Kim Whitley
Sherlyn Dahl

CHCCO PARTNERSHIP IN BUILDING A BETTER FUTURE

InterCommunity Health Network CCO

Community Health Centers of Benton & Linn Counties

CHC of Benton & Linn County

6 Primary Care clinics

Corvallis (2), Alsea, Monroe, Lebanon, Sweet Home

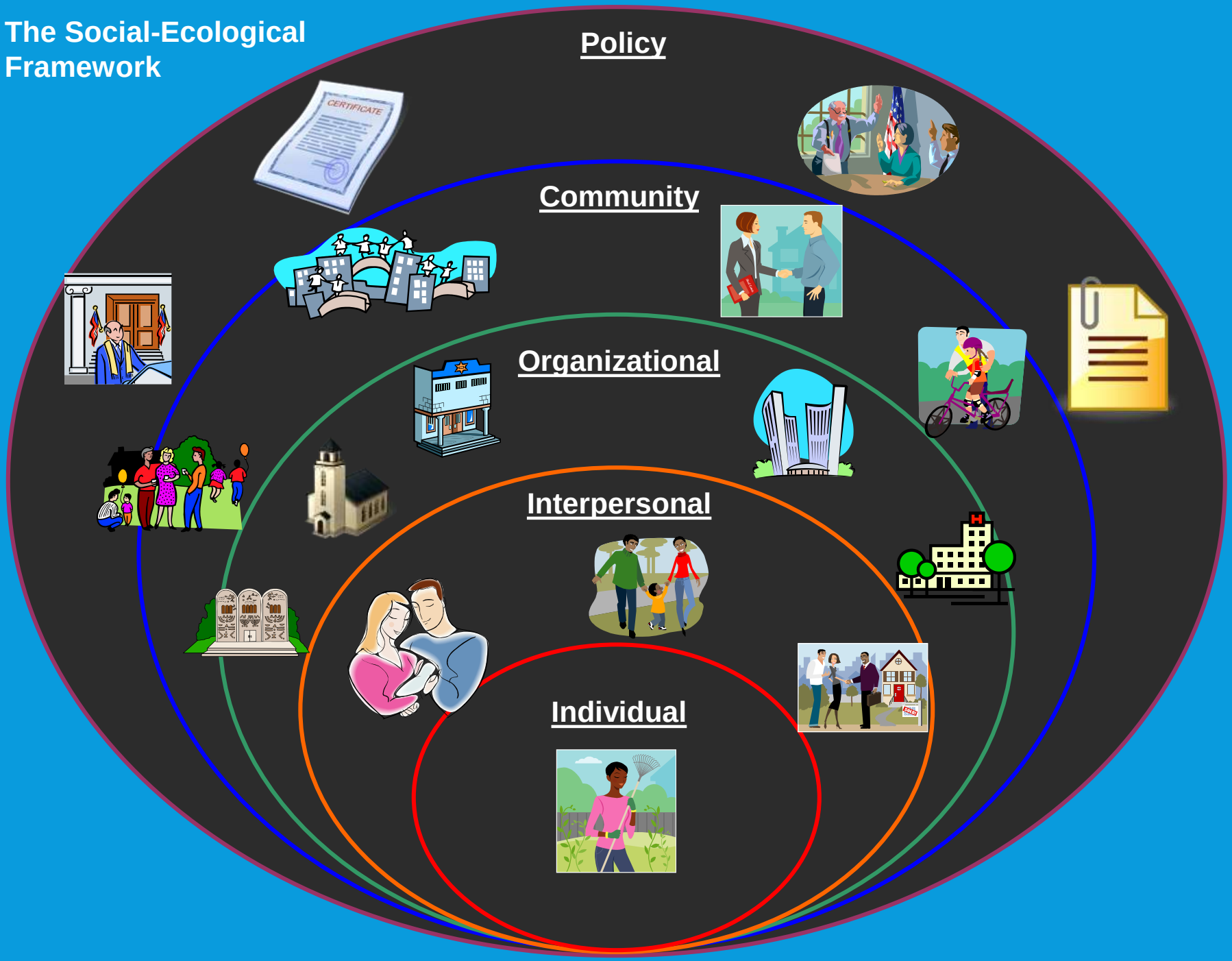
Additional Services

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

Target populations

Latino/Hispanic
Veterans & Seniors
Complex health needs

The Social-Ecological Framework



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

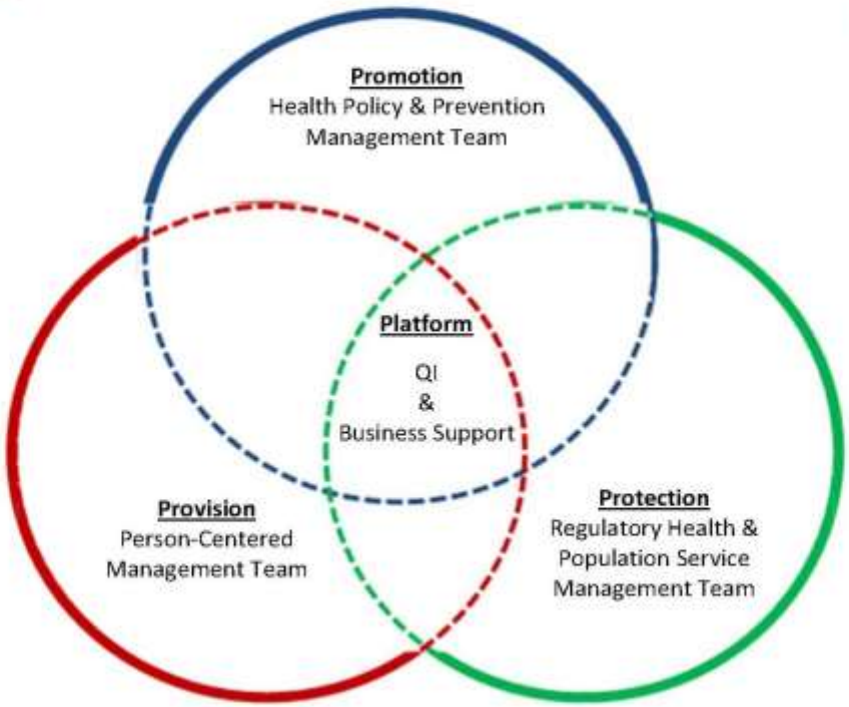
- Behavioral Health Care
- Addictions Services
- Oral Health
- Family Planning
- Primary Care Alsea
- Primary Care Benton
- Primary Care East-Linn
- Primary Care Lincoln
- Primary Care Monroe
- Primary Care Sweet Home

Person-Centered Services

- Health Navigation
- Crisis Mental Health
- Developmental Diversity
- Women Infants Children
- Nurse Home Visiting

Population-Centered Services

- Communicable Disease
- Immunization
- Epidemiology
- Healthy Communities
- Emergency Preparedness
- Water, Septic & Solid Waste
- Food Safety
- Health Policy



CHC Medical Director | MH Medical Director | Deputy Director of Clinic Operations | Chief Financial Officer | Health Officer | Prevention & Public Health Deputy Director

Health Center Director

Health Department Director

"Engaged Communities and Blended Services Achieving Better Health"

June 2016

IHNCCO

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

Your Community Health Plan

InterCommunity Health Network CCO

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.

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

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

COLLABORATION WAS ESSENTIAL

"**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

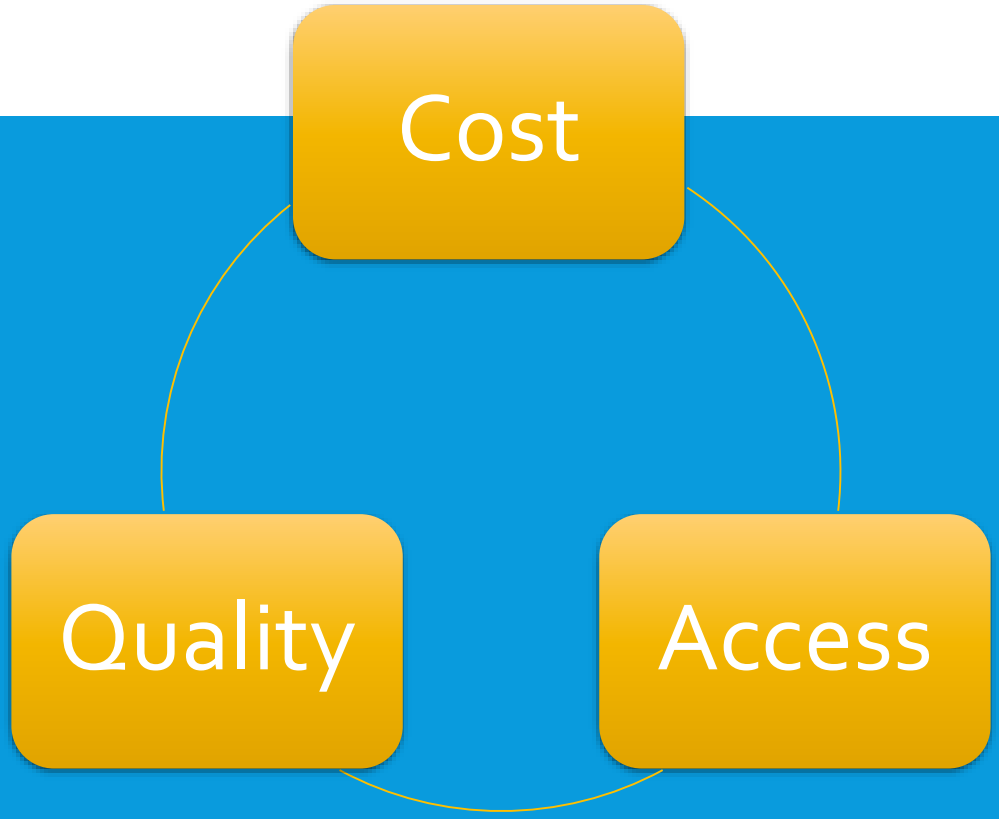
1. Guide vision and strategy
2. Support aligned activities
3. Establish shared measurement
4. Build public will
5. Advance policy
6. Mobilize funding

There are Five Conditions to Collective Impact Success

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

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

Community Health Centers of Benton & Linn Counties

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

Community Health Assessment	CHA
Community Health Improvement Plan	CHIP
Intercommunity Health Network Coordinated Care Organization	IHN-CCO
Community Health Needs Assessment	CHNA
Regional Health Assessment	RHA

The past (2012-2014)

Linn County CHA	2012	Linn County Public Health
Benton County CHA	2012	Benton County Healthy Communities Team
Lincoln County CHA	2013	Contracted to Benton County Epidemiologist
IHN-CCO CHIP process	2014	Relied on Linn, Benton, and Lincoln County CHAs
Samaritan Health Services CHNAs (3)	2013	Contracted to Benton County Epidemiologist

The present (2015-2018)

A coordinated approach to health assessment		
Regional Health Assessment (RHA)	2015	Created by the Regional Health Assessment Team
Linn County CHA	2017	RHA Team and Linn County Public Health
Benton County CHA	2017	RHA Team and Benton County Healthy Communities
Lincoln County CHA	2018	RHA team and Lincoln County Public Health
IHN-CCO CHIP process	2018	Built from the Regional Health Assessment
SHS CHNAs (5)	2016	Built from the Regional Health Assessment

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

Legend for Quality Metrics (under construction)

Indicates a clinical outcome measure of focus
Indicates an access to care measure
Indicates a clinical outcome measure

Tabs are formatted with a grid of data and a matching graph at the organizational, site, then provider level
Only patients assigned to their panel show in a provider's totals
Provider totals are rolled up into a team total, than a site total as appropriate
The organizational total is the actual numbers eligible for our annual UDS report.

Measure	Highest Benchmark	Last Org. #	Internal Focus	Access to Care	Clinical Quality	Adult Only	Pediatric Only	Adult & Pediatric	2018 CCO	MU	PCPCH	UDS
Colorectal Cancer (CRC) Screening	50.8%	37.4%	x		x	x			50.8%		47.0%	x
DM HbA1c Poor Control	19.0%	30.1%			x	x			19.0%			x
HTN BP Control	69.0%	59.8%			x	x			69.0%		64.0%	x
Pap	73.0%	42.4%	x		x	x			63.5%		73.0%	x
SBIRT	16.5%	51.0%	x		x			x	16.5%		13.0%	
WCC 12-21yrs	53.0%	41.6%	x		x			x	51.8%		53.0%	
Access	N/A	N/A		x				x				
BMI - Adult	47.0%	32.6%			x	x					47.0%	x
BMI - Child	43.0%	4.6%			x		x		30.4%	x	43.0%	x
DM HbA1c Control	60.0%	58.9%			x	x					60.0%	x
DM HbA1c Frequency	89.4%	85.9%			x	x			89.4%		86.0%	
Immunizations @ 2yrs	82.0%	22.0%			x		x		78.6%		82.0%	x
Breast Cancer Screen (Mammogram)	TBD	43.0%			x	x				x	TBD	
Tobacco Cess. With Intervention	93.0%	94.6%			x			x	25.0%	x	93.0%	x
Depression (PHQ-9)	52.9%				x			x	52.9%		25.0%	x
DM LDL Control	40.0%				x	x					40.0%	
Peak Flow	N/A				x	x						
WCC 15mos	77.0%				x		x		73.9%		77.0%	
WCC 3-6yrs	74.0%				x		x				74.0%	

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.

Colorectal Cancer (CRC) Screening	
Updated: 7/10/2018	
Modifications: NQF0034 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	
Denominator: patients on a provider's panel, 50-75 years of age, with an office visit during the past 12 months.	
Numerator: 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.	
Exclusions: patients with a diagnosis or past history of total colectomy or colorectal cancer, Panel Managers exclude terminal patients from FIT testing	
Frequency/Source: monthly - Business Objects/SA90/Report Development/Quality Metrics - Colorectal Cancer Screening	
Reported To: CCO, PCPCH, UDS	
Workflow / Process Document: Colorectal Cancer Screening Colonoscopy	Colorectal Cancer Screening FIT Testing

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

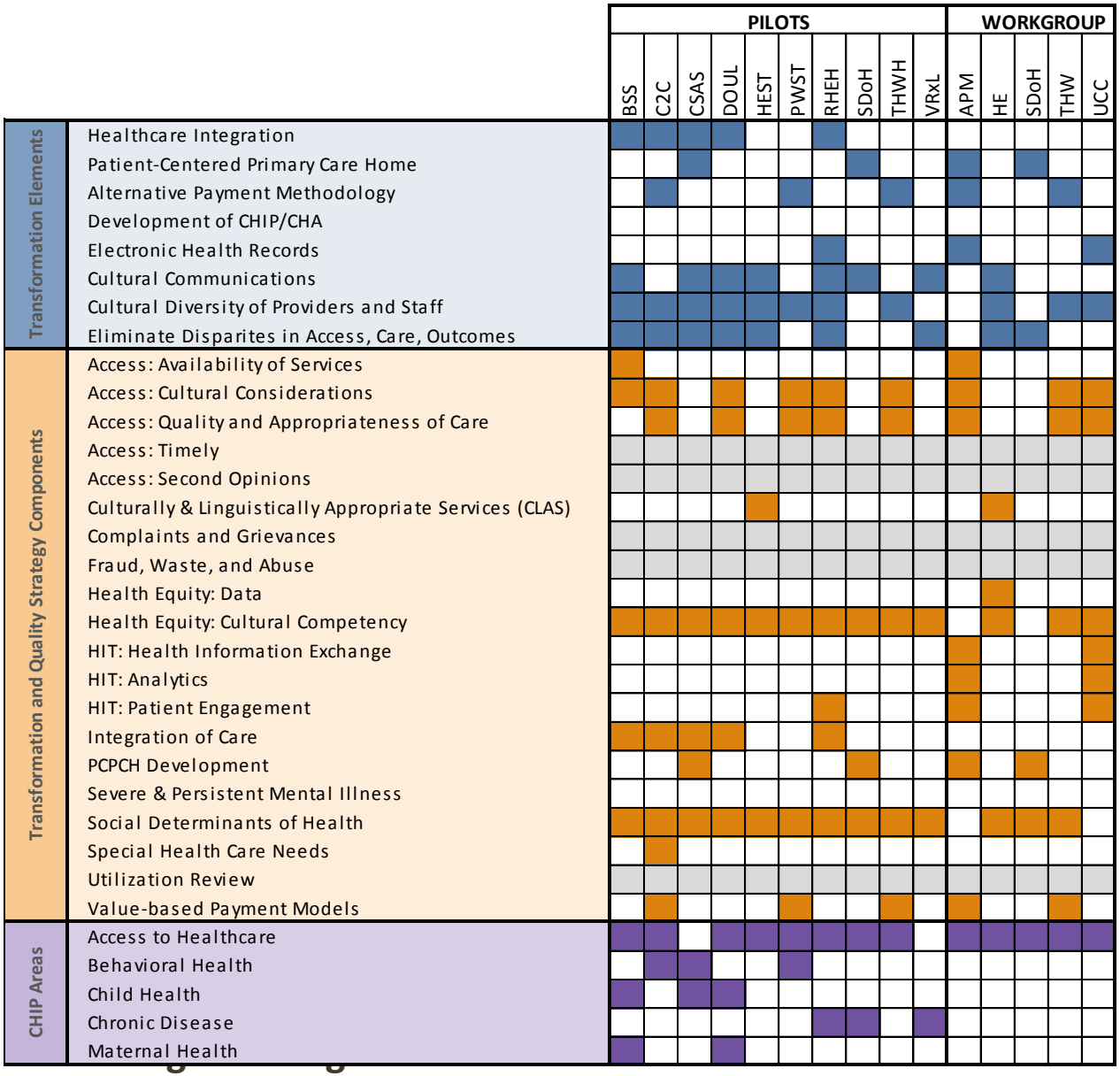
DELIVERY SYSTEM TRANSFORMATION (DST)

- 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~



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

IHN-CCO DST Transformation Pilot Crosswalk

CCO Incentive Metrics - Active Pilots

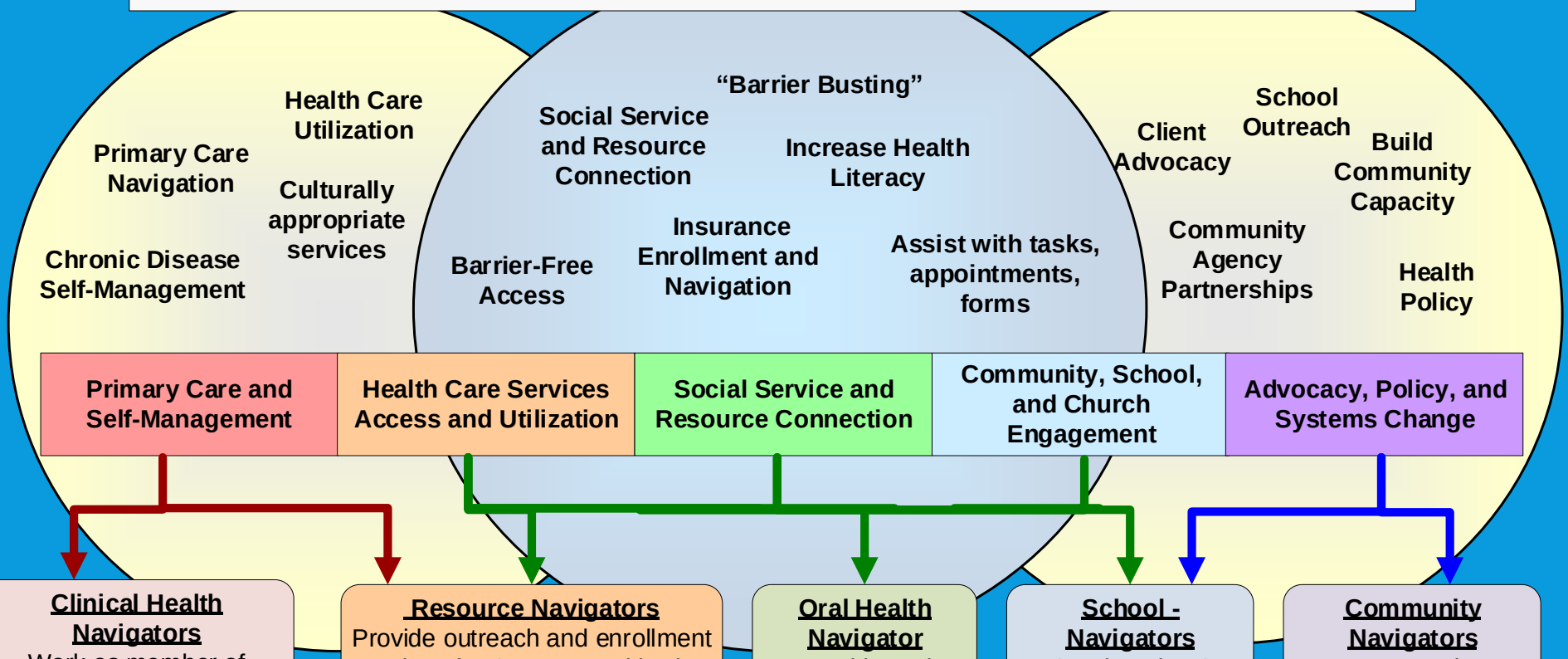
CCO Incentive Metrics	BSS	C2C	CSAS	DOUL	HEST	PWST	RHEH	SDoH	THWH	VRxL
Adolescent well-care visits										
Ambulatory care: Emergency department (ED) visits		■								
CAHPS composite: Access to care	■									
Childhood immunization status										
Cigarette smoking prevalence							■			
Colorectal cancer screening										
Controlling high blood pressure										
Dental sealants										
Depression screening and follow-up plan										
Developmental screening (0-36 months)										
Disparity measure: ED visits among members with mental illness		■								
Diabetes: HbA1c poor control							■			
Effective contraceptive use										
Health assessments within 60 days for children in DHS custody										
Patient-Centered Primary Care Home enrollment										
Timeliness of prenatal care				■						
Weight assessment and counseling for children and adolescents										

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



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

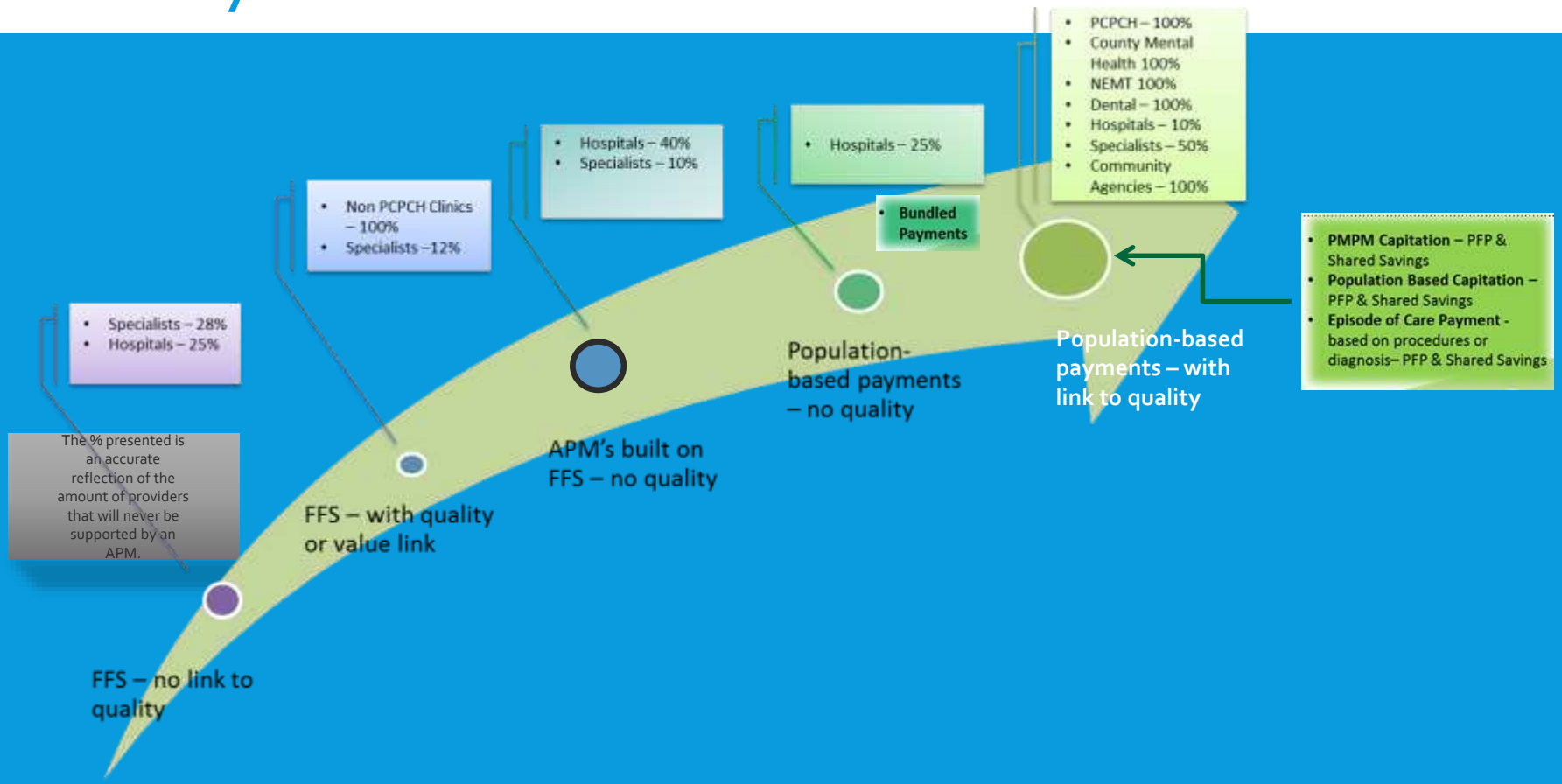
Clinical ⟷ Resource ⟷ Community

BCHS HEALTH NAVIGATION TEAM – 28 CHWS STRONG

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 persons "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

IHN-CCO APM FRAMEWORK & ROADMAP 2017 & BEYOND



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

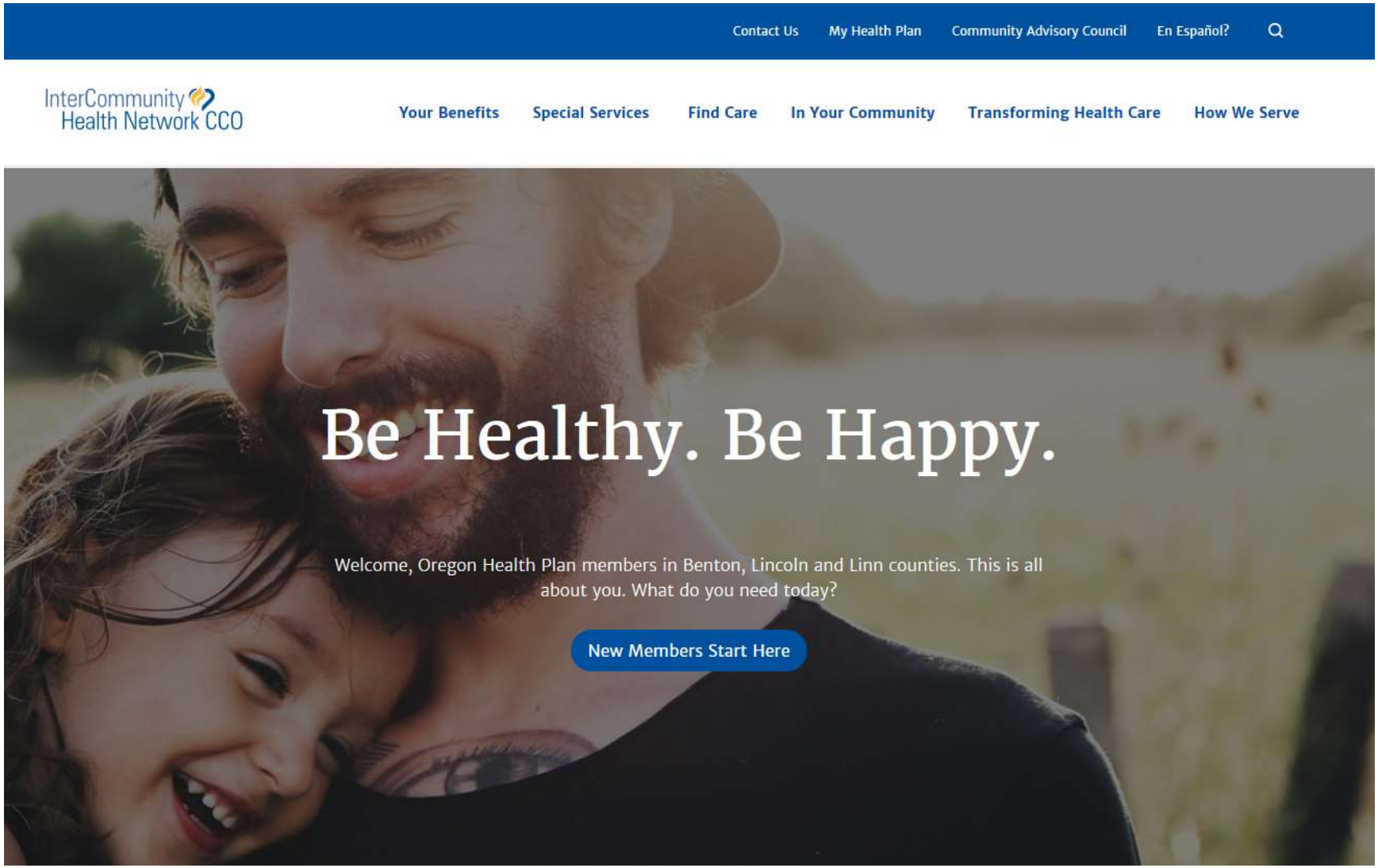
CLINICAL IMPACT OF APM

- 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

Inform	One way communication providing balanced and objective information to assist understanding about something that is going to happen or has happened.
Consult	Two way communications designed to obtain public feedback about ideas on rationale, alternatives and proposals to inform decision making.
Involve	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.
Collaborate	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.



IHNtogether.org

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

QUESTIONS

Kim Whitley
COO, Samaritan Health Plans

Sherlyn Dahl, BSN, MPH
Executive Director
Community Health Centers of Benton and Linn Counties