Council

- Tammy Baney, Chair Commissioner, Deschutes County
- Mike Shirtcliff, Vice-Chair, DMD President and CEO, Advantage Dental
- Mike Ahern Commissioner, Jefferson County
- Ken Fahlgren Commissioner, Crook County
- Chuck Frazier Citizen Representative
- Megan Haase, FNP CEO, Mosaic Medical
- Greg Hagfors CEO, Bend Memorial Clinic
- Stephen Mann, DO Board President, Central Oregon Independent Practice Association
- Linda McCoy Citizen Representative
- Karen Shepard CFO, St Charles Health System
- Dan Stevens Senior VP, Government Programs, PacificSource Health Plans
- Marc Williams, MD Behavioral Health Practitioner

Deschutes County Building DeArmond Room (Bend)
Conference Line: 1.719.325.2630
Participant Code: 137417#

Welcome—Commissioner Baney

12:30-12:35 Patient Story—Lindsey Hopper

12:35-12:45 Public Comment

12:45-1:10 Quality Incentive Measure (QIM) Update—Lindsey Hopper/Dan Stevens
- Final 2013 OHA Report (changes pending)—Lindsey Hopper/Dan Stevens
- QIM Sheets—Lindsey Hopper
- Action Item: Advise COHC staff on approach to take in developing strategy

1:10-1:20 Transformation Plan Deliverables/Update—Lindsey Hopper/Dan Stevens/Linda McCoy
- Status Report—Lindsey Hopper/Dan Stevens
- Health Equity Task Force (CAC Endorsement) —Linda McCoy
- Action Item: Prepare for significant June review and action by Board (see attached spreadsheet)

1:20-3:10 Strategic Initiative Final Reports—Wade Miller/Rick Treleaven
- Pediatric RNCC Strategic Initiative—Wade Miller (30 min)
  - Final Report
- Multi-Disciplinary Pain Clinic—Rick Treleaven (30 min)
  - Final Report
- Discussion (50 min)
  - See attached spreadsheet (from last Board meeting) re: seeking Global Budget dollars to assist in framing review and discussion.
- Action Item: Provide direction to Finance on Global Budget withhold, and provide direction to PacificSource, as applicable

3:10-3:15 Strategic Planning—Lindsey Hopper
- Survey
- Workgroup meeting schedule

3:15-3:20 COHIE Board Nomination—Tammy Baney
- Action Item: Approve nominated Board representative

3:20-3:30 CCO Operations—Dan Stevens
- Narrative update
- CCO Dashboard

Consent Agenda
- Approval of the draft minutes dated April 10, 2014 subject to corrections/legal review
- COHC Finance Report and Dashboard (new mechanism—please share feedback)
- Acceptance of Kenny LaPoint and Regina Sanchez to the Community Advisory Council

Written Reports
- Ops endorsement of Chronic Pain Strategic Initiative and Ops APM support
- SB 204 Sunset Report and supporting materials
- CCO Narrative Report
- COHC Executive Director Report
- Dental Integration Update Report
- MCH Quarterly Report
- COHC Executive Director Strategic Planning Report
- CAC Panel Reports
- Finance Committee (distributed via email)
- Provider Engagement Panel RNCC Report
- CHA/CHIP Status Report
- Health Thru Housing Funding Request for $40,000 (note application of COHC Surplus Funding Policy—this is included in the packet so that partners are aware of a need in the community and not because it will be considered by the Board for COHC funding)

FACT SHEET: Elective Delivery QIM

2013 Status:
Benchmark met (0.6%)

QIM Summary:
The purpose of this QIM is to reduce early elective deliveries—defined as inductions or C-sections occurring without medical indication between 37 and 39 completed weeks of gestation. There is evidence showing that an infant born at 37 weeks has worse health outcomes than one born at 40 weeks. OHA says it is a national priority to limit elective deliveries to pregnancies that have completed at least 39 weeks gestation.

The denominator includes Medicaid and CHIP enrollees delivering newborns with >=37 and <39 weeks of gestation completed. Multiple births are excluded. The numerator includes elective deliveries within this time frame. OHA will calculate weighted averages depending on information supplied by hospitals.

2013 benchmark: 5.0%

Primary Entities Impacting QIM:
St. Charles (all sites)
[Additions pending review with partners]

Primary Challenges:
The small data set makes this very difficult to track without bumping up against patient confidentiality concerns. This raises the question of how OHA expects CCOs in smaller markets to manage this metric. Our data issues here paint a different picture than you might see in Portland metro.

[Additions/edits pending review with partners]

QIM Contract Strategy:
[Pending discussions and review with partners]

PSCS QIM Strategy:
[Pending discussions and review with partners]

St. Charles Strategy:
[Pending information submission by St. Charles]

Ops Recommendations (To Date):
None

CAC Recommendations (To Date):
None

Opportunities for Ops:

Opportunities for CAC:

Transformation Element	July 1 OHA contract deliverable	Q2 Critical Work	Operations	CAC	PEP	Finance	Board	Notes
1. Integration	Integrated care work team project plan is approved by COHC; ongoing review of cost, quality and experience outcomes being achieved by integrated care sites.	Develop Dashboard for integration sites						UC Denver project may be used to satisfy this requirement. PS may handle the dashboard internally.
2. PCPCH Assignment	Assessment of community PCPCH certification opportunities in partnership with COHC is complete. Contractor to increase the number of Members assigned to a PCPCH clinic in places as endorsed by COHC.	Complete Assessment; Recommendations to COHC by May 1	Endorse: 4/18/2014	N/A	N/A	N/A	Endorse: 5/8/14	Unsure whether document has been created.Document not presented at 4/18 Ops meeting. Not on May Board agenda.
3. Alternative Payment	Alternative Payment Methodology (APM) work groups are established to develop recommendations on payment methodologies. APM work group recommendations endorsed by Health Councils.	Health Council endorsement of APM methodologies				Review/Finalize: 5/6/14	Endorse: 6/12/14	Element may be met on 5/6/14 by Finance. May be timely for June Board endorsement.
4. CHA/CHIP	Contractor standardizes CHA and CHIP updates considering the community partner agencies' community health assessment and plan needs	The MAPP tool is being considered; ensure approval by June COHC mtg (PS/COHC)	Update group: 5/16/14	Endorse: 5/1/14			Endorse: 6/12/14	Element has been met.
5. Health Information Exchange	Form a neutral Central Oregon HIE governance entity by the 3rd quarter of 2013, with participation from the region's largest providers. Formalize a business plan and financing plan for a comprehensive community HIE strategy by end of 2013. By July 2014, all providers participating in regional HIE governance will have interfaced their electronic health records to the HIE platform.	Conduct gap analysis with COHIE Define interface to ensure success meets spirit of proposed benchmark	Update at each meeting			Endorsed: 4/1/14	Update at each meeting	COHIE reports that they are on track to meet this deliverable.

6. Member Eng. & Communication (Tailored to Health Literacy, Cultural and Linguistic Needs of Members)	Complete written self-assessment to identify at least two (2) areas to improve Member communications with particular focus on Hispanic/Latino and Indian/Alaska Native (AI/AN) populations; Outline system requirements necessary to implement recommended changes.	Health Equity Task Force – Report & Recommendations COHC endorsement	Update group: 5/16/14	Endorsed: 5/1/14			Review: 5/8/14 Endorse: 6/12/14	Endorsed by CAC. Further endorsement neseccary and more information pending for June Board review. No review at May Board meeting.
7. Diversity & Cultural Competency	Engage all appropriate and essential partners throughout CCO to organize a committee to review, define and set Community adopted standards to be established and approved by Central Oregon and Columbia Gorge Health Councils.	Health Equity Task Force – Report & Recommendations COHC Endorsement	Update group: 4/4/14	Endorsed: 5/1/14			Review: 5/8/14 Endorse: 6/12/14	Endorsed by CAC. Further endorsement neseccary and more information pending for June Board review. No review at May Board meeting.
8. Q1 Plan to Reduce Disparities	Complete written self-assessment of system data gaps; Ensure that at least 2 operational or system changes to improve granular data collection, reporting and analysis related to language, race and ethnicity are completed. Quality Improvement Plan focused on eliminating racial, ethnic and linguistic disparities is adopted.	PacificSource Quality Disparities Study; Report May; Plan finalized June	Endorse: 5/2/14				Review: 5/8/14 Endorse:6/12/14	Document not created and no new information at this time.

Strategic Initiative Pilot Year Review
Pediatric RN Care Coordinator (COPA)
May 2014

Current Status

May 28, 2014 concludes the pilot year of the Pediatric RN Care Coordinator (RNCC) Project. At this time, the board of the Central Oregon Health Council (COHC) and community partners will review the outcomes and determine the future viability of the RNCC program. Per the contract, based upon the outcomes, an expansion or continuation is to be considered. It is critical that a decision is reached because the funding directly impacts patients and the RNCC employee in the position as of May 28, 2014. Discontinued funding would result in immediate release of patients from the panel, the RNCC position would be terminated and the employee released, and all quality incentive metric work going forward would stop. We strongly believe the delivered outcomes from this pilot represent significant savings that can be extrapolated further for even greater savings and improved patient outcomes. Therefore it is recommended that only two options be considered based on the level of investment and anticipated savings:
1) Expand the program to include the additional patients identified that qualify for this program, or
2) Extend the current program for a second year.

The RNCC monitors a panel of patients and, in accordance with each patient's individual care plan, meets with the patient and families as they are seen in the office, or provides a quarterly core service contact per the Patient Centered Primary Care Home (PCPCH) guidelines.

The RNCC at Central Oregon Pediatric Associates (COPA) is the lead contact for public health agencies and other community organizations when medical collaboration or coordination is needed for a COPA PacificSource Community Solutions (PCS) patient.

Findings

Panel Dynamics

The RNCC panel size was established using American Academy of Pediatric Care Coordination Recommendations. The panel consists of 108 pediatric patients who have chronic and complex health conditions. Eight of these patients were added to the panel at the request of PCS because they were classified as Integrated Care Management (ICM) patients. All of the patients in the panel are PCS patients and have a minimum of 2 Affordable Care Act (ACA) qualified diagnosis, or 1 ACA qualified diagnosis and 2 additional risk factors. The top ACA diagnoses represented within the panel are as follows: 36 asthma patients, 35 behavioral health patients, 28 obese patients, 25 ADHD patients and 7 diabetic patients. The age breakdown of the panel is as follows: 31 Adolescents (12 through 18 years of age), 66 children (3

through 11 years of age), and 11 infant/toddler (under 3 years of age). 31 patients or 28% of the panel are Hispanic.

ICM Panel Benefit

Emergency Department (ED) and hospital admission utilization was assessed for the 8 ICM patients of specific interest to PCS. The assessment was conducted in the following manner: In the 9-months prior to implementation of the RNCC the 8 patient panel had 21 ED visits and 31 hospital admissions. In the nine months post-implementation of the RNCC, the 8 patient panel had 12 ED visits and 12 hospital admissions. In that 9 months after the RNCC position was implemented ED visits were reduced by 9 and hospital admissions were reduced by 19. This information may allow us to reasonably project a similar benefit for the entire 108 patient panel. Although this assessment only samples a 9-month benefit period, the initial data suggests that Care Coordination of the type provided by the RNCC has reduced the frequency of ED and hospital admission utilization.

Strategic Initiative Metrics

1. Asthma Assessment

This is a self-reported metric where the target is to have >50% of the asthma patients in the RNCC panel with a documented asthma assessment. The quarterly asthma assessment includes a day-time and night-time symptom assessment in the patient's medical record, a peak flow if they were seen in the office, and an Asthma Medication Ratio (AMR) assessment if the information was available on the AMR report.

Target = >50% RNCC Outcome = 80%

2. Documented Care Plans

This is a self-reported metric where the target is to have >80% of panel patients documented as having an active Care Plan in the medical record. COPA's Tier 3 Patient Centered Primary Care Home (PCPCH) status shares in this requirement. The RNCC has maintained compliance in this area for the panel of patients throughout the project year.

Target = >80% RNCC Outcome = 100%

3. Quarterly Core Service

This is a self-reported metric where the target is to have >80% of panel patients documented as having a quarterly core service provided per the PCPCH guidelines. The RNCC has maintained 100% compliance in this area for the RNCC panel of patients throughout the project year.

Target = >80% RNCC Outcome = 100%

4. Annual Adolescent Well Child Check (WCC)

This is a self-reported metric that was added 3 months into the RNCC project year. The Coordinated Care Organization (CCO) was focused on this metric and COPA wanted to participate on a smaller scale to demonstrate care coordination influence with this metric. 29 of the adolescents within

the RNCC panel are up to date or have their annual WCC scheduled before May 31, 2014. The CCO Benchmark is ≥ 53.2%.

Target = >53.2% RNCC Outcome = 94%

5. Stratified Risk Score

This is a metric that was added 3 months into the RNCC project year and is something that we continue to assess monthly. We specifically target ED utilization, hospital admissions, overall stratified risk scores and total cost to the community. PCS provided a stratified risk score with the desire to assess the impact of the RNCC program. We will continue to work with PCS to show improvements and to quantify the overall program savings. However, the 8 ICM patients discussed earlier are a significant indicator of the potential for this program.

Organizational Metrics

In addition to the RNCC Initiative Metrics, COPA also strategically worked as an organization to meet OHA Performance Measures and PCPCH Core and Menu Quality Measures. We believe these will have additional positive impacts to our community and showcase additional impacts for this program. A brief description of those is as follows:

1. Influenza Immunization, NQF0041:

In 2012/2013 COPA gave 5,358 Flu Vaccine doses. With increased access to flu vaccine appointments and with expanded flu clinics (including additional weekend and evening appointments and appointments at all three locations) we were able to give 7,257 flu vaccine doses: or an additional 1,899 flu vaccine doses when compared to last season.

No Benchmark Yet COPA Outcome: 35% increase in doses administered

2. Developmental Screening in the first 36 months of life:

On October 28, 2013, COPA implemented standardized Ages and Stages questionnaires during routine 9 month, 24 month and 30 month Well Child Checks. We are projecting to be above the CCO benchmark by the end of 2014 with this process implementation and will continue to work with PCS to ensure we meet this metric.

Benchmark Rate: 50% COPA Outcome: 2013 10%, with 2014 projection >50%

3. Childhood Immunization Status, NQF0038:

2013 Meaningful Use data reflects all 19 COPA providers are above the benchmark in the Combination 2 immunization specifications. COPA average is 88%.

Benchmark Rate: 82% COPA Outcome: 88%

4. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, NQF0024:

2013 Meaningful Use data reflects that all 19 providers are exceeded the benchmark by having a BMI percentile assessment completed and on file.

Benchmark Rate: 50% COPA Outcome: 90%

Expanded Community Impact

Using the framework from our partners at Mosaic Medical, we have continued to refine the RNCC position and expand its reach into the community. The RNCC has taken on additional roles and responsibilities.

1. As the LAUNCH Program services are transitioning out, the RNCC has taken on this role within our organization. She will provide care coordination services for these patients and will handle any community referrals between COPA providers and community agencies.

2. The RNCC is working with the Oregon Health Authority to follow up on newborn hearing screens and psychotropic monitoring.

3. The RNCC has become the lead contact person at COPA for Neighbor Impact.

4. The RNCC has become the main contact for any community agency needing to access care coordination at COPA. (Developmental Disabilities, CaCoon, Head Start, PCS Care Management, Bend La Pine / Redmond School District).

Challenges/Board Input

1. Use of appropriate medications in children with asthma metric

This metric requires that the RNCC assess the percentage of members in the panel who were identified as having moderate to severe persistent asthma and who were appropriately prescribed medication during the measurement year. The barriers to this metric are that identifying moderate to severe persistent asthma based on chart notes is difficult and ICD-9 codes do not differentiate asthma severity. ICD-10 implementation appears to improve coding functionality but it will not be available until October 2015. Recommendation: Remove metric going forward and work to replace it with another CCO approved metric.

2. Follow up care for children prescribed ADHD medication metric

The criterion used by the CCO for ADHD follow up does not include MD telephonic, Behavioral Health Consultant (BHC), or other care coordination codes and the technical specifications will not be changed per the CCO representative. COPA has always met the intent of this metric by utilizing the above mentioned methods. COPA has implemented an ADHD follow-up process that targets meeting the technical specifications of this metric. The new process was implemented in January 2014. Training in the new process was conducted throughout January 2014. We will work with PCS going forward to monitor the new process and its effectiveness.

3. Panel selection process

The initial RNCC panel selection process began by using the recognized ACA qualified diagnosis codes. However, this list has two limiting factors: 1) Many diagnoses are not clearly defined until a child is older---asthma diagnosis codes often show up as reactive airway codes until a child is over 2 years of age, and ADHD diagnosis codes do not show up on a child's problem list until they reach

school age. 2) The ACA qualified list is missing obvious chronic conditions for the pediatric specialty---prematurity, cystic fibrosis, and cerebral palsy are just a few of the missing codes that should qualify as chronic health conditions for pediatrics. Recommendation: CCO and COPA providers work together to determine panel criterion going forward.

4. Number of complex and chronic care patients exceeds one RNCC position.

COPA has currently identified over 450 patients that would benefit from the RNCC program. Currently one RNCC position is not enough to provide services to all of the patients identified. The AAP recommends pediatric care coordination panel sizes of approximately 100 patients. Other Pediatric RN Care Coordination programs support this recommendation: specifically that RNCC position turnover increases and job satisfaction decreases as panel sizes exceed 100 patients. Recommendation: CCO board to determine number of children they would like to invest in with this program and staff the program accordingly with the proposed 1:100 ratio.

Analysis for Return on Investment (ROI)

The total investment to start the Pediatric RNCC project was $91,800. $78,000 came from PCS and $13,800 came from the COPA Providers; with the largest percentage of this total cost going directly to salary and benefits and a smaller portion going to administrative and professional costs.

We know during the immediate 9 month period following the RNCC position implementation, the smaller ICM panel of 8 patients had a reduction of 9 ED visits and 19 hospital admissions. Assuming we would achieve similar benefits with a full year of the program we would anticipate a reduction of 12 ED visits and 25 hospital admissions for these same 8 patients. Extrapolated cost savings at 50% impact and 100% impact assumptions for the entire 108 patient panel are listed below to recognize the significant potential ROI with this RNCC pilot project.

	Annual ED Visit Reduction	Annual ED Cost Savings (*$1,233 per visit)	Annual Hospital Admission Reduction	Annual Hospital Admission Cost Savings (**$7,200 per stay)	Total Annual Cost Savings in ED and Hospital Admissions
8 ICM Patients	**12**	**$14,796**	**25**	**$180,000**	**$ 194,796**
50% Success Assumption for 108 patients	81	$99,873	169	$1,216,800	$ 1,316,673
100% Success Assumption for 108 patients	162	$199,746	337	$2,426,400	$ 2,626,146

**Average ER visit cost over the cost of an office visit (Washington Post, Sarah Kliff, "An average ER visit costs more and a months rent" March 2, 2013)*

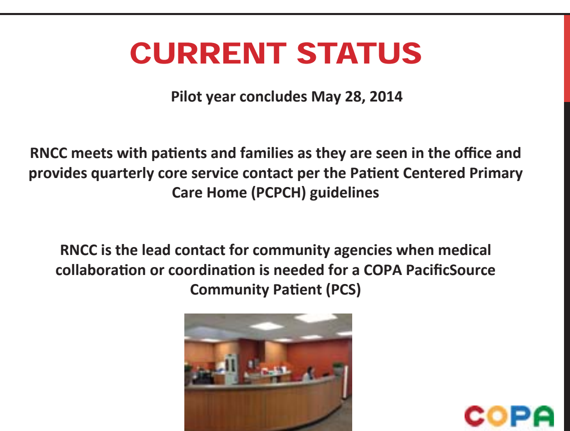
**AHRQ, Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, 2010

The program has demonstrated a positive impact on individual health and a cost savings within the community which supports, at a minimum, extending the project for an additional year. A decision to expand the RNCC project suggests the potential to improve the overall health of our community while capturing additional savings on a larger scale. It is COPA's desire to continue the partnership with the CCO partners and expand the program within their scope and vision for care coordination within the community.

	Option 1 Extend Program (1 RNCC)	**Option 2A** Expand Program (2 RNCCs)	**Option 2B** Expand Program (3 RNCCs)
Investment	$91,800	$183,600	$275,400
Patient Panel Size	100 patients	200 patients	300 patients
Estimated Annual Savings to Global Budget (using 50% assumption)	$1.3 M	$2.6 M	$3.9 M

STRATEGIC INITIATIVE METRIC RECAP FOR PILOT YEAR

Accountable / Domain	Quality Indicator	Current	Target	Comments
RNCC NQF 001	Asthma Assessment	Sep 2013: 46% Dec 2013: 76% Mar 2014: 80% **April 2014: 80%**	>50% Asthma Panel Patients have an Asthma Assessment Documented (day/night symptoms, medication use, peak flow if possible)	**MEETING**
RNCC NQF 0036	Use of appropriate medications for children with asthma		>50% Asthma Panel Patients	See Challenges for barriers to meeting metrics
RNCC Medical Home Requirement	Follow up care for children prescribed ADHD/ADD medication		>50% ADHD/ADD Panel Patients	January 2014, COPA implemented process that will meet this metric going forward.
RNCC Medical Home Requirement	Medical Home patients identified will have a documented plan of care	Sep 2013:100% Dec 2013: 98% Mar 2014: 100% **April 2014: 100%**	≥80% of all Panel patients have a documented plan of care	**MEETING**
RNCC Medical Home Requirement	Medical home patients will have core service follow up quarterly	Sep 2013: 92% Dec 2013: 98% Mar 2014: 100% **Apr 2014: 100%**	≥80% of all Panel patients have a quarterly core service documented	**MEETING**
RNCC *CCO Metric	Annual Adolescent WCC	Sep 2013: 45% Dec 2013: 45% Mar 2014: 86% **Apr 2014: 94%**	≥ 53.2% of all Panel patients 12 years and older have an updated WCC appointment (CCO Benchmark)	**MEETING**
RNCC *PCS Risk Score	Stratified Risk Score	Monthly Tracking	Monthly tracking continues to watch for trends	**ONGOING**



RNCC PANEL SELECTION

AAP Care Coordination Recommendations:
(100 Patient Panel Goal)

Step 1: Initial Panel Qualifications
- PCS patient
- 2 ACA diagnoses or 1 ACA diagnosis and 2 risk factors

Identified >450 patients

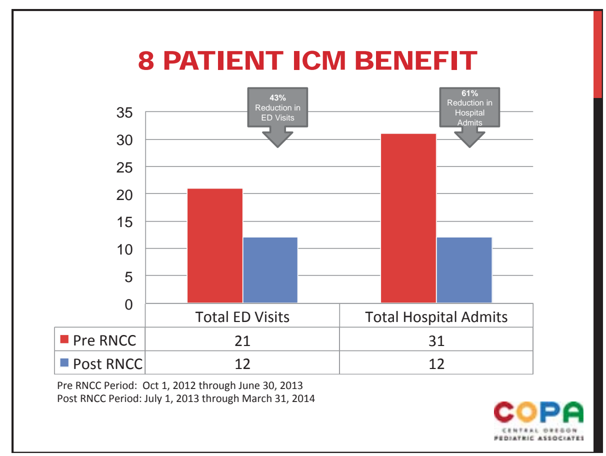
Step 2: Final Panel Qualifications
- Top ED utilizers
- Top Office visit utilizers
- Physician input and preference

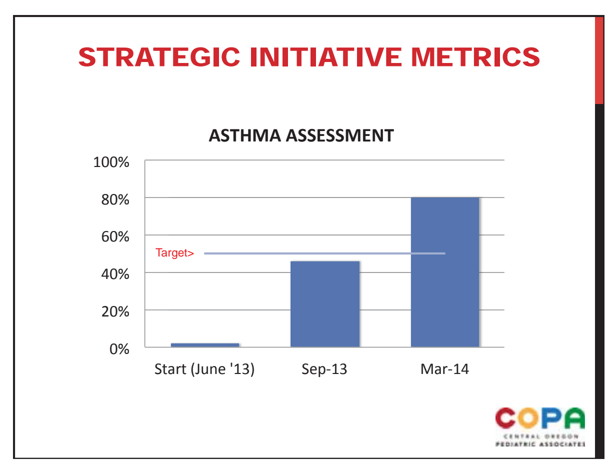
FINAL PANEL DYNAMICS

(108 Patient Panel Total)

Demographics:
- ✓ 31 Adolescents (12 through 18 years of age)
- ✓ 66 children (3 through 11 years of age)
- ✓ 11 infants/toddlers (under 3 years of age)
- ✓ 31 Hispanic patients

Diagnosis:
- ✓ 36 Asthma
- ✓ 35 Behavioral Health
- ✓ 28 Obesity
- ✓ 25 ADHD
- ✓ 7 Diabetes
- ✓ 13 ICM


8 PATIENT ICM BENEFIT
43% Reduction in ED Visits
61% Reduction in Hospital Admits
35
30
25
20
15
10
5
0
Total ED Visits
Total Hospital Admits
Pre RNCC 21 31
Post RNCC 12 12
Pre RNCC Period: Oct 1, 2012 through June 30, 2013
Post RNCC Period: July 1, 2013 through March 31, 2014
COPA
CENTRAL OREGON PEDIATRIC ASSOCIATES


STRATEGIC INITIATIVE METRICS
ASTHMA ASSESSMENT
100%
80%
60%
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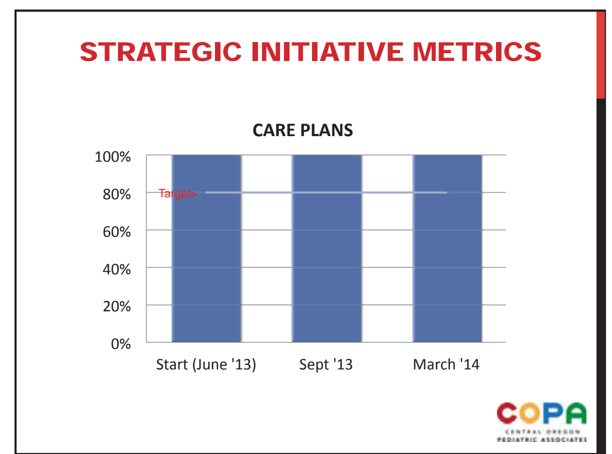
Target>
Start (June '13)
Sep-13
Mar-14
COPA
CENTRAL OREGON PEDIATRIC ASSOCIATES


STRATEGIC INITIATIVE METRICS
CARE PLANS
100%
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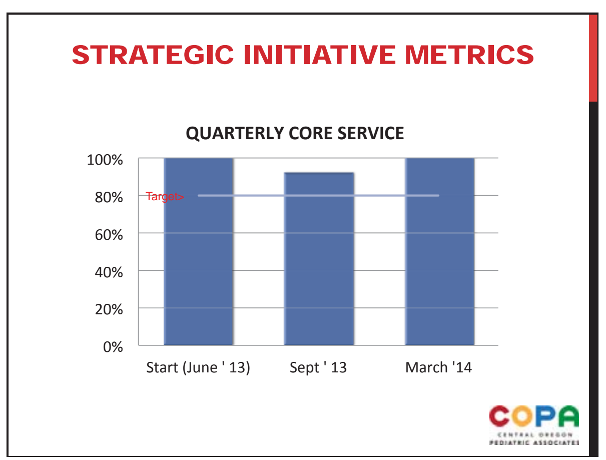
Target>
Start (June '13)
Sept '13
March '14
COPA
CENTRAL OREGON PEDIATRIC ASSOCIATES


STRATEGIC INITIATIVE METRICS
QUARTERLY CORE SERVICE
100%
80%
60%
40%
20%
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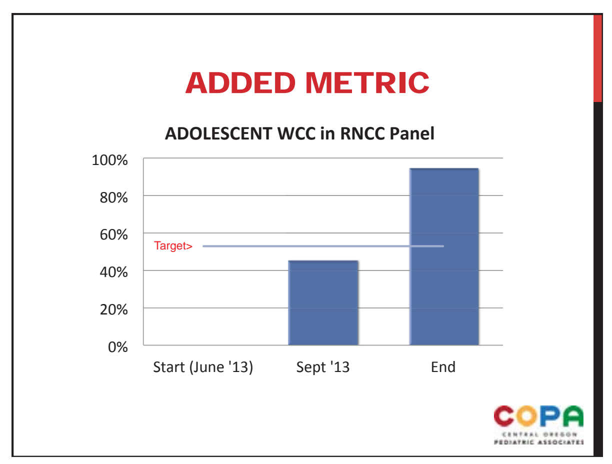
Target>
Start (June ' 13)
Sept ' 13
March '14
COPA
CENTRAL OREGON PEDIATRIC ASSOCIATES

ADDED METRIC



ORGANIZATIONAL METRICS

Developmental Screening in the first 36 months of life

- October 28, 2013, COPA implemented Ages and Stages Questionnaires during 9 month, 24 month and 30 month Well Child Checks. On target to be above the CCO benchmark of 50% at the end of 2014.

Childhood Immunization Status, NQF0038

- 2013 Meaningful Use attestation that all 19 COPA providers are above the benchmark of 82% in the Combination 2 immunization specifications. COPA average 88%!

Weight Assessment and Counseling for Nutrition and Physical Activity for Chilren/Adolescents, NQF0024

- 2013 Meaningul Use attestation that all 19 COPA providers are above the benchmark of 43%. COPA average is 90%

EXPANDED IMPACT

1. As LAUNCH Program services are transitioning out, the RNCC is picking up this role within our organization
2. Working with Oregon Health Authority to follow up on newborn hearing screens and psychotropic monitoring
3. Lead Contact person for Neighbor Impact
4. Contact point for any community agency

Developmental Disabilities
CaCoon
Head Start
PCS Care Management
Bend La Pine / Redmond School District

CHALLENGES

1. Use of Appropriate medications in children with asthma metric

Current diagnoses and coding with ICD-9 does not differentiate between asthma severity. ICD-10 implementation appears to improve coding functionality but it will not be available until October 2015.

2. Follow up care for children prescribed ADHD medication metric

Criterion used by the CCO for ADHD follow up does not include MD telephonic, Behavioral Health Consultant, or other care coordination codes. COPA has implemented an ADHD follow-up process that targets meeting the technical specifics of this metric. Process implemented in January 2014.

CHALLENGES

3. **Panel Selection Process**

   ACA qualified diagnoses have limitations:
   - Often diagnosis are not clearly defined until a child is older
     - Asthma shows up as Reactive Airway until 2 years of age
     - ADHD not diagnosed until children are school aged
   - Missing known chronic pediatric diagnoses
     - Cystic Fibrosis, Prematurity, and Cerebral Palsy

4. **Number of complex and chronic patients exceeds one RNCC position**

   Currently over 450 patients identified that would benefit from the RNCC program. One RNCC position is not enough to provide services to all of the patients identified.

RECOMMENDATIONS

- **Remove appropriate medications in children with asthma metric and replace with CCO approved metric**
- **CCO and COPA providers work together to determine panel criterion going forward. We believe we can have an even more impactful outcome that will help meet additional CCO metrics.**
- **CCO board to determine number of children they would like to invest in with this program and staff the program accordingly with the proposed 1:100 ratio**

RETURN ON INVESTMENT (ROI) ANALYSIS

	Annual ED Visit Reduction	Annual ED Cost Savings (*$1,233 per visit)	Annual Hospital Admission Reduction	Annual Hospital Admission Cost Savings (**$7,200 per stay)	Total Annual Cost Savings in ED and Hospital Admissions
8 ICM Patients	**12**	**$14,796**	**25**	**$180,000**	**$ 194,796**
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**AHRQ, Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, 2010

OPTIONS FOR PROGRAM WITH ROI

	Option 1 Extend Program (1 RNCC)	**Option 2A** Expand Program (2 RNCCs)	**Option 2B** Expand Program (3 RNCCs)
Investment	$91,800	$183,600	$275,400
Patient Panel Size	100 patients	200 patients	300 patients
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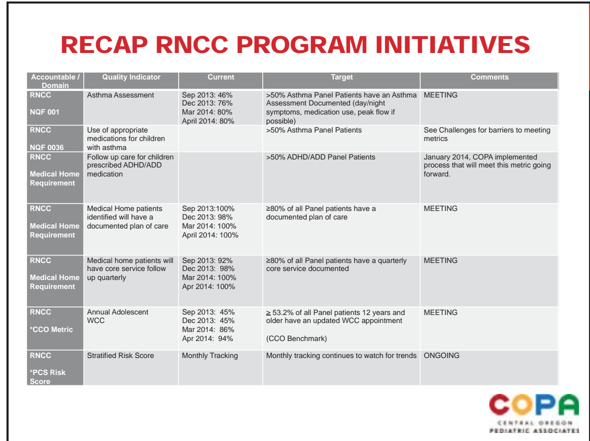
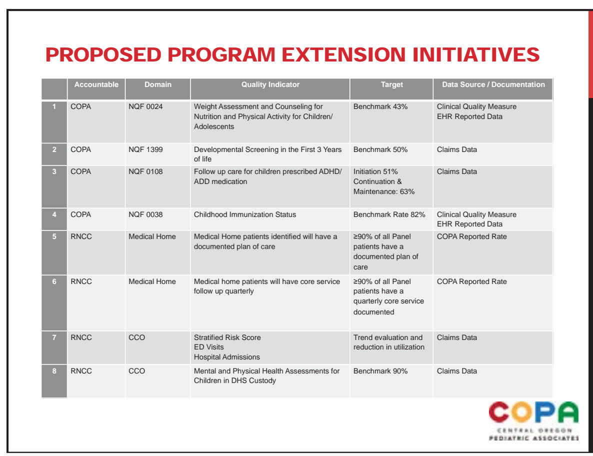


RECAP RNCC PROGRAM INITIATIVES

Accountable / Domain	Quality Indicator	Current	Target	Comments
RNCC NQF 001	Asthma Assessment	Sep 2013: 46% Dec 2013: 76% Mar 2014: 80% April 2014: 80%	>50% Asthma Panel Patients have an Asthma Assessment Documented (day/night symptoms, medication use, peak flow if possible)	MEETING
RNCC NQF 0036	Use of appropriate medications for children with asthma		>50% Asthma Panel Patients	See Challenges for barriers to meeting metrics
RNCC Medical Home Requirement	Follow up care for children prescribed ADHD/ADD medication		>50% ADHD/ADD Panel Patients	January 2014, COPA implemented process that will meet this metric going forward.
RNCC Medical Home Requirement	Medical Home patients identified will have a documented plan of care	Sep 2013:100% Dec 2013: 98% Mar 2014: 100% April 2014: 100%	≥80% of all Panel patients have a documented plan of care	MEETING
RNCC Medical Home Requirement	Medical home patients will have core service follow up quarterly	Sep 2013: 92% Dec 2013: 98% Mar 2014: 100% Apr 2014: 100%	≥80% of all Panel patients have a quarterly core service documented	MEETING
RNCC *CCO Metric	Annual Adolescent WCC	Sep 2013: 45% Dec 2013: 45% Mar 2014: 86% Apr 2014: 94%	≥ 53.2% of all Panel patients 12 years and older have an updated WCC appointment (CCO Benchmark)	MEETING
RNCC *PCS Risk Score	Stratified Risk Score	Monthly Tracking	Monthly tracking continues to watch for trends	ONGOING



PROPOSED PROGRAM EXTENSION INITIATIVES

	Accountable	Domain	Quality Indicator	Target	Data Source / Documentation
1	COPA	NQF 0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	Benchmark 43%	Clinical Quality Measure EHR Reported Data
2	COPA	NQF 1399	Developmental Screening in the First 3 Years of life	Benchmark 50%	Claims Data
3	COPA	NQF 0108	Follow up care for children prescribed ADHD/ ADD medication	Initiation 51% Continuation & Maintenance: 63%	Claims Data
4	COPA	NQF 0038	Childhood Immunization Status	Benchmark Rate 82%	Clinical Quality Measure EHR Reported Data
5	RNCC	Medical Home	Medical Home patients identified will have a documented plan of care	≥90% of all Panel patients have a documented plan of care	COPA Reported Rate
6	RNCC	Medical Home	Medical home patients will have core service follow up quarterly	≥90% of all Panel patients have a quarterly core service documented	COPA Reported Rate
7	RNCC	CCO	Stratified Risk Score ED Visits Hospital Admissions	Trend evaluation and reduction in utilization	Claims Data
8	RNCC	CCO	Mental and Physical Health Assessments for Children in DHS Custody	Benchmark 90%	Claims Data

WHY COPA'S PROGRAM?

- COPA single handedly covers nearly half of all OHP children in the tri-county region – 9,011 in total as of March, 2014 and growing.
- The pilot program targeted just over 1% of these children
- With such significant volumes, together we can specifically target the children with the most to gain, improve their lives, reduce time away from school all while saving substantial global budget dollars.
- COPA is open 7 days a week, 364 days per year – that means access when you need it most, until 8PM evenings, every weekend and holidays too. Access, plus a ready alternative to the ER.

Dr. Mary Brown, Dr. John Chunn, Dr. Val Bailie, Dr. Dale Svendsen, Dr. Brenda Hedges, Dr. Caroline Gutmann, Dr. Kim Wollmuth, Dr. Jen Lachman, Dr. John Peoples, Dr. Erin Garza, Dr. Dana Perryman, Dr. Megan Karnopp, Dr. Logan Clausen, Dr. Linda Steiner, Dr. Mary Rogers, Carissa Honeycutt PA-C, Cris Ricker PA-C, Joeth Ryan PA-C, Hailey Garside PNP

PROVIDER ENGAGEMENT PANEL REPORT TO COHC
RN Care Coordinator Strategic Initiative (COPA)

PEP Meeting Date:	April 8, 2014
PEP Meeting Location:	Virtual
PEP Meeting Focus:	RNCC Strategic Initiative
Participants:	Lindsey Hopper, COHC Zach Pangares, COHC Muriel DeLaVergne-Brown, MPH, RN—Crook County Phillip Dove, MD—La Pine Community Health Center Dana Perryman, MD—Central Oregon Pediatric Associates Kim Swanson, PsyD—St. Charles Sharity Ludwig, B.S., RDH, EPP—Advantage Dental

General Comments on the Project:

The RNCC work is similar to pure prevention work, which means that the work can be hard to track and make for difficult ROI calculations.

Comments on Project Data and Representations:

Participants observed that it appeared COPA had met most of its target metrics.

Discussion Questions:

1. With what COPA has learned, what are the elements of this project that might be applicable to other communities?
   - Dr. Dove asked how this project might be replicable in La Pine and what COPA had learned.
   - Dr. Perryman commented on the issue of how to pay for the RNCC without wraparound payments.
   - Dr. Perryman also noted that the RNCC was able to provide good assistance connecting people to community services and in seeking services outside the region when required.
2. In what area with this project did COPA see the most results and achieve the most successes?
   - Question was asked by Dr. Dove.
   - Dr. Perryman reported the following: initiation of asthma care plans, follow-up and better care for kids with diabetes, and helping address multiple needs for kids and families with chronic conditions.
3. Some of the QIMs are not a great fit for some providers. Are there other benefits/metrics that could be tracked with a similar project elsewhere?
   - Dr. Dove noted that the ADHD metric, for example, is not a great fit for what he observes in La Pine. He sees many kids coming in on meds because in small communities, it is difficult for kids and families

to get services and medication can be one way of dealing with that access challenge. For his clinic, success might be getting someone off ADHD medications when they are inappropriately prescribed and no in meeting the follow-up requirements for the ADHD QIM.

- Dr. Dove would prefer to see some way to track student grades or improvement of patient welfare.
- Discussion of issues surrounding multiple EHR platforms in the region.
- Lindsey observed that this discussion highlights that some QIMs are not an accurate picture of better care in every scenario or community.

4. How should COPA address tracking asthma efforts because the coding does not capture severity?
    - Dr. Dove suggested tracking uses of inhaler or certain tracked episodes.
    - Discussion was had regarding different EMR platforms in the region. Dr. Dove reported that he could generate run reports on items like inhaler use and had done similar work regionally with multiple providers on the same platform. Dr. Perryman reported that such reports could not be easily generated and shared by different EMR platforms.
    - Dr. Dove wondered whether it would be easier to track BMI or some other childhood obesity measure.
    - Lindsey suggested an entirely different measure if COPA succeeds in securing funding from PacificSource. It does not make sense to fight coding challenges if COPA has a chance to address them going into a new funding arrangement.
5. Does the RNCC save money on a cap payment structure?
    - Dr. Perryman was unsure [Lindsey followed-up with Wade Miller, CEO of COPA—see below].
    - Muriel asked for more information about this, because internal savings are part of ROI and relevant for folks who operate under a cap.
    - Alternative payment methodologies may change how ROI should be calculated for this type of project.

Follow-Up Questions/Comments/Issues:

1. Consider how Mosaic developed its metrics over time. What initial successes/challenges did Mosaic encounter in implementing its similar program?

2. Wade Miller reported that while the RNCC may reduce the number of inappropriate COPA office visits, COPA did not experience significant ROI/internal savings as result. COPA has capacity for office visits—often the same day or in several days. COPA does not directly realize savings for diverted or avoided ER visits. COPA also does not capture community savings when the RNCC connects children and families to appropriate community resources or programs.

STRATEGIC INITIATIVE FINAL REPORT

MULTI-DISCIPLINARY PAIN CLINIC (MPC)

A joint project between
The Center
and BestCare Treatment Services

The Need

For people covered by Medicaid, poorly managed pain is a leading cause of:

- Lower patient satisfaction with medical care
- More difficulty in life functioning
- High utilization of health care services
- Contributes to depression, anxiety, and substance abuse

Target Population and Goals

Target Population

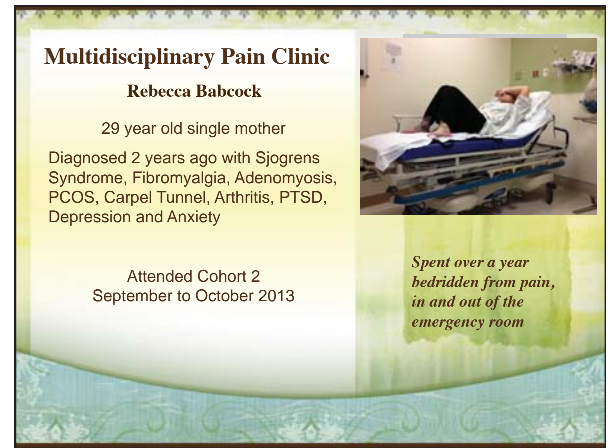
- Chronic, non-cancer pain
- Persistent ADRB's
- No identified active substance use disorder
- Annual health care spend > $2,000

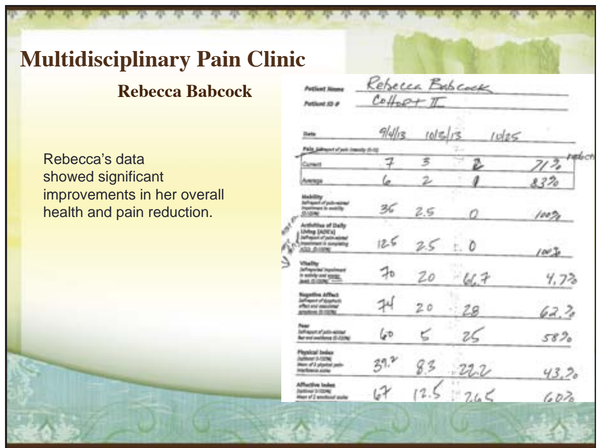
Goals

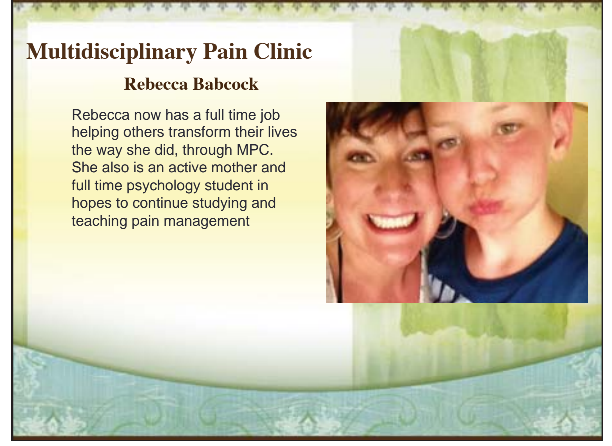
- Increased pain management skills and self-efficacy
- Decreased perceived pain
- Increased functioning
- Decrease use of opioid medications

Who Were the People We Served?

- Most were end of the line medically, because they had exhausted other medical treatment protocols.
- Continued to experience chronic, unmanaged pain that caused life damaging consequences
- High level of chronic stress
- High levels of depression and anxiety
- High feelings of anger, desperation, and hopelessness
- Often had high levels of conflict with their medical providers







Key Clinical Staff

James Nelson, MD

Physical Medicine and Rehabilitation, The Center

Mary Wells, LCSW

Pain Management Specialist, BestCare Treatment Services

Rebecca Babcock

Community Health Worker (Pain Specialty)

Core Services

- Eight week program
- Physical and behavioral health assessment
- Trial on non-narcotic pain medications
- Patient education on pain and pain management
- 1x1 coaching and counseling
- Management of co-morbid psychiatric conditions
- Community Health Worker
- Mindfulness-based pain management
- Acupuncture, Massage & Yoga
- Referral to physical therapy

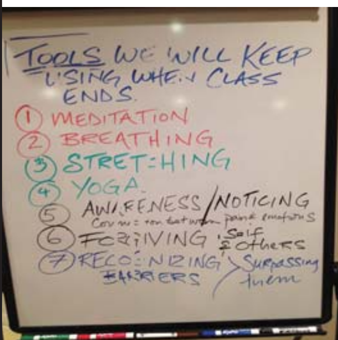
Connection

- Sharing
- Listening
- Identifying the old "pain story" and creating the New story
- Building and Maintaining Trust
- Keeping the space and the Group Safe

Eight Week Curriculum

1. Pain and the Brain
2. Pain and Sleep
3. Pain and Medication
4. Pain, Anxiety, Depression, and Stress
5. Pain and Relationships
6. Learned Neuro-pathways: both tissue and non-tissue based pain
7. Pacing and Flare-up Management (Movement!)
8. Reaffirming Healthy Reward System

A Typical Day at the Clinic



- Meditation
- Sharing and Connection
- Education
- Yoga
- Massage
- Homework

A Typical Day at the Clinic

We always provide lunch:

Teach an Anti-Inflammatory Diet

Introduce people to vegetables, fruit, and lean proteins

A Typical Day at the Clinic

Objectives for Determining Return on Investment

- Decrease overall health care spend by more than $1,700 in first year post-intervention
- Favorable patient satisfaction
- Favorable physician satisfaction

Outcomes

Overall

- We ran five cohorts
- All cohorts showed improvements that were clinically and statistically significant
- On average, reported pain, depression, & anxiety dropped by half
- Patient emotional distress dropped by 44%
- Patient physical functioning improved by over a third

Outcomes

Patient Retention, Patient Satisfaction, & Provider Satisfaction

Patient Retention: 85% of the patients completed the program

Average Patient Satisfaction Scores per cohort ranged from 3.76 to 4.84 on a 5-point scale

Referring Providers were universally supportive of the program at a three-month follow-up survey

Outcomes

Pain Outcomes Profile (POP)

- Current Pain: Cut in half (except cohort 3)
- Average Pain: Cut in half (except cohort 3)
- Physical Index *(self report on physical limitations imposed by pain)*: Improved by about a third
- Affective Index *(self report on emotional distress caused by pain)*: Average improvements per cohort ranged from 25% to 62% (except cohort 3)

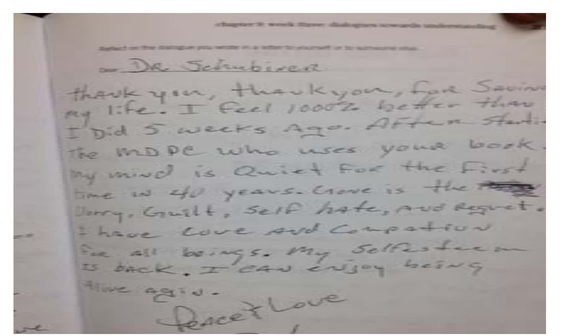
Outcomes

Depression and Anxiety

- PHQ-9: Most scores went from moderately severe depression to within normal range
- GAD-7: Most scores dropped from moderate anxiety to mild anxiety or to within normal range

These changes were both statistically valid and clinically meaningful

How Did the Lives of Patients Change?



Dr. Schubiner

thank you, thank you, for Savin
my life. I feel 1000% better than
I Did 5 weeks Ago. After Starti
The MDPE who uses your book.
My mind is Quiet for the First
time in 40 years. Gone is the
Worry, Guilt, Self hate, and Regret.
I have Love and Compassion
For all beings. My Selfesteem
is back. I can enjoy being
Alive again.

Peace & Love

Return on Investment

Return on Investment Study

- We attempted to run a report on ROI
- Some indications that it was running in the right direction
- Far too early to make any conclusions

Return on Investment

- In the 60 days before treatment, the MPC patients had cost on average $1,297
- In the year before entry into the MPC, the MPC patients had cost an average of $14,920
- The ROI question for the MPC: with these outcomes, can the clinic reduce the average health care spend for these patients by 21% in the following year, from $14,920 to $11,786?

Funding Idea

- The Multi-disciplinary Pain Clinic costs $250,000 a year and is very likely to reduce costs for all three of the capitated contracts under the CCO: hospital, COIPA, and WEBCO.
- Fund the clinic with proportional amounts from each contract. The burden per contract would be small, and the return on investment easier to see.

Conclusion: A Dilemma

The Health Care community of Central Oregon funded the Strategic Initiatives to discover practices that were innovative, integrative, and would meet the Triple Aim.

The Multi-Disciplinary Pain Clinic is a successful example of a Strategic Initiative. It worked and we saw outcomes that were better than we had hoped for.

There is no mechanism to fund the successful Strategic Initiatives going forward. The MPC has been shut down.

Conclusion: A Dilemma

The successful conclusion of the Strategic Initiatives puts the CCO in Central Oregon at a crossroads:

Can it solve the problem of how to fund innovative approaches that improve health care?

Or will the CCO just be an exercise in better managing the existing silos?

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Strategic Initiative Final Report
MULTI-DISCIPLINARY PAIN CLINIC
April 2014

Project Description

For people covered by Medicaid, poorly managed pain is one of the leading causes of patient dissatisfaction with medical care, poor life functioning, and high utilization of health care services. Recognizing this, PacificSource Community Solutions and the Central Oregon Health Council identified the implementation of a comprehensive pain management program as a Year One goal for the Coordinated Care Organization. A comprehensive approach to pain management would include patient education delivered in primary care, a specialty pain management program, and a co-occurring addiction and pain management program.

Though there is broad community support for a comprehensive approach to pain management, and there is good evidence that behavioral health approaches are clinically effective, there has been little work done to show the cost-effectiveness of these interventions in the Medicaid population. Poorly managed chronic pain is part of the clinical presentation of nearly every high utilizing adult in the CCO plan. A comprehensive pain management system should produce significant improvements in patient outcomes and significant cost savings. In an era of zero sum health care budgets, this hypothesis needs to be tested. The Multi-Disciplinary Pain Clinic (MPC) was set up as a time-limited trial of a specialty pain management program, testing for efficiency, clinical outcomes, and cost-benefit. The purpose of this report is to provide Pacific Source Community Solutions and the Central Oregon Health Council the data and analysis from this trial, so that these bodies can make an informed decision on the continuation or expansion of these services.

The MPC engaged complex pain patients that currently are high utilizers of medical services, and/or demonstrated aberrant behaviors with regard to their opioid medication. The 8 week group format program provided: pain and lifestyle education, alternative evidence-based treatments, brief counseling, and coordination with the patient's medical team with the goal of improving coping, functioning and reducing pain and medical utilization. Opioid and benzodiazepine tapering were frequent treatment goals. Groups of up to 10 patients were gathered for the intensive process 3 days per week. Two groups were run in an overlapping schedule. Breaks between concurrent groups were utilized to engage new pain patients, provide support and training, and to provide coordination of follow up care with primary care services. Follow-up services include a support group and continuation of alternative treatments.

Patient Characteristics

Criteria for entry into the program: Patients were eligible for the program if they were currently on Oregon Health Plan, had chronic, non-cancer pain, and had at least $2,000 in medical spend in the last year. People with active addiction were determined to be ineligible.

After Cohort 3, we implemented improved processes that ensured that prospective patients were medically stable, in that they had already received a competent course of treatment and were still left with chronic, unmanageable pain.

The patients we admitted were almost all at the end of the line medically. There was nothing else for them and they still hurt and their lives were deteriorating to an extent that they were angry, desperate, depressed, and of course anxious. Admitted patients were those who had exhausted other medical treatment protocols. They continued to experience chronic, unmanaged pain that caused negative, life damaging consequences, coupled with feelings of anger, desperation, and hopelessness that contributed to co-occurring anxiety and depression. They were mostly poor and almost all had mental health issues and significant psychosocial stress. Almost all had multiple medical concerns and many were in recovery from drugs and alcohol addiction.

Characteristics of cohorts 1, 2, 4, and 5 were roughly similar. Due to errors in patient selection, cohort 3 had a number of patients who were medically unstable and had significant behavioral health problems, a combination that resulted in particularly low motivation.

Findings

Overall: The MPC ran five cohorts. All cohorts showed improvements that were clinically meaningful and statistically significantly during the treatment phase. On average, patient reported pain, depression, and anxiety dropped by half. Patient physical functioning improved by over a third and patient emotional distress dropped by 44%.

Patient Retention: Thirty-five patients completed the program, while six dropped out, giving us an 85% completion rate. These are particularly impressive scores given that these patients were usually referred to the clinic precisely because they were difficult patients and had histories of high no-show rates and poor follow-through with recommended treatment. This shows a high acceptance and engagement with this form of treatment.

Pain Outcomes Profile (POP): The cohorts' reported "current pain" on entry into the program ranged from a mean high of 7.2 to a mean low of 5.29 on a ten point scale. This means that as they were filing out the forms on the first day, this was a pretty uncomfortable group of people, with some people in the group experiencing a lot of

pain. The cohorts' reported "average pain" upon entry into the program ranged more narrowly from a mean high of 7.4 to a mean low of 6.25 on a ten point scale. This was a group of people who most days, most of the time, were experiencing so much pain that they could not function normally in their lives. With the exception of cohort 3, the other cohorts reported that their current and average pain was cut in half. Even in cohort three, where co-occurring behavioral health issues dominated, we saw gains in their reported pain.

The Pain Outcome Profile for the Physical Index and the Affective Index are averages on a 100 point scale. On entry, the cohorts' average scores were in the middle range on both the PI and AI, with the low mean at 43.7 and the high mean at 61.83. This means that at entry, on average, patients felt that they had lost half of their functioning due to their chronic pain. With the exception of cohort 3, the patients' perception of their physical functioning improved by around a third, and their experience of emotional distress improved from 25% to 62%.

PHQ-9 and GAD-7: The PHQ-9 is a depression screening tool widely used in primary care, and the GAD-7 is a widely used scale for anxiety. The average scores for people entering the program represented moderate to moderately severe depression and moderate anxiety. Consistent with their chronic pain, these patients presented with life damaging levels of depression and anxiety well beyond clinical threshold. On average, patients' scores on these two scales dropped in half during the eight weeks of treatment, many times into the normal range of function. Surprisingly, cohort 3 reported greater decreases on the depression and anxiety scales than their reported reduction in experienced pain. The drops in the scores are clinically significant, with most people dropping into a normal range for depression and anxiety.

SUD Screening

On entry into the program all patients were given two screening tools, the Addiction Behaviors Checklist (ABC) and the Opioid Risk Tool (ORT). Consistently, the patients scored low on the ABC, but moderately high on the ORT. These measures demonstrate effective patient selection for the program, including patients not in active addiction, but who are often physically dependent on opioid analgesics and in considerable physical and emotional distress. Only one patient was identified as in active addiction and engaged in outpatient substance use disorder treatment. Many patients were in recovery from addiction and struggling to manage their chronic pain and its consequences without relapse. The presence of poorly managed chronic pain creates a higher risk of return to active addiction. These patients were often our most motivated members of the group.

Patient Satisfaction Surveys

There were methodological problems with the patient survey provided to the first cohort, so their responses that not been included. A new survey was implemented with cohort two and completed for all subsequent cohorts. At the end of treatment, patients were given a 15 question patient satisfaction survey, with 13 questions answered on a 5 point scale and two questions were narrative. The ratings were 5 = GREAT, 4 = GOOD, 3 =

OK, 2 = FAIR, and 1 = POOR. The survey had three questions on the referral process, six questions on the clinical components, and four questions on overall impressions of the program. The patients reported high scores for the referral process. Most of the scores for the clinical processes were high. Of the clinical components, the encounters with the doctor were rated the lowest, perhaps related to the planned decrease in their prescription pain medications. Massage therapy was the one modality that all patients scored at a "5", indicating a very high value that patients placed on this service. Question #12 "Do you feel that your pain levels have been reduced?" elicited a highly variable response, with cohorts 2 and 4 endorsing high responses, while cohort 3 and 5 giving this question their lowest scores. We do not have a working hypothesis for this variation. In the narrative question "What skills/tools work the best for you?" the most common response was meditation and the second most common was yoga.

Physician Satisfaction Surveys
Nine physicians returned surveys that were given three months after their referred patient completed the program. The physicians came from The Center, Desert Orthopedics, Mosaic, and St. Charles Family Care, and represented the majority of the referring physicians. We asked four "yes/no" questions:

1. Do you feel your patient has demonstrated improved outcomes as a result of MPC?
2. Do you view the program as beneficial and medically efficient?
3. Does this program improve your job satisfaction in providing care to complex patients with persistent problems?
4. Would you recommend this program to other providers for referring their pain patients?

All the physicians answered yes to all the questions, with many enthusiastic comments added.

Return on Investment
The actual cost per patient to deliver this program was $3,075. The experiment that was at the core of the Pain Management initiative was to pilot a program that would decrease patients' perceived pain, increase their functioning, and decrease their health care utilization enough to pay for the program. The initial prediction was that by six months post-treatment we would see strong trends toward recoupment of the expense, and after one year we would see clear evidence.

There has not been a sufficient post treatment period to document a return on investment for this program:

- Only the first three out of five cohorts had any time after treatment for a post period. Cohort 4 and cohort 5 were excluded from the ROI analysis as there had not been 60 days' worth of claims for a post period for them when the analysis was conducted.
- Five of the patients in the remaining cohorts were excluded because they were not enrolled on OHP for the entire pre and/or post period.
- The 15 patients that remained do not represent a large enough sample size to determine ROI.

- Among those 15, there were no substantial or statistically significant changes in their claims experience.

Given these limitations, there were possible reductions in proportion of days covered with opiate prescriptions (though not statistically significant, and possibly due to chance). The same dynamic can be seen with morphine equivalent dosing, a possible reduction, but not enough data points to determine statistical significance.

All the other items in the review, such as ER visits, visits with a specialist, or opiate drug costs, did not have changes that were substantive or statistically significant. Again, the "N" is so small and the time period so short, that any result, positive or negative, has so be viewed as inconclusive.

Analysis of Metrics

This program exceeded our expectations for outcomes. A patient population of poor and distressed people who had exhausted standard medical care and still experienced significant chronic unmanaged pain, reported significant drops in pain, increased mobility, capacity for self-care, and reported mood, while decreasing their use of prescription pain medications. High program completion rates and high patient satisfaction scores reflect patient engagement, critical to achieving outcomes in this sort of intervention. The high satisfaction rates reported by the referring providers are related to ease of referral into the program and real gains they observed when their patients returned. ***We have multiple lines of evidence that this program is achieving clinically significant results with a challenging and expensive patient population.*** The patient cohorts have not been treated and observed long enough to fully determine whether the intervention decreases future medical utilization enough to financially offset the expense of the program.

Conclusions and Next Steps

PacificSource Community Solutions and the Central Oregon Health Council face a difficult dilemma. The Multi-disciplinary Pain Clinic was a clinically successful intervention, popular with both patients and referring providers. The MPC addressed a key strategic goal of the COHC, managing the chronic pain needs of CCO members. The MPC focused on a high-spend, highly distressed patient population. It is likely that such a successful intervention with this population will produce savings in future health care spend. We will not be able to document a clear return on investment for a minimum of five months. The program was shut down in March 2014. Implementation of such a program is complex. Finding the staff with the right training and drive in the future is not guaranteed. Each month that the program remains shut down makes it more difficult to reinstitute. The CCO runs a high risk that it will lose the opportunity to make the kind of change in practice that is the whole purpose of the CCO structure. Yet, the ongoing funding mechanism for this practice is not immediately clear. Though this is a small program, the problem it presents goes to the core of whether the CCO, as currently structured, can actually implement the kind of innovative and integrated services to meet the complex needs of such challenging patients.

PSCS and the COHC appear to have three options at this conjure:

1. Eliminate funding to manage chronic pain needs of members with effective psycho-social approaches such as the MPC going forward.
2. Fund the program for at least a six month period, using temporary or one-time funds.
3. Identify a mechanism to fund the program through the global budget.

CCO's were set up to be laboratories to experiment on creating methods of care that can transform health care. The Strategic Initiatives came about by the key parties to the CCO creating a fund to experiment on promising practices The Multi-disciplinary Pain Clinic, along with other successful approaches, is an example of the kind of initiative we hope can be transformative. Solving the problem of how to provide ongoing funding to successful experiments that improved health care delivery will help determine whether the CCO will be a transformative agent, or simply an exercise to better manage the existing buckets of money.

Multi-Disciplinary Pain Clinic
Clinical Outcome Scores March 2014

Cohort 1

		Pain Scores				Mental Health Screen	
		Pain Outcomes Profile				PHQ-9	GAD-7
		Current Pain	Average Pain	Physical Index	Affective Index		
Mean Scores	Admit	7.20	7.40	51.36	48.60	12.20	7.80
	D/C	3.40	4.60	36.85	36.50	9.40	8.20
	Change	**(3.80)**	**(2.80)**	**(14.51)**	**(12.10)**	**(2.80)**	**0.40**
Percent Change		-53%	-38%	-28%	-25%	-23%	5%

Cohort 2

		Pain Scores				Mental Health Screen	
		Pain Outcomes Profile				PHQ-9	GAD-7
		Current Pain	Average Pain	Physical Index	Affective Index		
Mean Scores	Admit	6.63	7.38	43.70	56.63	10.88	14.88
	D/C	3.57	3.57	31.08	32.07	5.14	3.86
	Change	**(3.06)**	**(3.81)**	**(12.62)**	**(24.56)**	**(5.74)**	**(11.02)**
Percent Change		-46%	-52%	-29%	-43%	-53%	-74%

Cohort 3

		Pain Scores				Mental Health Screen	
		Pain Outcomes Profile				PHQ-9	GAD-7
		Current Pain	Average Pain	Physical Index	Affective Index		
Mean Scores	Admit	6.50	6.50	61.83	60.94	15.63	13.50
	D/C	5.63	6.25	50.35	58.23	9.75	9.88
	Change	**(0.87)**	**(0.25)**	**(11.48)**	**(2.71)**	**(5.88)**	**(3.62)**
Percent Change		-13%	-4%	-19%	-4%	-38%	-27%

Cohort 4

		Pain Scores				Mental Health Screen	
		Pain Outcomes Profile				PHQ-9	GAD-7
		Current Pain	Average Pain	Physical Index	Affective Index		
Mean Scores	Admit	5.29	6.86	47.71	51.43	12.86	12.00
	D/C	2.14	3.14	27.00	19.43	4.71	4.14
	Change	**(3.15)**	**(3.72)**	**(20.71)**	**(32.00)**	**(8.15)**	**(7.86)**
Percent Change		-60%	-54%	-43%	-62%	-63%	-66%

Cohort 5

		Pain Scores				Mental Health Screen	
		Pain Outcomes Profile				PHQ-9	GAD-7
		Current Pain	Average Pain	Physical Index	Affective Index		
Mean Scores	Admit	6.75	6.25	47.25	58.88	14.88	11.63
	D/C	3.00	3.13	29.75	33.13	6.75	5.13
	Change	**(3.75)**	**(3.12)**	**(17.50)**	**(25.75)**	**(8.13)**	**(6.50)**
Percent Change		-56%	-50%	-37%	-44%	-55%	-56%

Multi-Disciplinary Pain Clinic
Referring Provider Three Month Follow-up Survey

Referring Providers	Clinic	1. Do you feel your patient has demonstrated improved outcomes as a result of MPC?		2. Do you view the program as beneficial and medically efficient?		3. Does this program improve your job satisfaction in providing care to complex patients with persistent problems?		4. Would you recommend this program to other providers for referring their pain patients?	
		Yes	No	Yes	No	Yes	No	Yes	No
Rojo	The Center	X		X		X		X	
Nelson	The Center	X		X		X		X	
Ugalde	The Center	X		X		X		X	
Paulson	The Center	X		X		X		X	
Hill	The Center	X		X		X		X	
Bonito	Desert Orthopedics	X		X		X		X	
Markovich	Mosaic	X		X		X		X	
Press	Mosaic	X		X		X		X	
Gonsky	SCFC	X		X		X		X	

Multi-Disciplinary Pain Clinic
Patient Satisfaction Scores

	Cohort 5	Cohort 4	Cohort 3	Cohort 2
Referral Process				
1. How would you rate the referral process to MPC?	4.38	4.50	3.88	5.00
2. How would you rate your initial contact with MPC?	4.63	4.33	3.50	4.83
3. How would you rate the amount of time between referral and the start of class?	4.13	4.00	4.13	5.00
Clinical Componants				
4. How would you rate the materials presented during the MPC classes?	4.50	4.83	4.50	4.50
5. How would you rate the 1-on-1 contact with Mary W?	4.13	4.66	3.88	4.83
6. How would you rate the contact with the doctor?	3.25	3.50	3.50	4.83
7. How would you rate your experience with the yoga class?	4.38	5.00	4.38	4.83
8. How would you rate your experience with acupuncture?	4.50	5.00	3.13	5.00
9. How would you rate your experience of massage?	5.00	5.00	5.00	5.00
Overall PainCare Program				
10. Did you feel respected during the program?	4.38	4.83	4.50	5.00
11. Do you feel your pain needs were accomodated?	4.00	4.83	3.13	4.83
12. Do you feel that your pain levels have been reduced?	2.50	4.83	2.25	4.50
13. Do you feel well informed about the advantages, disadvantages, and limitations of your MPC exit plan?	3.75	4.83	3.13	4.83
Narrative Questions				
14. What skills/tools work the best for you?				
15. If you could recommend on change, what would it be?				
Scores Summed	53.50	60.14	48.88	62.98
Overall Mean Score	**4.12**	**4.63**	**3.76**	**4.84**

Options for seeking global budget dollars to fund or continue transformation initiatives

	Source	Decision criteria	Accountability for decision	Timing
QIM Quality Fund	40% of any OHA QIM payments are allocated into a Quality Fund	Intended to fund quality projects or work that enhances the region's ability to achieve 100% QIM payout each year. Distribution guidelines are pending with Finance.	COHC Finance Committee. Escalates to COHC if not unanimous.	OHA QIM allocation for 2013 performance year will be made by June 30th.
Earmark dollars in a provider contract for strategic investments	Provider contracts. This would involve removing dollars from FFS or capitation payments within a provider contract, and using them to develop or fund specific programs.	Negotiated by PCS and providers.	TBD	TBD. (2014 PCS/WEBCO contract is the first example of this.)
COHC discretionary levy or 'tax' model	Some, or all, CCO/COHC participants make a voluntary contribution to COHC to fund transformation initiatives	Firm criteria yet to be developed. Possible precedent exists with Strategic Initiatives Funding and Transformation Funds projects.	COHC	
COHC surpluses	Per JMA, surpluses returned to COHC based on annual global budget fiscal performance	Distribution policy endorsed by COHC.	COHC	Variable, but considered once a year
Annual global budget 'earmark' for Transformation	Not a current source, but possibility for future.	TBD, if approved by COHC and participants. Pending Finance approval of APM guidelines.	TBD	TBD
Request of PCS	Not a valid source for sizable fund requests; all global budget dollars committed in provider contracts and, per JMA, surpluses capped and committed as well.	COHC could direct PCS to consider funding requests below a certain level.	PCS requests are really requests for dollars from: 1) profit; 2) admin; 3) medical services. Will likely be brought back to COHC.	N/A

OHA request	PCS annual bid process with OHA. These would be OHA increased payments to CCO specific to strategic initiatives.	If CCO is meeting it global budget cost reduction targets, PCS will argue certain strategic investments are needed in order to sustain results.	TBD	Annually, 4th quarter.
Grants/Other Funders (Not part of Global Budget)	Apply for grants or find alternative funders that have a keen interest in healthcare transformation.	Varies	Varies	Varies

CCO Operations Update – April/May 2013

Submitted by Dan Stevens

2013 Quality Incentive Measures

On April 30th OHA sent CCOs their preliminary final performance report on the 2013 QIMs. CCOs have until May 30th to validate the data and formally submit challenges to OHA. Once final scoring is tallied, we anticipate meeting a majority of the 17 measures but actual performance level (and therefore incentive rewards) is still difficult to accurately predict. The region's performance is 'on the bubble' with at least 3 of the QIM measures and the PacificSource performance analytics team is scrutinizing the data to ensure internal data sources and performance levels match those of OHA. Results of the preliminary report will be discussed at the May 8th COHC meeting, along with an update on PacificSource's validation efforts.

Dental Services Integration

Efforts continue toward integrating Dental Care Organizations into the CCO on July 1st. The CCO has been in contracting discussions with the DCOs operating in Central Oregon, both individually and together. Discussions continue to be productive and are inclusive of both the necessary core operating elements for integration, and the desire to create mechanisms that will enable oral health services to enhance our region's transformation goals.

Other integration efforts

Integration of non-emergent transportation services has been delayed by OHA. CCOs can opt to integrate NEMT as early as July, but we will take advantage of the additional time to work with the regional transportation system to ensure full compliance with the HIPAA privacy components of their important health related work. Integration of Mental Health residential services has also been delayed by OHA, until January 2015.

CCO Dashboard

The May CCO performance dashboard has been submitted with Board materials. Noteworthy items include:

- Updated membership numbers through end of March, reflecting a continued upward trend mainly due to enrollments through Cover Oregon. April numbers, not reflected in the dashboard, are up again as Cover Oregon expanded its enrollment period.
- Central Oregon has 15,000 more residents insured and covered by the CCO, than were covered in December 2013. Providers are doing incredible work accommodating that many new patients in such a short period of time.

- Financial measures need to be interpreted with caution (ie; net income overstated) due to OHA's mis-allocation of expansion members into higher rate categories. In the CFO report at the May meeting, we will discuss measures we are taking to account for an anticipated financial reconciliation OHA will be performing in the 2nd quarter.
- Some of the CCO service levels have fallen below target due to the magnitude of new enrollment. For example, "calls answered within 30 seconds" is currently at 37% against a goal of >80%. Additionally, Grievances are slightly up primarily due to members' difficulty accessing care in what they would view as a reasonable timeframe. Claims payment turnaround time remained better than target in the first quarter.
- A new 'data insight of the month' reflects a Top 10 list, in two areas: (1) diagnoses by number of patients served; and (2) diagnoses by total dollars paid. These insights are intended to shed light on spending patterns within the Medicaid budget.

CCO Dashboard April 28, 2014

Central Oregon Region

CCO Membership (Member Months)

Mar 13	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
30,673	30,711	30,542	30,364	30,292	30,262	30,181	30,167	30,172	29,501	39,189	42,043	44,263

FINANCE

2014 Year to Date Income Statement (YTD) - Central Oregon

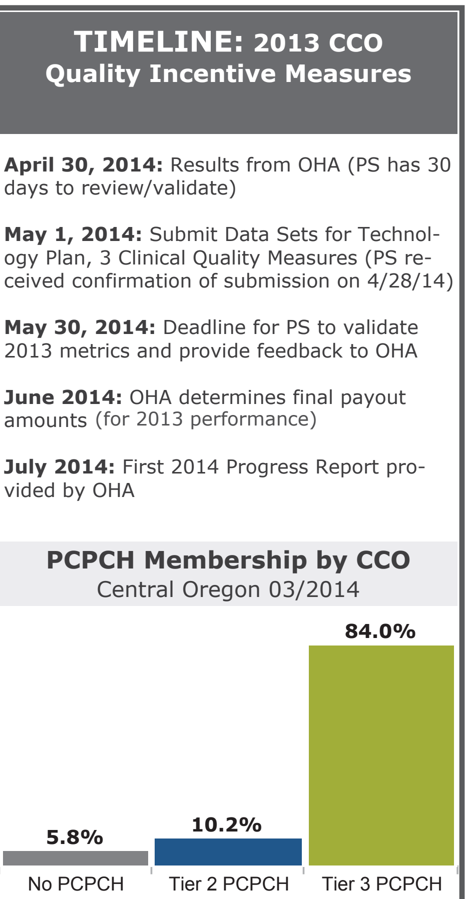
	2014 YTD (Mar)	Budgeted Target 2014 YTD (Mar)	Difference (Variance)
Total Revenue	$47,022,566	$45,968,718	$1,053,848
Medical Claims Expense	($38,028,957)	($40,414,891)	$2,385,934
General & administrative expenses	($2,708,500)	($2,647,798)	($60,702)
Underwriting income	$6,285,109	$2,906,029	$3,379,080
Net income	$3,019,457	$1,008,118	$2,011,339

% of PMPM Total Spend - Central Oregon (Inc thru 1/14, Pd thru 3/14)

2012					2013						2014					
OP	IP	Phys	Rx	Misc	OP	IP	Phys	Rx	Misc	BH	OP	IP	Phys	Rx	Misc	BH
16%	21%	26%	15%	6%	17%	22%	25%	14%	7%	15%	20%	18%	26%	14%	7%	14%

Current ($) PMPM Estimates: Central Oregon (Inc thru 1/14, Pd thru 3/14)

	BH	OP	IP	Phys	Rx	Misc	Phys (YTD)	Phys + BH (YTD)
2011	$44.1	$45.8	$66.0	$75.2	$34.1	$13.9	$235.0	$279.1
2012	$39.8	$41.1	$51.8	$64.9	$38.3	$14.7	$210.9	$250.7
2013	$37.5	$44.0	$56.4	$65.7	$36.6	$17.8	$220.5	$257.9
2014	$39.1	$56.9	$51.9	$72.4	$40.2	$20.8	$242.2	$281.2



TIMELINE: 2013 CCO Quality Incentive Measures

April 30, 2014: Results from OHA (PS has 30 days to review/validate)

May 1, 2014: Submit Data Sets for Technology Plan, 3 Clinical Quality Measures (PS received confirmation of submission on 4/28/14)

May 30, 2014: Deadline for PS to validate 2013 metrics and provide feedback to OHA

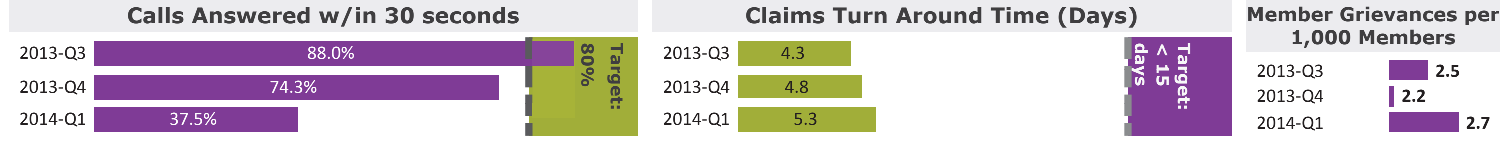
June 2014: OHA determines final payout amounts (for 2013 performance)

July 2014: First 2014 Progress Report provided by OHA

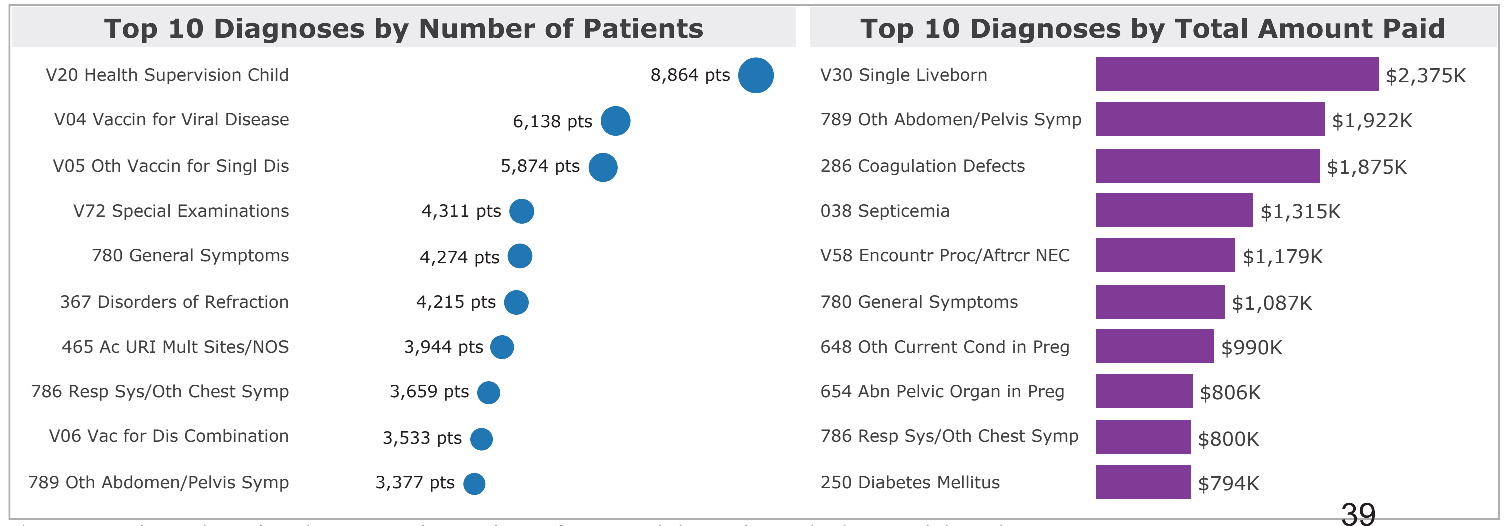
PCPCH Membership by CCO

Central Oregon 03/2014

MEMBER EXPERIENCE (BOTH CCO REGIONS COMBINED)



DATA INSIGHT OF THE MONTH: TOP 2013 DIAGNOSES



* Diagnosis data is by 3-digit diagnosis code. For dates of service 1/1/2013 thru 12/31/2013, pd thru 2/2014.

Definitions

BH: *Behavioral Health (mental health, substance abuse and addictions)*

Dev'l Screenings: *Developmental Screenings. Done to identify developmental delays at an early age. Oregon Health Authority CCO measures only include CPT code 96110, though other procedures are considered developmental screening/assesment.*

ED: *Emergency Department/ Emergency Room Services*

General Administrative Expense: *Expenses related to the administration of the plan including, but not limited to, staff salary and benefits, telephone, depreciation, software licenses, utilities, etc.*

Medical Claims Expense: *Claims-related expenses, including capitation, pharmacy, disease management and network fees, pharmacy rebates (if applicable), health services expenses and IBNR (incurred but not received).*

MM: *Member Months. One member month = one person enrolled for a whole month. If a person is enrolled for an entire year, that is equivalent to 12 member months. If a person is enrolled for 2 out of 4 weeks in the month, that is 0.5 member months.*

Net Income: *Underwriting Income combined with results of activities not directly related to continuing operations, on an after tax basis.*

PCPCH: *Patient-Centered Primary Care Home (as defined by OHA)*

PMPM: *Per member per month*

Premium Taxes & OMIP: *State mandated taxes collected on a per member mer month (PMPM) or % of premium basis.*

Rx: *Prescription*

SBIRT: *Screening, Brief Intervention and Referral to Treatment. A screening and intervention method for alcohol and substance misuse.*

Total Revenue: *Premiums collected for insurance, net of HRA costs. Premiums for Oregon Health Plan recipients are received from the state of Oregon.*

Utilization: *Use of a good or service*

Underwriting Income: *Income after Operations and other activities not directly related to continuing operations.*

YTD: *Year to date. For this dashboard, YTD is based on a calendar year beginning Jan 01, 2013.*

Important Notes

GENERAL:

All data is subject to revision. Data for each month is updated with the most current and complete estimates at the time of updating.

FOOTNOTES: CLAIMS PMPM ESTIMATES

- MH capitation had been added to the PMPMs and claims processed on the Behavioral Health entitites behalf have been removed to the best of our ability. This presents a change from the methods used to provide PMPMs in previous months.

- Claims Processing Error Correction: St. Charles overpayment estimates for Central Oregon Outpatient in early 2013 have been removed prior to 08/2013 based on estimate from PH Tech. PMPM estimates may be subject to revision based on claims processing errors identified after the paid date.

- For PMPM Estimates: Incurred through 1/2014 paid through 03/2014. PMPM Estimates for 2010 thru 2012 were updated with most recent information 3/2014.

- Completion factors applied to PMPM estimates only. Completion factors NOT applied to utilization metrics unless otherwise indicated.

- Excludes: MH/CD Fee-for-service claims and MH ASO and 7 11 drugs. Includes withhold.

- Claims processed on ABHA's behalf are removed by taking 1/3 of total amount of Inpatient, Outpatient and Physician.

- Claims processed on WEBCO's behalf are removed by a flag using logic from PH Tech.

-Behavioral Health coverage in Gorge Region began 11/2012.

***Note: Behavioral Health (BH) is excluded from the Chart "*% Change in PMPM $ Spend (from Previous)*" because 2010-2012 estimates of PMPM did not include capitation data prior to CCO formation.**
Therefore, **a combined PMPM (*Med + BH (YTD)*) from years prior to 2013 are not directly comparable to 2013** since Behavioral Health capitation $ is only included for the time after CCO formation. If you want **to compare over time, instead use *Medical (YTD)*** which includes Medical and Rx but excludes BH.

Expense	Monthly Spend	Budget	Status	Comments
Accounting & Bookkeeping	$200.00	$916.67		
Advertising & Promotions	$0.00	$83.33		
Bank & Merchant Fees	$10.00	$8.33		
Community Education	$0.00	$416.67		
Computer & Equipment	$0.00	$291.67		
Consumer Expense Reimbursement	$65.90	$791.67		
Conferences & Events	$0.00	$625.00		
Data Analyst/WEBCO	$0.00	$2,833.33		
Dues & Subscriptions	$662.00	$333.33		Purchase of Webinar platform (year subscription)
Evaluation/Miscellaneous Fund	$0.00	$1,333.33		
Food & Beverages	$580.30	$916.67		
Insurance	$1,059.30	$1,000.00		
Intern Expense	$0.00	$666.67		
Internet/Voice	$0.00	$150.00		
Labor	$0.00	$22,500.00		
Labor/Benefits (PT Admin)	$0.00	$2,916.67		
Legal Fees	$2,370.00	$1,250.00		Retainer Fee (front loaded)
Member Education	$0.00	$333.33		
Miscellaneous	$0.00	$125.00		
Office Furniture	$589.99	$458.33		Upfront expense, expect to taper off
Office Supplies	$1,313.71	$583.33		Upfront expense, expect to taper off
Postage & Shipping	$0.00	$50.00		
Printing & Copying	$0.00	$458.33		
Professional Development/OHA Conference	$200.00	$833.33		
Rent/Office Space	$761.05	$875.00		
Taxes & Licenses	$0.00	$41.67		
Travel	$193.23	$1,250.00		
Website	$20.00	$1,083.33		

	On track monthly, on track yearly
	Off track monthly, on track yearly
	Off track monthly, off track yearly

CENTRAL OREGON HEALTH COUNCIL
SCHEDULE OF REVENUES, EXPENDITURES AND CHANGES IN FUND BALANCE - BUDGETARY BASIS
FOR THE PERIOD ENDED MAR 31, 2014

	Annual Budget Operations	Annual Budget Initiatives	Maternal/Child Health Jan-Mar Actual	Chronic Pain Jan-Mar Actual	RN Care Coordination Jan-Mar Actual	Research Data Analyst Jan-Mar Reserve	Operations Jan-Mar Actual	Initiatives Jan-Mar Actual	Variance Over (Under)
REVENUES									
Contract Income	$ 552,000	$ -	$ -	$ -	$ -	$ -	$ 188,638	$ -	$ 363,362
Miscellaneous Income	-	-	-	-	-	-	86	-	(86)
Total Revenues	$ 552,000	$ -	$ -	$ -	$ -	$ -	$ 188,724	$ -	$ 363,276
EXPENSES									
Accounting & Bookkeeping	$ 11,000	$ -	$ -	$ -	$ -	$ -	$ 985	$ -	$ 10,016
Advertising & Promotions	1,000	-	-	-	-	-	-	-	1,000
Bank & Merchant Fees	100	-	-	-	-	-	-	-	100
Community Education	5,000	-	-	-	-	-	-	-	5,000
Computer & Equipment	3,500	-	-	-	-	-	-	-	3,500
Consumer Expense Reimbursement	9,500	-	-	-	-	-	761	-	8,739
Conferences & Events	7,500	-	-	-	-	-	905	-	6,595
Data Analyst/WEBCO	34,000	-	-	-	-	-	-	-	34,000
Dues & Subscriptions	4,000	-	-	-	-	-	662	-	3,338
Evaluation/Miscellaneous Fund	16,000	-	-	-	-	-	-	-	16,000
Food & Beverages	11,000	-	-	-	-	-	2,587	-	8,413
Insurance	12,000	-	-	-	-	-	1,589	-	10,411
Intern Expense	8,000	-	-	-	-	-	-	-	8,000
Internet/Voice	1,800	-	-	-	-	-	-	-	1,800
Labor	270,000	-	-	-	-	-	46,489	-	223,511
Labor/Benefits (PT Admin)	35,000	-	-	-	-	-	-	-	35,000
Legal Fees	15,000	-	-	-	-	-	2,370	-	12,630
Member Education	4,000	-	-	-	-	-	594	-	3,406
Miscellaneous	1,500	-	-	-	-	-	-	-	1,500
Office Furniture	5,500	-	-	-	-	-	1,776	-	3,724
Office Supplies	7,000	-	-	-	-	-	2,585	-	4,415
Postage & Shipping	600	-	-	-	-	-	-	-	600
Printing & Copying	5,500	-	-	-	-	-	-	-	5,500
Professional Development/OHA Conference	10,000	-	-	-	-	-	200	-	9,800
Rent/Office Space	10,500	-	-	-	-	-	2,664	-	7,836
Taxes & Licenses	500	-	-	-	-	-	-	-	500
Travel	15,000	-	-	-	-	-	521	-	14,479
Website	13,000	-	-	-	-	-	78	-	12,922
Contract Labor		187,921	45,053	33,292	19,500	-		97,845	90,076
Total Expenses	$ 517,500	$ 187,921	$ 45,053	$ 33,292	$ 19,500	$ -	$ 64,766	$ 97,845	$ 542,810
Change in Net Assets	$ 34,500	$ (187,921)	$ (45,053)	$ (33,292)	$ (19,500)	$ -	$ 123,958	$ (97,845)	
Fund balances - beginning			$ 135,159	$ 49,938	$ 19,500	$ 103,000	$ 330,014	$ 307,596	
Fund balances - ending			$ 90,105.50	$ 16,646.20	$ -	$ 103,000.00	$ 453,971.87	$ 209,751.70	

OPERATIONS COUNCIL ENDORSEMENT
OF CHRONIC PAIN STRATEGIC INITIATIVE

At the May 2, 2014 meeting of the Operations Council, the Operations Council endorsed the Chronic Pain Strategic Initiative and moved that all parties work to fund this project going forward at $250,000 per year.

OPERATIONS COUNCIL SUPPORT OF WITHHOLD FROM GLOBAL BUDGET

At the May 2, 2014 meeting of the Operations Council, the Operations Council supported the proposed Alternative Payment Methodology principle of a withhold from the Global Budget, with such withhold to be reserved before funds are allocated to various contracts in order to pay for prevention, upstream, cross-discipline, and transformational work.