The past (2012-2014)

<table>
<thead>
<tr>
<th>Organization</th>
<th>Year</th>
<th>Role or Description</th>
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<tbody>
<tr>
<td>Linn County CHA</td>
<td>2012</td>
<td>Linn County Public Health</td>
</tr>
<tr>
<td>Benton County CHA</td>
<td>2012</td>
<td>Benton County Healthy Communities Team</td>
</tr>
<tr>
<td>Lincoln County CHA</td>
<td>2013</td>
<td>Contracted to Benton County Epidemiologist</td>
</tr>
<tr>
<td>IHN-CCO CHIP process</td>
<td>2014</td>
<td>Relied on Linn, Benton, and Lincoln County CHAs</td>
</tr>
<tr>
<td>Samaritan Health Services CHNAs (3)</td>
<td>2013</td>
<td>Contracted to Benton County Epidemiologist</td>
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</table>
The present (2015-2018)

<table>
<thead>
<tr>
<th>A coordinated approach to health assessment</th>
<th></th>
<th></th>
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<tbody>
<tr>
<td>Regional Health Assessment (RHA)</td>
<td>2015</td>
<td>Created by the Regional Health Assessment Team</td>
</tr>
<tr>
<td>Linn County CHA</td>
<td>2017</td>
<td>RHA Team and Linn County Public Health</td>
</tr>
<tr>
<td>Benton County CHA</td>
<td>2017</td>
<td>RHA Team and Benton County Healthy Communities</td>
</tr>
<tr>
<td>Lincoln County CHA</td>
<td>2018</td>
<td>RHA team and Lincoln County Public Health</td>
</tr>
<tr>
<td>IHN-CCO CHIP process</td>
<td>2018</td>
<td>Built from the Regional Health Assessment</td>
</tr>
<tr>
<td>SHS CHNAs (5)</td>
<td>2016</td>
<td>Built from the Regional Health Assessment</td>
</tr>
</tbody>
</table>
THE REGIONAL HEALTH ASSESSMENT

- Standardizes the template for Community Health Assessments
  - Consistent topics and data sources
  - Consistent voice and format
  - Coordinated updating of data

- Centralizes data and analysis in a single team that serves the needs of the region

- Regionalizes common data
  - Highlights similarities and differences
  - Strengthens comparisons with IHN-CCO member data
The future (2019-)

A coordinated approach to publicly funded health improvement

Regional Health Assessment with county-level highlights and IHN-CCO member comparisons

Used to produce:

| County CHIPS aligned through prioritization process and common data | IHN-CCO CHIP | Other data and planning documents (e.g. CHNAs, Biennial plans) |

Driving:

Coordinated strategies and planning for publicly funded health improvement at the local and regional level.
**COALEScing Around Metrics..... Health Center Data Alignment**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Highest Benchmark</th>
<th>Last Org. #</th>
<th>Internal Focus</th>
<th>Access to Care</th>
<th>Clinical Quality</th>
<th>Adult Only</th>
<th>Pediatric Only</th>
<th>Adult &amp; Pediatric</th>
<th>2018 CCO</th>
<th>MU</th>
<th>PCPCH</th>
<th>UDS</th>
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<tr>
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<td>37.4%</td>
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<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>50.8%</td>
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<td>DM HbA1c Poor Control</td>
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<td>30.1%</td>
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<td>X</td>
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<td></td>
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<td></td>
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<tr>
<td>BMI - Adult</td>
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<td>BMI - Child</td>
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<td></td>
<td></td>
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<td>30.4%</td>
<td>43.0%</td>
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<tr>
<td>DM HbA1c Control</td>
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<td>58.9%</td>
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<td>X</td>
<td></td>
<td></td>
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<td></td>
<td>60.0%</td>
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<td>DM HbA1c Frequency</td>
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<td>89.4%</td>
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<td>Immunizations @ 2yrs</td>
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<td>78.6%</td>
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<td>Breast Cancer Screen (Mammogram)</td>
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<td></td>
<td>X</td>
<td>TBD</td>
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<td>Tobacco Cess. With Intervention</td>
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<td>Depression (PHQ-9)</td>
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<td></td>
<td>X</td>
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<td></td>
<td></td>
<td></td>
<td>52.9%</td>
<td>25.0%</td>
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<tr>
<td>DM LDL Control</td>
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<td>Peak Flow</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
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<tr>
<td>WCC 15mos</td>
<td>77.0%</td>
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<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>73.9%</td>
<td>77.0%</td>
<td></td>
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<tr>
<td>WCC 3-6yrs</td>
<td>74.0%</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>74.0%</td>
<td></td>
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</table>
TEAM LEVEL VIEW

- Team level views include information on how the measure was modified for the purposes of internal tracking, numerator and denominator definitions, exclusion(s), reporting authority, and hyperlinks to clinical workflows.

- Graphs show monthly progress at the provider, team, site, and organization levels.

<table>
<thead>
<tr>
<th>Colorectal Cancer (CRC) Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Updated:</strong> 7/10/2018</td>
</tr>
<tr>
<td><strong>Modifications:</strong> NOFO034 with the following changes: restricted to patient's on a PCP panel, ran for last 1 year instead of last 2 years, FIT testing completed annually instead of every 2 years</td>
</tr>
<tr>
<td><strong>Denominator:</strong> patients on a provider’s panel, 50-75 years of age, with an office visit during the past 12 months.</td>
</tr>
<tr>
<td><strong>Numerator:</strong> patients with a documented screening for colorectal cancer: fecal occult blood test (FOBT) or fecal immunochemical test (FIT) during the past, flexible sigmoidoscopy during the past 5 years, or colonoscopy during the past 10 years.</td>
</tr>
<tr>
<td><strong>Exclusions:</strong> patients with a diagnosis or past history of total colectomy or colorectal cancer, Panel Managers exclude terminal patients from FIT testing</td>
</tr>
<tr>
<td><strong>Frequency/Source:</strong> monthly - Business Objects/SA90/Report Development/Quality Metrics - Colorectal Cancer Screening</td>
</tr>
<tr>
<td><strong>Reported To:</strong> CCO, PCPCH, UDS</td>
</tr>
<tr>
<td><strong>Workflow / Process Document:</strong> Colorectal Cancer Screening Colonoscopy, Colorectal Cancer Screening FIT Testing</td>
</tr>
</tbody>
</table>
MUTUALLY REINFORCING ACTIVITIES
THE DELIVERY SYSTEM TRANSFORMATION COMMITTEE

- Open to anyone in Linn, Benton and Lincoln Counties that can positively affect the health outcomes of IHN-CCO members
- Provide learning and collaboration opportunities
- Support care teams that work to coordinate patient care, (Patient Centered Primary Care Home), as the foundation of the IHN-CCO
- Approve and oversee pilots and the IHN-CCO Transformation Plan
- Welcome innovative ideas and efforts
DELIVERY SYSTEM
TRANSFORMATION (DST)

• Supported over 50 pilots
• Awarded over $19 million to community partners
• Involved 50 + partner organizations since it began in 2012
# IHN-CCO DST Transformation Pilot Crosswalk

Eight Elements of Transformation, Transformation and Quality Strategy Components (TQS), and Community Health Improvement Plan Health Impact Areas (CHIP Areas)

~Active Pilots and Workgroups~

<table>
<thead>
<tr>
<th>Transformation Elements</th>
<th>PILOTS</th>
<th>WORKGROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Integration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient-Centered Primary Care Home</td>
<td></td>
<td></td>
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<tr>
<td>Alternative Payment Methodology</td>
<td></td>
<td></td>
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<tr>
<td>Development of CHIP/CHA</td>
<td></td>
<td></td>
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<tr>
<td>Electronic Health Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural Communications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural Diversity of Providers and Staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eliminate Disparities in Access, Care, Outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access: Availability of Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access: Cultural Considerations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access: Quality and Appropriateness of Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access: Timely</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access: Second Opinions</td>
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</tr>
<tr>
<td>Culturally &amp; Linguistically Appropriate Services (CLAS)</td>
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<td></td>
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<tr>
<td>Complaints and Grievances</td>
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<td></td>
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<tr>
<td>Fraud, Waste, and Abuse</td>
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<tr>
<td>Health Equity: Data</td>
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<td></td>
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<tr>
<td>Health Equity: Cultural Competency</td>
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<td></td>
</tr>
<tr>
<td>HIT: Health Information Exchange</td>
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<td></td>
</tr>
<tr>
<td>HIT: Analytics</td>
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<tr>
<td>HIT: Patient Engagement</td>
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<tr>
<td>Integration of Care</td>
<td></td>
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<tr>
<td>PCPCH Development</td>
<td></td>
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<tr>
<td>Severe &amp; Persistent Mental Illness</td>
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<td></td>
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<tr>
<td>Social Determinants of Health</td>
<td></td>
<td></td>
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<tr>
<td>Special Health Care Needs</td>
<td></td>
<td></td>
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<td>Utilization Review</td>
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</tr>
<tr>
<td>Value-based Payment Models</td>
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</tr>
</tbody>
</table>

**CHIP Areas**

- Access to Healthcare
- Behavioral Health
- Child Health
- Chronic Disease
- Maternal Health

**KEY**

- C2C: CHANCE 2nd Chance
- BSS: Breastfeeding Support Services
- CSAS: Children's SDoH and ACEs Screening
- DOUL: Community Doula
- HEST: Health Equity Summits and Trainings
- PWST: Peer Wellness Specialist Training
- RHEH: Regional Health Education Hub
- SDoH: SDoH with a Veggie Rx Intervention
- THWH: Traditional Health Worker Hub
- VRxL: Veggie Rx in Lincoln County
- APM: Alternative Payment Methodologies Workgroup
- HE: Health Equity Workgroup
- SDoH: Social Determinants of Health Workgroup
- THW: Traditional Health Workers Workgroup
- UCC: Universal Care Coordination Workgroup
<table>
<thead>
<tr>
<th>CCO Incentive Metrics</th>
<th>BSS</th>
<th>C2C</th>
<th>CSAS</th>
<th>DOUL</th>
<th>HEST</th>
<th>PWST</th>
<th>RHEH</th>
<th>SDoH</th>
<th>THWH</th>
<th>VRxL</th>
</tr>
</thead>
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<td>Adolescent well-care visits</td>
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<td>Ambulatory care: Emergency department (ED) visits</td>
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<td>CAHPS composite: Access to care</td>
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<td>Childhood immunization status</td>
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<td>Cigarette smoking prevalence</td>
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<td>Colorectal cancer screening</td>
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<td>Controlling high blood pressure</td>
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<td>Dental sealants</td>
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<td>Depression screening and follow-up plan</td>
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<td>Developmental screening (0-36 months)</td>
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<td>Disparity measure: ED visits among members with mental illness</td>
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<td>Diabetes: HbA1c poor control</td>
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<td>Effective contraceptive use</td>
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<td>Health assessments within 60 days for children in DHS custody</td>
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<td>Patient-Centered Primary Care Home enrollment</td>
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<td>Timeliness of prenatal care</td>
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<td>Weight assessment and counseling for children and adolescents</td>
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Rev 7/25/18
**CASE STUDY: DST-FUNDED CHW/HEALTH NAVIGATOR PILOTS**

- **2008-2014**: CHC has established, robust Community Health Worker/Health Navigator (CHW/HN) program
  - 9 HNs working in the clinic, OHP/resource, and community

- **2014**: Pilot for CHC to hire, train, and supervise 4 CHW/HNs placed into Samaritan PCPCHs
  - Working as part of clinical care team with RNCC/ providers

- **2015**: Pilot for 2 CHW/HNs to be co-placed in elementary and middle schools
  - Total of 3 HNs working in the schools

- **2017**: Pilot for 1 CHW/HN to be the “CHW Training Hub Coordinator” and to establish a state-approved CHW Training Hub in the IHN-CCO region
Benton County Health Services
Community Health Worker / Health Navigator Roles
along the Service Continuum

Primary Care and Self-Management
Health Care Services Access and Utilization
Social Service and Resource Connection
“Barrier Busting”

Primary Care Navigation
Health Care Utilization
Culturally appropriate services

Social Service and Resource Connection
Insurance Enrollment and Navigation
Assist with tasks, appointments, forms

Barrier-Free Access
Increase Health Literacy

Chronic Disease Self-Management

Client Advocacy
School Outreach
Build Community Capacity

Advocacy
Community Agency Partnerships
Health Policy

Clinical Health Navigators
Work as member of primary care team; provide health system navigation and self-management support

Resource Navigators
Provide outreach and enrollment services for Oregon Health Plan as well as social service resources and supports

Oral Health Navigator
Provide oral health outreach, education, and dental system navigation

School - Navigators
Co-placed at 3 schools to assist families to navigate health and social service systems

Community Navigators
Interpretation Translation Advocacy Capacity Building

Clinical ↩️ Resource ↩️ Community
CASE STUDY #2
ALTERNATIVE PAYMENT METHOD (APM)
APPROACH TO SUPPORT PCPCH DEVELOPMENT

- Measuring quality of service
- Providers are able to treat all aspects of a person’s “health”
- Members receive the right care at the right place at the right time
- Reduction in high cost inappropriate use of services
- Medication Therapy Management services are integrated into medical homes
- Care Coordination is integrated into medical homes
- Behaviorists and mental health is integrated into medical homes and in the schools
- Preventive screening has increased
- Coordination and collaboration between all providers treating a member has increased
The % presented is an accurate reflection of the amount of providers that will never be supported by an APM.

Population-based payments – with link to quality

- PCPCH – 100%
- County Mental Health 100%
- NEMT 100%
- Dental – 100%
- Hospitals – 10%
- Specialists – 50%
- Community Agencies – 100%

- PMPM Capitation – PFP & Shared Savings
- Population Based Capitation – PFP & Shared Savings
- Episode of Care Payment – based on procedures or diagnosis – PFP & Shared Savings

The framework and roadmap for 2017 & beyond focus on transitioning from fee-for-service (FFS) to population-based payments with a link to quality, starting at 25% hospitals and 28% specialists, to 100% of PCPCH and other services.
APM PILOTS

- OHA/OPCA started July 1, 2014
  - Paid a monthly PMPM (per member per month) for all engaged patients

- IHN-CCO started January 2015
  - Paid a monthly PMPM (per member per month) for enrolled OHP patients
  - Rate of PMPM based on the rate group the member is assigned

- Required reporting on touches & visits
CLINICAL IMPACT OF APM

- Detached payment from a provider visit/schedule
- Increased reliance on team
  - Added FTE to fully staff teams
- Supported alternative methods for access
  - Team member visits
  - Navigators
  - Group visits
- Enhanced focus on quality & outcomes
- Provided resources for innovation & integration
CONTINUOUS COMMUNICATION
## COMMUNICATION MUST HAVE’S

<table>
<thead>
<tr>
<th>Inform</th>
<th>One way communication providing balanced and objective information to assist understanding about something that is going to happen or has happened.</th>
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<tbody>
<tr>
<td>Consult</td>
<td>Two way communications designed to obtain public feedback about ideas on rationale, alternatives and proposals to inform decision making.</td>
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<tr>
<td>Involve</td>
<td>Facilitating active participation by stakeholders designed to help identify issues and views from a diverse range of perspectives so that concerns and aspirations are understood and considered throughout a decision making process.</td>
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<tr>
<td>Collaborate</td>
<td>Working together in partnership to determine how to develop understanding of all issues and interests as stakeholders work out alternatives and identify preferred solutions to support the process of decision making.</td>
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</table>
Be Healthy. Be Happy.

Welcome, Oregon Health Plan members in Benton, Lincoln and Linn counties. This is all about you. What do you need today?

New Members Start Here
PROJECT GOALS

Provide a website experience where:

· Members find high value in using the website to take control of their own health improvement, which includes how they can optimally use their health plans and/or find access to health services.

· Stakeholders find high value in using the website to improve the health of the community, which includes health determinants that go beyond health care.

· Site content does promote the ongoing mission and goals of IHN-CCO.
Cascading Levels of Linked Collaboration Amplify Impact

**Depth of Impact through Vertical Alignment**
- Cross-sector leaders formulate a **common agenda**
- The core strategy then translates into **key program initiatives**, each with a set of **workgroups**
- Workgroups carry out work at the ground-level while **maintaining a common focus and set of objectives**

**Breadth of Impact through Horizontal Coordination**
- Backbones guide working groups in creating **aligned and coordinated** action across multiple organizations
- Groups tackle **many different dimensions** of a complex social problem **at once**
- Multi-dimensional approach **amplifies impact** across sectors / geographies

**Adoption Beyond the Central Scope of Impact**
- As working groups engage with outside organizations and share progress, **the circle of alignment grows**
- External stakeholders **adopt new practices aligned** with the effort

Source: Channeling Change: Making Collective Impact Work, 2012; FSG Interviews
HEALTH CENTER REPRESENTATION

Active Participation on CCO Committees
• Regional Planning Council (RPC)
• Delivery System Transformation (DST)
• Alternative Payment
• Quality Committee
• Regional Heath Information Collaborative
EVOLUTION OF SDOH WITHIN COMMUNITY

Started with committee structure in DST
  • Health Equity
  • Care Coordination
  • SDOH

Moving toward alignment of committees & their work with goal of advising IHN-CCO in application for CCO 2.0
STEPS TO REPLICATE

- Get executive stakeholder buy-in by starting with what they are familiar with
- Align initiatives across organizations through Forums, brainstorming sessions
- Build culture from the top down and the ground up inside and outside organizations
- Ensure leadership is hearing about success
- Recognize the skills of all participants
- Set the expectation from the beginning that this will be a gradual but steady
- Push the envelop to ensure maximum growth
- Communicate, communicate, communicate
STEPS TO REPLICATE
HEALTH CENTER PERSPECTIVE

- Know your strengths & identify those areas where you’re ready to contribute
- Be visible, attend meetings, actively participate
- Build relationships; think about when is it appropriate to lead vs being a meaningful participant
- Think about how you can contribute to larger system development which is a long-term commitment
- Continue to innovate internally
- Communicate, communicate, communicate