Conference Call Number: 1-888-808-6929
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Oregon Health Policy Board
AGENDA
October 4, 2016
OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
8:30 a.m. to 12:00 p.m.

#	Time	Item	Presenter	Action Item
1	8:30	Welcome	Zeke Smith, Chair	X
2	8:45	Director's Report	Lynne Saxton, Director, OHA	
3	9:00	Primary Care Payment Reform Update	Leslie Clement, OHA	
4	9:15	Oregon Behavioral Health Collaborative Update	Leslie Clement, OHA	
5	9:30	OHPB CCO Listening Session Discussion	Zeke Smith, Chair	
5	10:00	Break		
6	10:15	Healthcare Workforce Committee Update	Marc Overbeck, OHA Carla McKelvey, Vice-Chair	
7	11:00	Oregon Health Information Technology Update	Susan Otter, OHA	
8	11:45	Public testimony	Chair	
9	12:00	Adjourn	Chair	

Next meeting:
November 1, 2016
OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
8:30 a.m. to 12:00 p.m.

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Oregon Health Policy Board
DRAFT September 6, 2016
OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
8:30 a.m. to 12:30 p.m.

Item
Present: Board members present: Zeke Smith, Brenda Johnson, Carla McKelvey, Karen Joplin, Carlso Crespo and Joe Robertson Welcome and Call To Order, Chair Zeke Smith Zeke called attention to the CCO OHPB Listening Sessions flyer and briefly noted the Board's process and intent. You can find more info here. Zeke called for a moment of silence in honor of Senator Dr. Alan Bates, a founder of Oregon's health system transformation, who passed suddenly recently while fishing with his son in Southern Oregon. The Board voted to approve the July and August minutes unanimously. The Board voted to accept the Early Learning Council's report regarding metrics for home visiting with no opposition.
Director's Report, Lynne Saxton, OHA Director Saxton thanked Bill Bouska for his long service to the state and then briefed the Agency's budget build status. She noted the Agency's role in the cleaner air Oregon process and gave a status update regarding the behavioral health collaborative. She passed on an update regarding the Agency's eligibility and enrollment systems and informed that the 45 day backlog has been cleared. She spoke about stakeholder input and outreach and plans going forward to identify points of contact. She relayed issues regarding state hospital referrals and the process to work with interested stakeholders to improve community based care. Finally, she passed on a note regarding youth education regarding marijuana and noted the Agency is using an aggressive communications strategy to ensure effective outreach to youth. Carla asked about a webinar for the board regarding marijuana strategies and Brenda asked what the behavioral health collaborative was studying in particular. Lynne passed on the collaborative makeup, process, timeline and goal working with county and system stakeholders to ensure data driven improvements and prioritized list of recommendations.

HB 3396

Carla introduced the HB 3396 agenda item and HealthCare Workforce Committee Chair, Dr. David Pollock and Vice-Chair, Dr. Robyn Dreibelbis presented final recommendations from the committee's report for the Board's approval as mandated by HB 3396 regarding recommendations for rural provider recruitment and retention strategies and methods. The report is available in meeting materials here. Dr. Dreibelbis briefed the committee's timeline, process and recruitment and retention findings for programs. The committee's recommends:

- Enhancing data collection for all incentive programs
- Expanding awareness and ease of use for incentives among clinicians and employing sites
- Consolidating and restructuring programs for greater effectiveness and efficacy
- Including community support in statewide systems to encourage providers to practice in rural an non-rural underserved areas

The Committee recommended that the legislature continue to consider changes to make the credit more effective.

Carlos asked about team-based provider strategies and Karen asked about retaining effective strategies and how barriers to success will be addressed.

Lynne asked how future data could be used and Dr. Dreibelbis relayed the goals of data collection regarding hours per week devoted to primary care as well as the functionality of a calculator to estimate the needs of a rural community. Dr. Pollock spoke about payment reform's effect on rural provider recruitment and retention as well as primary care discipline scope of practice changes to work more efficiently and collaboratively. Brenda asked about community flexibility and Karen asked about operationalizing the incentive fund. Dr. Pollock relayed intent regarding increasing the ability of local communities to meet the needs of the community through community driven strategies as well as spreading best practices throughout local communities. Lynne spoke about how the behavioral health map may help inform needs. Zeke asked about recommendation effects on program funding and fund distribution and Carla said that piece remains but improved data, system efficiencies and other identified strategies such as a "Recruitment and Retention Collaborative" are the big changes and that future funding changes may be driven by recommendations in the future. The workforce committee recommends more resources for loan repayment and forgiveness programs.

The Board voted to accept the report as presented. Brenda and Zeke asked that the data be brought back to the Board in the future.

CCO Quarterly Report:

Lesley Clement, Director OHA Health Policy & Analytics Division and Mark Fairbanks OHA Chief Operating Officer and Chief Fiscal Officer briefed the OHA's first CCO quarterly report which can be found here. Lesley briefed Oregon Health Plan demographic and enrollment statistics. She spoke about CCO metrics and a few specific incentive measures CCOs are excelling at and then spoke about areas of opportunity including disability ED usage, behavioral health ED overutilization and contraception use. Carlos and Carla asked about equal access to quality care and Leslie and Lynne relayed the diversity of need in Oregon and the nature of Oregon's many local CCOs. Lesley described the complaints and grievance statistics in the report and Brenda asked for more exploration around the percentage of members assigned to a CCO who have been seen in the last 12 months. Lesley then briefed the health disparity section of the report and relayed information about member engagement, health disparities and cultural competencies; CCOs established their own metrics and work plans for these areas. Brenda asked how aspirational these goals are and Leslie relayed some were aspirational but some were baseline, more

basic and preliminary. She relayed that OHA's Transformation Center and Office of Equity and Inclusion provided TA as requested by CCOs regarding these measures.

Mark then briefed the finance section of the report which shows the organization and ownership models of CCOs as well as operating margins, capitalization, medical loss ratio, medical services ration and other financial issues. He spoke about the different kinds of CCO organization and parent/owner relationships and briefed the operating and total margin section of the report and highlighted 2014 unexpected population effects on rates. Joe asked about non-operating administrative costs and details are for CCOs and Carla asked if OHA is analyzing operating models to make recommendations regarding those models. Brenda asked about shareholder wealth in financial reports and Mark relayed that the level of specificity follows the financial reporting in the income statement contained on CCO balance sheets. Zeke asked about variation in cost and spend and what appropriate risk might appropriate and Mark relayed that analysis is ongoing, that rate development is the calibrating mechanism for risk and that rate variability should be narrowing. Lynne noted the ongoing work contained in the waiver development effort regarding transformation and global budgets. Mark spoke about medical services and medical loss ratios (MLR) and explained the medical services ratio calculates cost of services medical and non-medical services, like flexible services as a percentage of total ratio. He relayed that all CCOs will have to meet an 85% MLR. He briefed the section of the report which details CCO MLR and medical loss ratio. Karen asked how variation can be explained in investments and MLR and asked about a standard. Mark relayed OHA can provide analysis and further noted the past MLR requirements to specific populations. Joe asked if risk based capitalization requirements are the same for CCOs as they are for plans sold on the exchange.

<u>SB 440:</u>

Leslie introduced the presentation of SB 440 findings and recommendations from Quality Corporation (Quality Corps/ Q corp). Betsy Boyd-Flynn briefed Quality Corps services and details regarding work product development and process. Their presentation is available for review at wwlkjafdlk.com. She then briefed key findings from the OHPB focus areas and most common themes. She then briefed the 10 most urgent recommendations related to implementation from Quality Corp's perspective. Joe asked about a social determinants of health index to serve as a foundation for data collection and analysis. Zeke asked about which recommendations to prioritize and Betsy relayed all of Q Corps recommendations should be considered for prioritization.

Leslie spoke about the recommendations and relayed how they connect with the Board's workplan and goals, she noted the role of an updated Action Plan for Health to drive recommendations and how the upcoming 1115 waiver connects with policy recommendations for data. The Board confirmed its intent to build on the 2010 Action Plan for Health. Brenda asked about long term goals and vision and Leslie responded with information regarding Oregon's USDOJ Performance plan to improve outcomes for adults with SPMI and the plan's aspirational nature. She noted progress in achieving aspirational goals tied to 2010 and asked the Board about the interplay between new aspirational goals and building on identified aspirational goals. Zeke spoke about understanding how goals helped move forward reform and how they might connect with outcomes going forward. Lynne spoke about uniting goals, implementation and budgeting as well as social determinants of health and the impact of multiple points in decision making. She further noted the HST Quarterly report's ability to connect with goals identified in the 2010 Action Plan for Health and asked the Board to consider infrastructure needs when setting aspirational goals. She noted public health's role driving health from the state health improvement plan. Leslie noted the need to include housing and education in a refreshed Action Plan as well as the need to build on the successes identified in 2010 because they still need more attention to be realized as envisioned. She noted the role of the health information oversight committee that reports to the Board

and the potential role of further coordination with that group by the Board. She mentioned 42 CFR as they relate to opportunities and barriers for improved data sharing. Lynne relayed information regarding OHA and DHS coordination around foster care children. Leslie spoke to the 10 most urgent policy related recommendations. She addressed the coming committee charged with organizing and analyzing data and steps being taken to collaborate on technology solutions to advance transparency and the role of the Health Information Oversight Technology Committee and its role working to implement clinical quality metrics tool, provider directory, effective health information exchanges and common credentialing. She further noted the work being done to implement data collection around race, ethnicity, access, language and disability as well as the coming 1115 waiver's role to help with consistency. Carla noted the need for data system interoperability and Leslie noted complex systems as well as the need to improve access to data collection and reduced administrative burden for providers. Zeke asked the Board to accept the report and use an update action plan for health to make recommendations regarding data as well as creating a clear charge for the coming committee; he asked what's already being done and should be made visible to inform data plan reporting and recommendations. He asked for further details regarding opportunities to align public and private initiatives and resources and for the Agency to help inform the Board's recommendations regarding Quality Corp's report. The Board voted to accept the report from Quality Corps.
Public Testimony John Mullin from the Oregon Law Center spoke about the amount of complaints resolved as identified in the HST Quarterly report and non-emergency medical transportation complaint tracking and non-emergency medical transportation brokerage and provider issues.
OHPB video and audio recording To view the video, or listen to the audio link, of the OHPB meeting in its entirety click here.
Adjourn

Next meeting:
Oct 4, 2016
OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
8:30 a.m. to 12:30 p.m.

Primary Care Payment Reform Collaborative
Draft Recommendations for the Oregon Health Policy Board

September 2016

The goal of the Primary Care Payment Reform Collaborative is to "direct greater health care resources and investments toward supporting and facilitating health care innovation and care improvement in primary care" as a means to achieve the triple aim. The Collaborative focuses on primary care payment for the entire population, seeking to advance health for all Oregonians. The broad nature of the work required to advance this goal is reflected in the recommendations below.

Collaborative Governance
The Primary Care Payment Reform Collaborative should continue to be the long-term convener for all payers and providers—including those participating and not participating in CPC+—to work together to seek alignment and agreement around sustainable primary care transformation.

Technical Assistance
Primary care technical assistance (TA) should be delivered through a centralized structure supported by all payers via a sustainable, shared-funding model. TA activities should leverage existing TA supports, including the TA delivered through CPC+. TA should emphasize delivery mechanisms identified as effective by providers, with a focus on peer-to-peer, on-the-ground TA.

Measurement/Recommendations for the SB 440 Process
Primary care should be measured using a common set of quality and utilization metrics across all payers that align with existing measurement efforts. Metrics should focus on outcomes and apply to different populations, including children and individuals with special needs, substance use disorders, and behavioral health diagnoses. Metrics should be drawn from claims and clinical data with a phased approach, starting with what can be measured now and moving toward metrics that may require more sophisticated data collection efforts.

Data Aggregation
Assuming the following is in line with CMS's forthcoming guidance, a single source of aggregated data based on agreed-upon metrics is needed using shared definitions that clinics and payers can use across systems. Aggregation should start with data that is currently being used as well as relevant CPC+ measures, prioritizing claims-based clinical and cost/utilization measures to be able to demonstrate success. Recognizing that data timeliness and accuracy challenges exist, strategies should be developed to increase the timeliness of claims data and promote sharing of electronic health record (EHR) data that is as actionable as possible. Aggregation should be financed through a shared utility model from all payers based on population size. Oregon's data aggregation timeline should allow for CMS's full participation for the duration of CPC+.

Behavioral Health Integration
With the goal of changing primary care payment to promote behavioral health integration, payers should move from fee-for-service to value-based payments and eliminate carve-outs for behavioral health. Billing/coding assistance and TA on successful integration strategies should be made available to providers to ensure payment for behavioral health integration.

Behavioral Health Collaborative Workgroup Scope

DATA WORKGROUP

Problem Statement:

Fragmented financing, delivery systems, and services fail to serve and exacerbate poor health outcomes for children, adolescents, adults, and older adults.

1. Access to behavioral health services, both specialty and general, do not meet the needs of all Oregonians in the right places at the right times in a culturally and linguistically specific manner.
2. Continuum of care, service integration, and coordination between the systems of criminal justice, human services, health, and education is insufficient, administratively complex, and lacking in strategies addressing prevention for all populations.
3. Social determinants of health, including insufficient housing, employment, and transportation, create barriers to behavioral health resources that vary by community.

Workgroup Description:

The BHC Data workgroup must enhance the BH Map to reflect the current state of our behavioral health system, make policy, program and/or financial recommendations based on the data, and to identify data system tools to inform care coordination.

Workgroup Non-negotiables:

- Behavioral Health Mapping Tool should display various settings providing behavioral health services, i.e., mental health facilities, schools, primary care, etc.
- Accept and use available data, while including/explaining the limitations of data
- Include integrated, state-wide physical and behavioral health registries
- Include outcomes measures
- Include racial equity in data

Expected Deliverables:

- Connect and align with BH Map technical advisory committee to:
    - Identify the various entities accountable for the performance of the behavioral health system to be included on the BH Map
    - Identify the need, use of services, capacity, financing and outcomes to inform the BH Collaborative about what's working, what's not.
    - Identify policy, program and/or financial recommendations based on the data.
    - Identify the methodology for determining performance of responsible entities for the behavioral health system, including access and quality metrics. What does their funding and workforce look like?
    - Identify the methodology for measuring performance and resource utilization – what are the metrics to be considered a high performer?
    - Identify social determinants in each county.
- Identify what data system tools are needed to help inform care coordination, such as EDIE and PreManage. Identify opportunities to expand access to these tools. Identify

short-term improvements that could be made to provide data before more sophisticated tools/systems are in place. Capture work underway, such as CPC+ which is tasked with identifying data aggregation by payers to support primary care clinics.

Questions to Address Deliverables:

1. How can the BH Map be enhanced to reflect the current state of our behavioral health system by identifying the need, use of services, capacity, financing, and outcomes?
2. What are the entities that should be represented in the BH map as accountable for the behavioral health system?
3. How can the enhanced BH Map inform what is working?
4. What is the methodology and metrics to determine performance of entities responsible for the behavioral health system? (examples, access, quality, financing, workforce)
5. What is the methodology and metrics for an entity to be considered a high performer?
6. How can the enhanced BH Map identify policy, program and or/financial recommendations?
7. How do we ensure that we are receiving consistent, reliable data?
8. What data system tools are needed to help inform care coordination?
9. What are opportunities to expand these tools?
10. What short-term improvements could be made to provide data before more sophisticated tools or systems are in place?

Required Collaboration:

Behavioral Health Mapping Tool Technical Advisory Committee; the work of CPC+

Workgroup Action Items:

Action Item	Accountability	Deadline

Behavioral Health Collaborative Workgroup Scope

PAYMENT REFORM AND FINANCE WORKGROUP

Problem Statement:

Fragmented financing, delivery systems, and services fail to serve and exacerbate poor health outcomes for children, adolescents, adults, and older adults.

1. Access to behavioral health services, both specialty and general, do not meet the needs of all Oregonians in the right places at the right times in a culturally and linguistically specific manner
2. Continuum of care, service integration, and coordination between the systems of criminal justice, human services, health, and education is insufficient, administratively complex, and lacking in strategies addressing prevention for all populations.
3. Social determinants of health, including insufficient housing, employment, and transportation, create barriers to behavioral health resources that vary by community.

Workgroup Description:

The Payment Reform and Finance workgroup must recommend payment reform strategies for a 21st century behavioral healthcare system.

Workgroup Non-negotiables:

- Payment should take into account whether behavioral health services are provided onsite (at schools, primary care, judicial system, etc.) or referred out to another external entity, coordinated, and tracked.
- Payment reform models must include both public and private payers
- Shift the system away from fee for service for behavioral health services and interventions and provide limits to carving out behavioral health benefits in CCOs
- Address payment reform for prevention/health promotion
- Aligned financial and clinical metrics

Expected Deliverables:

- Create a framework that moves the system away from fee for service for behavioral health services and interventions, and limit to carving out of behavioral health benefits
- Identify financing models, recognizing the difference in cost structures between the public and private nonprofit sectors, consistent with Oregon's goal to provide evidence-based services and best practices using a fixed sustainable rate of growth that is tied to performance and outcomes.
- Connect and align with SB 231 and CPC+ work group. (Robin and Bill)
    - Review proposals and determine which will ensure that the multi-payer primary care payment reform model adequately addresses behavioral health.
    - Determine what type of payment methodology should be used to reflect complex care management.

- Review 1115 waiver (flex services, community benefits, and social determinants of health) renewal package (staff and Kevin C., Bill M.) and ensure that recommendations align with the 1115 waiver.
- Review current APM/VBP work (staff and TC), including best practices that exist and can be expanded. Make recommendations on APMs and VBPs to improve BH integration and care coordination.
- Identify opportunities to address non-Medicaid payment reform.
- Recommend payment changes that could incentivize early intervention and reduce high-cost care in restrictive environments.
- Identify opportunities to support a sustainable and qualified workforce through wage reform.

Questions to Address Deliverables:

1. What proposals will ensure that the multi-payer primary care payment reform model adequately addresses behavioral health?
2. What type of payment methodology should be used to reflect complex care management?
3. Are there APM/VBP best practices? Can they be expanded?
4. How do we use APMs and VBPs to improve BH integration and care coordination?
5. Are there opportunities to address non-Medicaid payment reform?
6. Are there payment changes that could incentivize early intervention and reduce high-cost care in restrictive environments?
7. How do we ensure wages that will recruit and retain a competent, skilled behavioral health workforce? *(will need to work with workforce group)*
8. How do we move upstream and pay for prevention?

Required Collaboration:

The Payment Reform and Finance Work Group must connect with existing workgroups, including SB 231, CPC+, 1115 waiver and APM/VBP work to recommend payment reform for a 21st Century Behavioral Healthcare system.

Workgroup Action Items:

Action Item	Accountability	Deadline

Behavioral Health Collaborative Workgroup Scope

WORKFORCE WORKGROUP

Problem Statement:

Fragmented financing, delivery systems, and services fail to serve and exacerbate poor health outcomes for children, adolescents, adults, and older adults.

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2. Continuum of care, service integration, and coordination between the systems of criminal justice, human services, health, and education is insufficient, administratively complex, and lacking in strategies addressing prevention for all populations.
3. Social determinants of health, including insufficient housing, employment, and transportation, create barriers to behavioral health resources that vary by community.

Workgroup Description:

The Workforce Workgroup will make recommendations for a workforce prepared to meet the needs of the 21st Century Behavioral Health System.

Workgroup Non-negotiables:

- Recommendations must address both current and future workforce
- Must address peer workforce, including definitions and standards
- Must address diversity among workforce
- Must address urban and rural differences
- Must consider reallocating/relocating behavioral health workforce in different locations to meet community behavioral health needs

Expected Deliverables:

- Create a method for determining network adequacy for behavioral health in a CCO
- Connect and align with BHI to determine workforce shortages, competency and training issues.
- Establish a plan to create a set of competencies for behavioral health working in non-traditional settings (e.g. primary care, schools, police departments) and what those settings are.
- Review work force data and identify workforce issues and proposed solutions.
- Recommend improvements to the licensing and certification process to maximize appropriate use of community health workers and peers.
- Recommend what should be standardized statewide and what should be flexible at local level.
- Recommend workforce changes that could enhance early intervention and prevention.

Questions to Address Deliverables:

1. Where are the BH workforce shortages?
2. What are the workforce competency and training issues?
3. How can we improve our licensing and certification process to maximize the appropriate use of community health workers and peer support specialists?
4. What should be standardized statewide and what should be flexible at the local level?
5. Are there workforce recommendations that could enhance early intervention and prevention?
6. How do we ensure wages that will recruit and retain a competent, skilled behavioral health workforce? *(will need to work with Payment Reform and Finance workgroup)*

Required Collaboration:
The Oregon Health Board Behavioral Health Integration Committee

Workgroup Action Items:

Action Item	Accountability	Deadline

Behavioral Health Collaborative Workgroup Scope

OUTCOMES WORKGROUP

Problem Statement:

Fragmented financing, delivery systems, and services fail to serve and exacerbate poor health outcomes for children, adolescents, adults, and older adults.

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2. Continuum of care, service integration, and coordination between the systems of criminal justice, human services, health, and education is insufficient, administratively complex, and lacking in strategies addressing prevention for all populations.
3. Social determinants of health, including insufficient housing, employment, and transportation, create barriers to behavioral health resources that vary by community.

Workgroup Description:

The Outcomes Workgroup must align with existing metrics to determine metrics geared towards the greatest system improvement for the 21st Century Behavioral Health System.

Workgroup Non-negotiables:

- Include outcomes that are patient reported (e.g. PROMIS measures)
- Risk stratify for different populations and their unique health needs (e.g. children and older adults)
- Align with existing metrics (CCO, USDOJ, public health data, grant requirements, surveys)
- Address coordination with different settings
- Identify mechanisms to require meaningful data is provided to clinicians in a timely manner

Expected Deliverables:

- Create a minimal data set for behavioral health that is to be used by all facilities, clinics, and clinicians participating in the CCO
- As often as possible, create outcomes that are patient reported (e.g. PROMIS measures)
- Create stratification process for different populations and their unique outcomes (e.g. children and older adults)
- Connect and align with existing metrics (CCO, USDOJ, public health data, grant requirements, surveys) (staff, Maggie) and identify which metrics will drive the greatest improvement.
- Recommend processes to be standardized, best practices to be mandated and what is needed to monitor and measure performance
- Align with the intent of SB 440 to standardize around key metrics.

- Create an auditing process that can be used to benchmark and hold clinicians accountable
- Identify mechanisms to require meaningful data are provided to clinicians in a timely manner

Questions to Address Deliverables:

1. What metrics will drive the greatest improvement?
2. What processes should be standardized?
3. Are there best practices that should be mandated? If so, which ones?
4. What is needed to measure and monitor performance?
5. How do we incorporate consumer directed outcomes into incentive metrics?
6. What metrics will measure successful coordination/handoffs between settings?
7. What type of auditing process could be created to benchmark and hold clinicians accountable?
8. What mechanisms are needed so meaningful data is provided back to clinicians in a timely manner?

Required Collaboration:
Align with SB 440

Workgroup Action Items:

Action Item	Accountability	Deadline

Behavioral Health Collaborative Workgroup Scope

SCOPE OF RESPONSIBILITY WORKGROUP

Problem Statement:

Fragmented financing, delivery systems, and services fail to serve and exacerbate poor health outcomes for children, adolescents, adults, and older adults.

1. Access to behavioral health services, both specialty and general, do not meet the needs of all Oregonians in the right places at the right times in a culturally and linguistically specific manner
2. Continuum of care, service integration, and coordination between the systems of criminal justice, human services, health, and education is insufficient, administratively complex, and lacking in strategies addressing prevention for all populations.
3. Social determinants of health, including insufficient housing, employment, and transportation, create barriers to behavioral health resources that vary by community.

Workgroup Description:

The Scope of Responsibility Workgroup will use the model presented by the Farley Center to make recommendations to manage care across settings.

Workgroup Non-negotiables:

- Responsibility for health and behavioral health must be shared across settings, including the mental/behavioral health system, hospitals and emergency departments, primary care, schools, housing, public safety, first responders, and the judicial system
- Sites are accountable for a) identifying; b) treating; c) referring; and, d) following up.
- Increase primary care provider ability and competence in caring for behavioral health needs
- Establish standards for referral pathways, warm hand-offs, transitions, and team based care
- Include role definition and scope for clinicians

Expected Deliverables:

- Based upon predefined pathways, determine how to hold sites accountable for a) identifying; b) treating; c) referring; and, d) following up
- Connect and align with PCPCH and CCBHC programs. Determine services that should mostly be provided in a primary care setting. Recommend a definition of when care should be managed by specialty behavioral health. Recommend which guidelines should be adopted and standardized for practices regarding referral, denials, and appropriate levels of care.
- Recommend pathways to identify who should be responsible and accountable for care coordination as an individual moves outside of the medical environment.

- Recommend pathways as individuals enter different places where needs are identified (schools, EDs, jails…) and care coordination between settings.

Questions to Address Deliverables:

1. Are there services that should mostly be provided in a primary care setting?
2. When should care be managed by specialty behavioral health clinicians?
3. Are there guidelines that should be adopted and standardized for practices regarding referral, denials, and appropriate levels of care?
4. What are the referral pathways?
5. What are core competencies and scope for PCPs, care coordinators, BH specialists?
6. Who should be responsible and accountable for care coordination as an individual moves outside of the medical environment?
7. How do we move toward team based care?

Required Collaboration:
PCPCH and CCBHC programs

Workgroup Action Items:

Action Item	Accountability	Deadline

Behavioral Health Collaborative Workgroup Scope

WASTE WORKGROUP

[feel free to rename workgroup]

Problem Statement:

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3. Social determinants of health, including insufficient housing, employment, and transportation, create barriers to behavioral health resources that vary by community.

Workgroup Description:

The Waste Workgroup will make system improvement recommendations streamline care coordination and system coordination.

Workgroup Non-negotiables:

- Take into account different layers of waste (e.g. administrative, system), and leverage the conceptual framework to name specific people and processes
- Increase efficiency by reducing the number of assessments and increasing coordination (multiple assessments due to lack of coordination between systems/programs)

Expected Deliverables:

- Identify what interferes with timely appropriate access. Identify unnecessary administrative responsibilities that get in the way of providing better care.
- Recommend tools or systems that could assist clinicians at the practice level to enhance access and quality.
- Determine what changes could be streamlined to enhance care coordination and system coordination.
- Determine what could be standardized to improve both consumer and provider experience.
- Determine what changes are needed to break down barriers between mental health and substance use disorder treatment.
- Determine what changes are needed to align different programs and services – are there policies that are different that could be aligned?

Questions to Address Deliverables:

1. What interferes with timely, appropriate access?

2. What unnecessary administrative responsibilities get in the way of providing better care?
3. What changes could be streamlined to enhance care coordination and system coordination?
4. Are there tools or systems that could assist clinicians at the practice level to enhance access and quality?
5. What could be standardized to improve both consumer and provider experience?
6. What changes are needed to break down barriers between mental health and substance use disorder treatment?
7. What changes are needed to align different programs and services?
8. Are there policies that are different that could be aligned?

Required Collaboration:

Workgroup Action Items:

Action Item	Accountability	Deadline

What do you think about CCOs in Oregon?

The Oregon Health Policy Board (OHPB), a nine-member group appointed by the Governor to oversee health policy at OHA, will hold a series of community meetings across the state in September and October to gather public input about Oregon's coordinated care organizations (CCOs) and how they deliver services to Oregon's most vulnerable citizens.

OHPB members will visit communities around the state to hear input about CCOs. An on-line survey will provide an opportunity for input for those not able to attend a community meeting. Public testimony is also welcome at the OHPB's regularly scheduled board meetings. They will use your comments and views to develop policy that will shape the future of coordinated care in Oregon.

- **Who**: OHPB wants to hear from Oregon Health Plan members, advocates, primary care providers and other stakeholders about what the future of Oregon's CCOs should look like, as the board develops the next Action Plan for Health.
- **What**: Input will be used for a report to the Governor, the Legislature and OHA delivered in January 2017.
- **When**: The board welcomes all public input and testimony to inform their recommendations. Listening session dates, times and locations are listed below:

City	Date and Time	Location
Bend	Thursday, September 1 11 a.m. to 1:30 p.m.	Deschutes National Forest Supervisor's Office 63095 Deschutes Market Rd. Aspen Ponderosa Conference Room
Tillamook	Friday, September 9 4 to 6:30 p.m.	Port of Tillamook Bay Officers' Mess Hall, 6825 Officer's Row
Medford	Wednesday, September 21 5:30 to 8 p.m.	Inn at Commons 200 N Riverside Avenue
Eugene	Monday, September 26 Noon to 2:30 p.m.	Unitarian Universalist Church 1685 W 13th Ave.
Hermiston	Friday, October 7 Noon to 2:30 p.m.	Eastern Oregon Trade & Event Center 1705 East Airport Rd.
Portland	Tuesday, October 18 4:30 to 7 p.m.	Ambridge Event Center 1333 NE Martin Luther King Jr. Blvd.

Please RSVP to HealthPolicyBoard.Info@state.or.us
For more information: www.oregon.gov/oha/OHPB/Pages/cc-future.aspx

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Workforce Committee Update

For The Oregon Health Policy Board

October 4, 2016

Agenda

- HB 3396 and next steps
- 2015-2017 HCWF Committee deliverables review
- Workforce Committee Charter for 2017
- Recruitment of new Committee members

1. HB 3396 Implementation

Background

- **Removed existing siloes of provider incentive programs and replaced with single OHA-administered "Health Care Provider Incentives Fund"**
- **Directed OHBP to "study and evaluate" existing programs and make recommendations to the Legislature regarding:**
  - **continuing, restructuring, consolidating or repealing current incentives;**
  - **prioritization of incentive funds to qualified providers; and,**
  - **consideration of new financial incentive programs.**
- **Recommendations and Report approved by OHPB at Sept meeting**
- **Next steps: Send to Legislature with cover memo from OHPB**

1. 3396 Implementation – Next Steps

- Oct 2016 – Feb 2017: OHA responsibilities
  - Develop draft work plan for implementation, including assessment of costs, funding, and staffing needs of each recommendation
  - Identify key partners for collaboration (e.g., ORH)
  - Ensure alignment with other OHA/OHPB efforts
- Oct 2016 – Feb 2017: HCWF Committee responsibilities
  - Provide clarity and guidance on priorities for "Health Care Provider Incentives Fund"
  - Establish timeline and priorities for deliverables (short-term vs. long-term)
  - Review and approve work plan for implementation
  - Monitor final tasks and deliverables, including ongoing evaluation
- OHPB – What level of oversight and input?

1. HB 3396 – Work Plan for Implementation

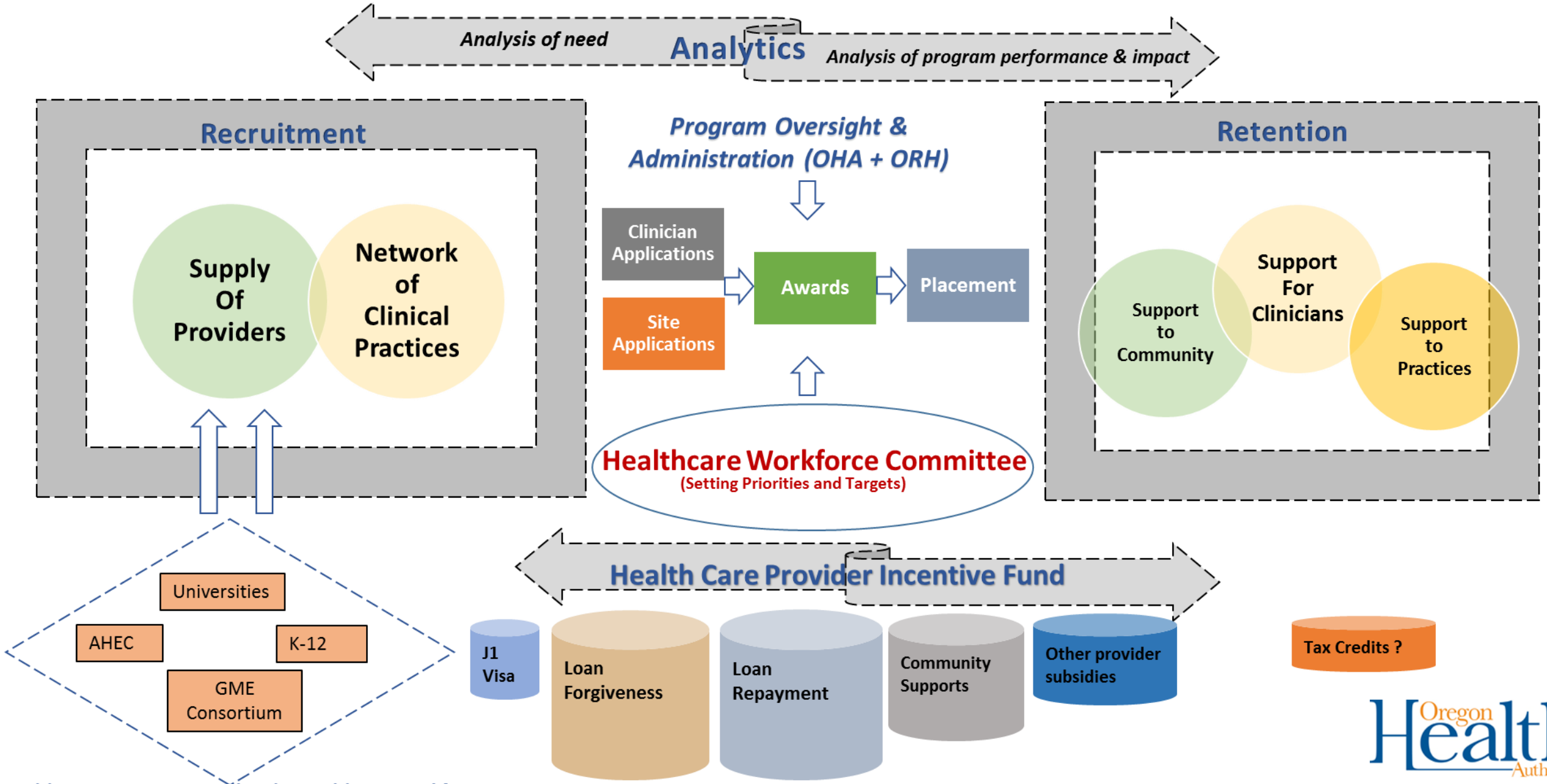
OHA and the HCWF will develop a prioritized timeline for recommendations, including:

- 2017 priority: **Plan for data monitoring** – comprehensive data collection that provides insight on drivers of program participation, provider retention and program effectiveness
- Development of **common online applications** for sites and clinicians seeking either federal or state incentive funds
- Creation of **online "Hub"** for information on provider incentive resources
- Establishment of a **"Collaborative" for Community Best Practices** around Recruitment and Retention, driven by needs of stakeholders
- Alignment and **monitoring of efforts around the comprehensive provider dataset** (Provider Directory) that's linked to other data sources (i.e. medical and/or nursing boards) through unique identifiers.
- Development **of "Incentive Optimizer"** tool to identify total costs to adequately staff all areas of the state with basic provider-to-population ratios of care

1. HB 3396 Implementation - Discussion

What aspects of this work does the OHPB want to emphasize in the memo to the Legislature?

A Transformed Model of System Supports for Recruitment and Retention



2. 2015-2017 HCWF Deliverables Update

- Baseline demographic and geographic profile of Oregon's behavioral health workforce Complete October 2015
- Provider Incentives Program Study (HB 3396) Complete Sept 2016
- Data Reporting Expect: January 2017
  - "Refresh" of the Biennial report on the ethnic and linguistic diversity of the healthcare workforce
  - Update to the Board on the projected demand and supply of primary care physicians
- Behavioral Health Integration recommendations Expect: December 2016

3. Discussion of Future Charter

Ideas that have emerged from the HCWF Committee:

- Continued development of the future of provider incentives (ongoing HB 3396 work)
- Focus on Rural Workforce – how to fill gaps
- Competencies needed to practice in a coordinated care/post ACA environment
- Allied Behavioral Health shortages
- Continuation of work on recommendations to support BH Integration with Primary Care
- Quantifying/identifying gaps around supply and distribution of the primary care workforce
- Pipeline Development

- Do any of these resonate? Other ideas or priorities to share with the Committee?

4. Recruitment for Committee

- Currently 3 vacancies; anticipate another 2 by year's end with term end dates
- Looking for:
  - Representation from Eastern and Southern Oregon
  - Community Colleges and Graduate Programs
  - Representation of the needs/interests of people with disabilities
  - Community health workers
  - Ethnic and racial diversity

Oregon Health Information Technology Update

Susan Otter
Director and State Coordinator for Health Information Technology

October 2016

Oregon Health Authority

Topics

- Update on Oregon's HIT environment:
  - Highlights from 2015/2016
- Planned work – coming back to the Board in 2017
  - HITOC: Strategic Plan Update
  - Behavioral Health HIT Scan
  - Annual report
- HITOC membership

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How does Health IT support CCOs and the coordinated care model?

Selected characteristics of the coordinated care model:

- Care coordination, population management throughout the system
- Integration of physical, behavioral, oral health
- Accountability, quality improvement and metrics
- Alternative payment methodologies
- Patient engagement

Coordinated care model relies on access to patient information and the Health IT infrastructure to share and analyze data

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Goals of HIT-Optimized Health Care

1. Sharing Patient Information Across the Care Team

- Providers have access to meaningful, timely, relevant and actionable patient information to coordinate and deliver “whole person” care.

2. Using Aggregated Data for System Improvement

- Systems (health systems, CCOs, health plans) effectively and efficiently collect and use aggregated clinical data for quality improvement, population management and incentivizing health and prevention.

3. Patient Access to Their Own Health Information

- Individuals and their families access their clinical information and use it as a tool to improve their health and engage with their providers.

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OHA's HIT Priorities (a short list)

Past	• Physical health: EHR Adoption and Meaningful Use payments • Basic common exchange: Direct secure messaging

Current	• Support for care coordination (CCOs, PCPCHs, local HIE)
	  • Hospital event notifications (EDIE/PreManage)
	  • Core infrastructure components (Provider directory, e.g.)
	• Initiatives/pilots/grants:
	  • Telehealth, OpenNotes, end of life/ePOLST
	  • Behavioral health consent, opiate prescribing/PDMP

Future	• Support for value based payment and population management
	• New opportunities for funding and evolution of governance
	• Advancing care coordination
	  • Interoperability and query
	  • Connecting care team
	  • Expanding notifications to other transitions of care
	• Support for consumer access/mobile health

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Oregon Health IT Adoption and Use: highlights for 2015/2016

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Oregon HIT highlights in 2015/2016

- Adoption of Electronic Health Records
  - 74% of Oregon physicians have a certified EHR
  - Oregon is in top tier of states for federal “meaningful use” incentives
- CCO investments in HIT
  - Regional HIEs
  - Care coordination, case management tools
  - Population management, analytics
- Emergency Department Information Exchange and PreManage spreading across the state
- Telehealth pilots and consumer access to full clinical record

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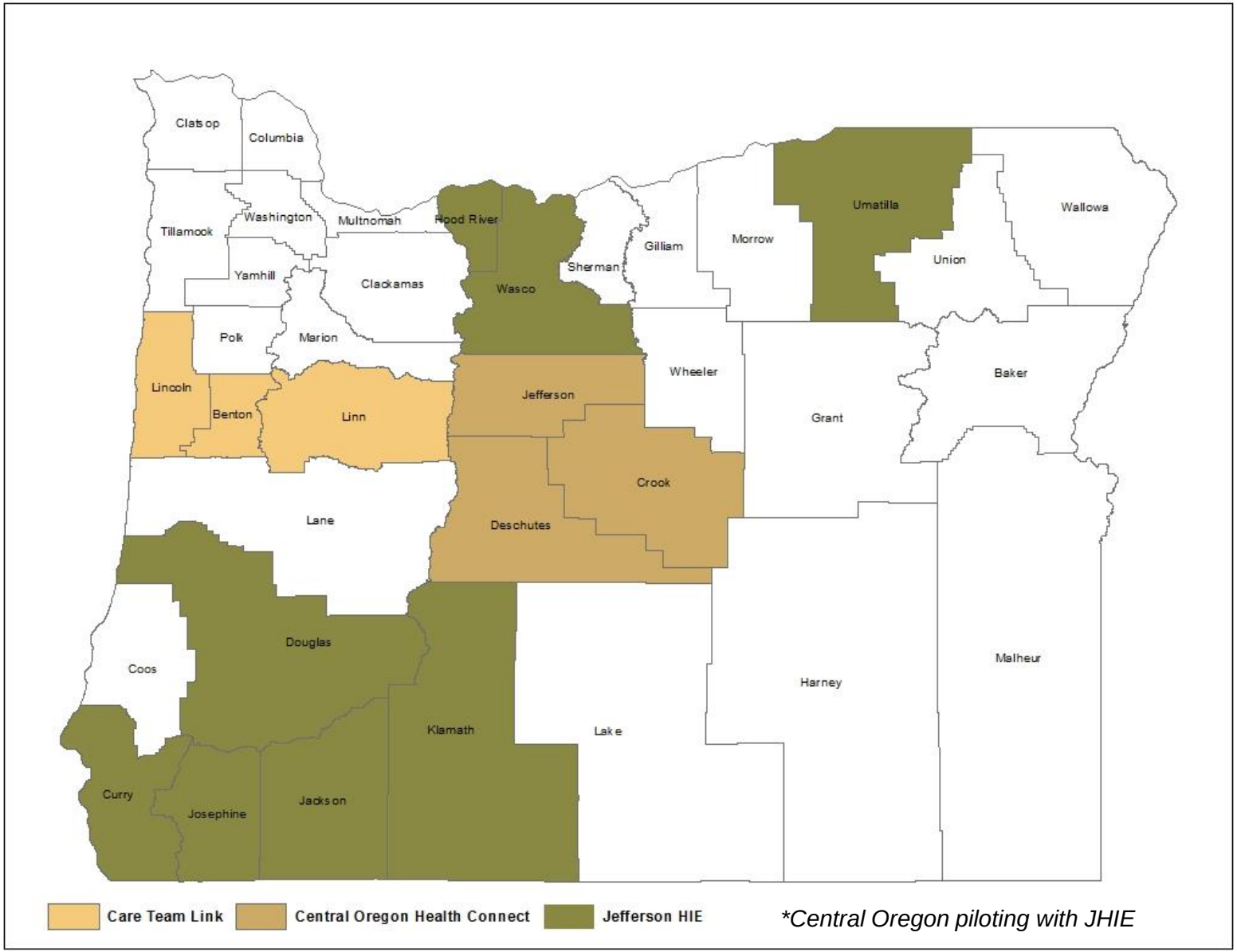
Health Information Exchange Options

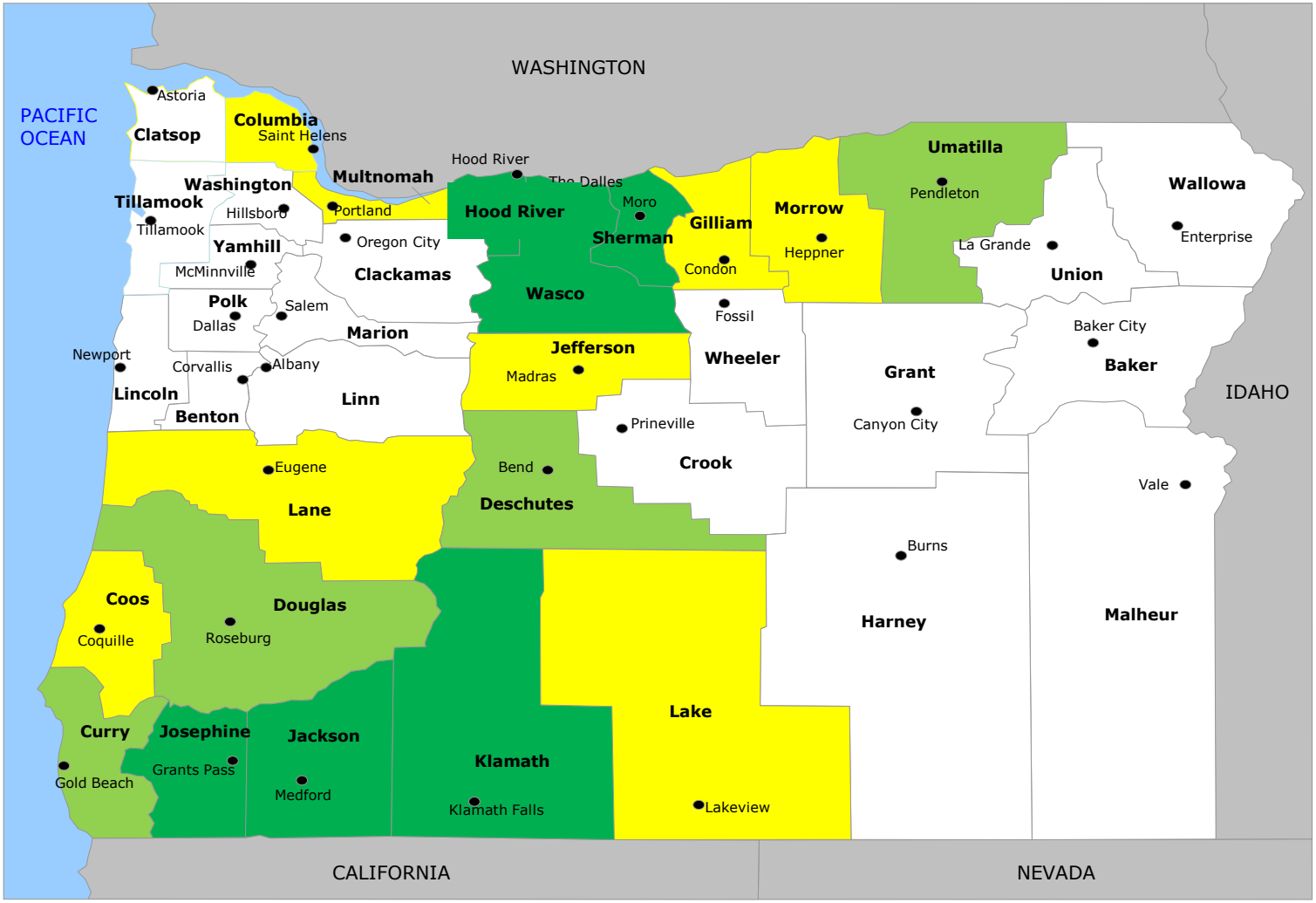
- State-supported
  - Direct secure messaging (e.g., via EHRs, HIEs, CareAccord)
  - EDIE/PreManage
  - Public health reporting (e.g., Immunization registry, PDMP)
  - HIE-enabling (Provider Directory, FlatFile Directory for Direct secure messaging addresses)
- Other HIE
  - Regional HIEs (JHIE, RHIC)
  - Vendor-driven solutions/National networks:
    - Epic Care Everywhere, CommonWell, Sequoia: Carequality
  - Federal Network (Sequoia: eHealth Exchange)
    - Connection to federal agencies: SSA, CMS, VA, etc.
  - Organizational efforts:
    - By CCOs, health plans, health systems, IPAs, etc.
    - Including private HIEs, point-to-point interfaces, HIT tools, hosted EHRs, etc. that support sharing information across users

Regional HIEs – by County*



*Central Oregon piloting with JHIE

JHIE Coverage Area as of Feb 2016



Enrolled hospitals & clinics
Enrolled clinics
Some Interest in participating
Currently no activity

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Sharing Hospital Event Data

- The Emergency Department Information Exchange (EDIE) Utility
  - Collaborative effort led by the Oregon Health Leadership Council with OHA and other partners
  - Connects hospital event data from OR, WA
  - Notifies ED of high utilizers – provides critical information for ED
- PreManage
  - Provides real-time notifications to subscribers when their patient/member has a hospital event
  - Dashboards provide real-time population-level view of ED visits
- Care guidelines—
  - Subscribers can add key care coordination information into PreManage, viewable by other users

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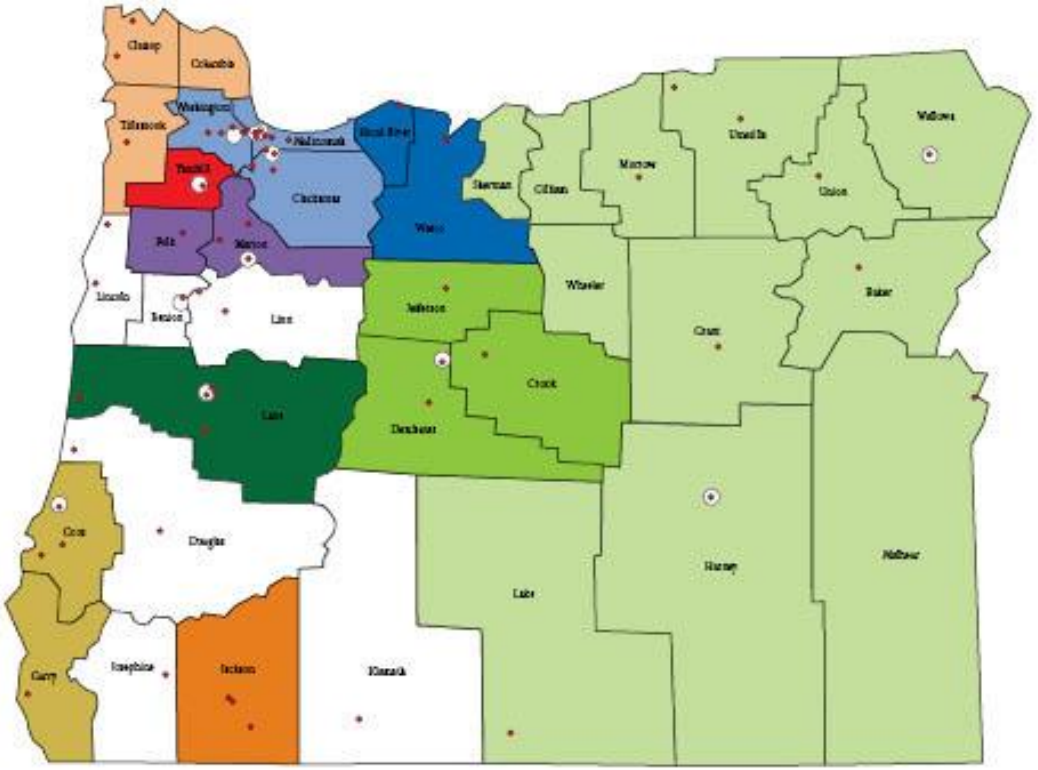
Adoption of hospital notifications by CCOs, hospitals, and ACT teams



CCO geographic coverage is adjusted to county level but does not depict exact service areas by ZIP code.

Legend

- Hospitals on EDIE
- Assertive Community Treatment teams subscribed to PreManage

CCOs subscribed to PreManage

- Columbia Pacific CCO
- Eastern Oregon Coordinated Care Organization (in process of PreManage adoption)
- FamilyCare Health and Health Share of Oregon
- Jackson Care Connect
- PacificSource Community Solutions — Central Oregon
- PacificSource Community Solutions — Columbia Gorge
- Trillium Community Health plan (in process of PreManage adoption)
- Western Oregon Advanced Health (in process)
- Willamette Valley Community Health
- Yamhill County Care Organization

Upcoming Health IT opportunities and efforts

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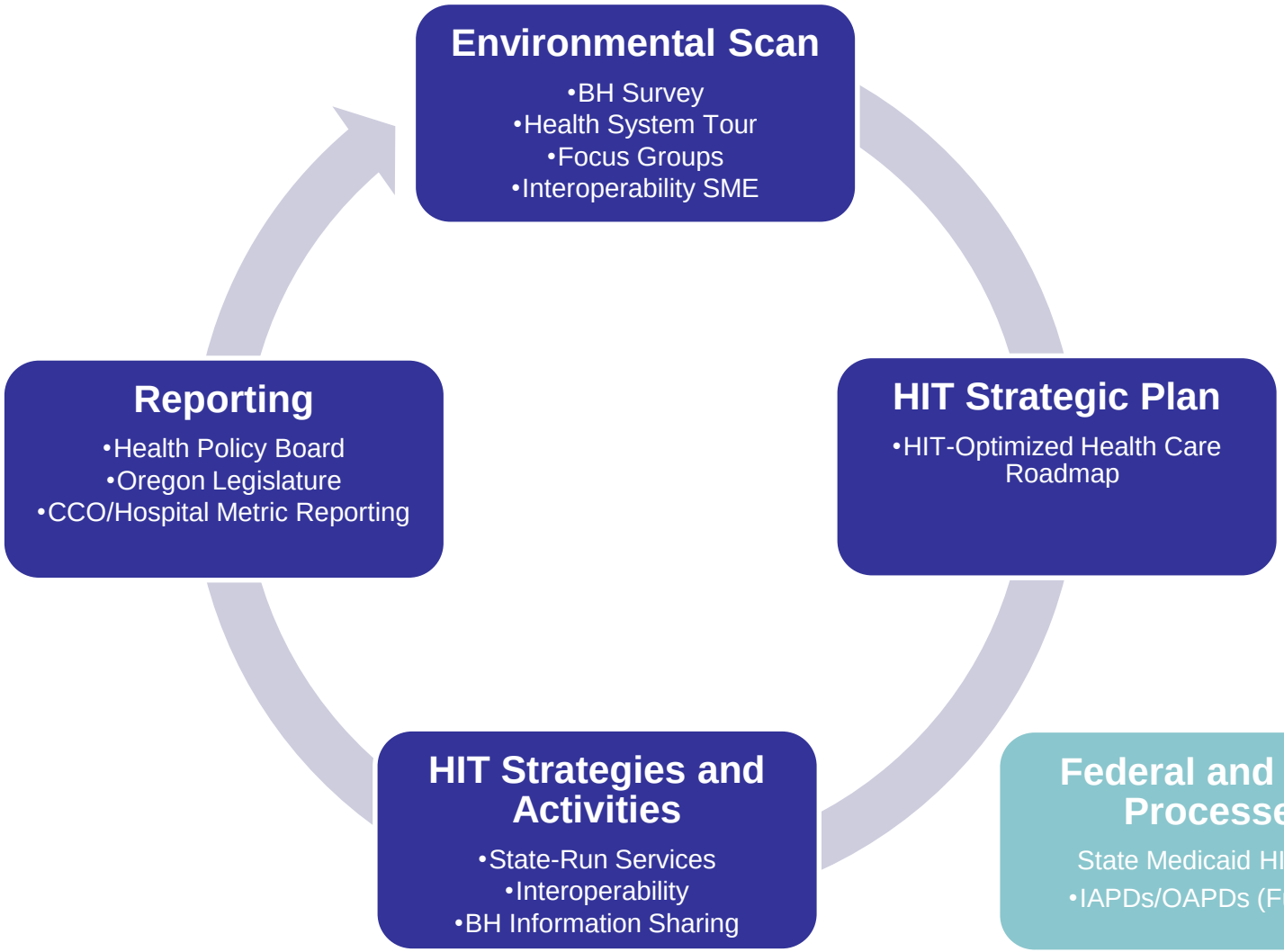
Environmental Scan
•BH Survey
•Health System Tour
•Focus Groups
•Interoperability SME
HIT Strategic Plan
•HIT-Optimized Health Care Roadmap
Federal and State Processes
State Medicaid HIT Plan
•IAPDs/OAPDs (Funding)
HIT Strategies and Activities
•State-Run Services
•Interoperability
•BH Information Sharing
Reporting
•Health Policy Board
•Oregon Legislature
•CCO/Hospital Metric Reporting

Updating Oregon's HIT Strategic Plan

- The Business Plan Framework is set through 2017
  - An update to this plan is slated for 2017
  - "Monitor and adapt" principle
- HITOC process —
  - HITOC and OHA will turn to its advisory groups to inform this plan
  - Stakeholder engagement planned: behavioral health scan; listening tour of health systems; interoperability workgroup
- Changing environment (waiver, MACRA, CPC+, etc.)
  - New funding opportunity (HIE Onboarding for Medicaid) requires more centralized role
  - Good time to re-evaluate state role and other strategic plan components

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2010 Action Plan for Health and HIT

- Goal: Electronic health information is available when and where it is needed to improve health and health care through a secure, confidential health information exchange.
- Maximizing EHR adoption and connectivity
- Focus on developing/connecting regional health information exchanges
- Establishing the Office for Health Information Technology (OHIT) to coordinate planning and implementation
- Establishing a “state-designated entity” to connect local and regional health information exchange operations

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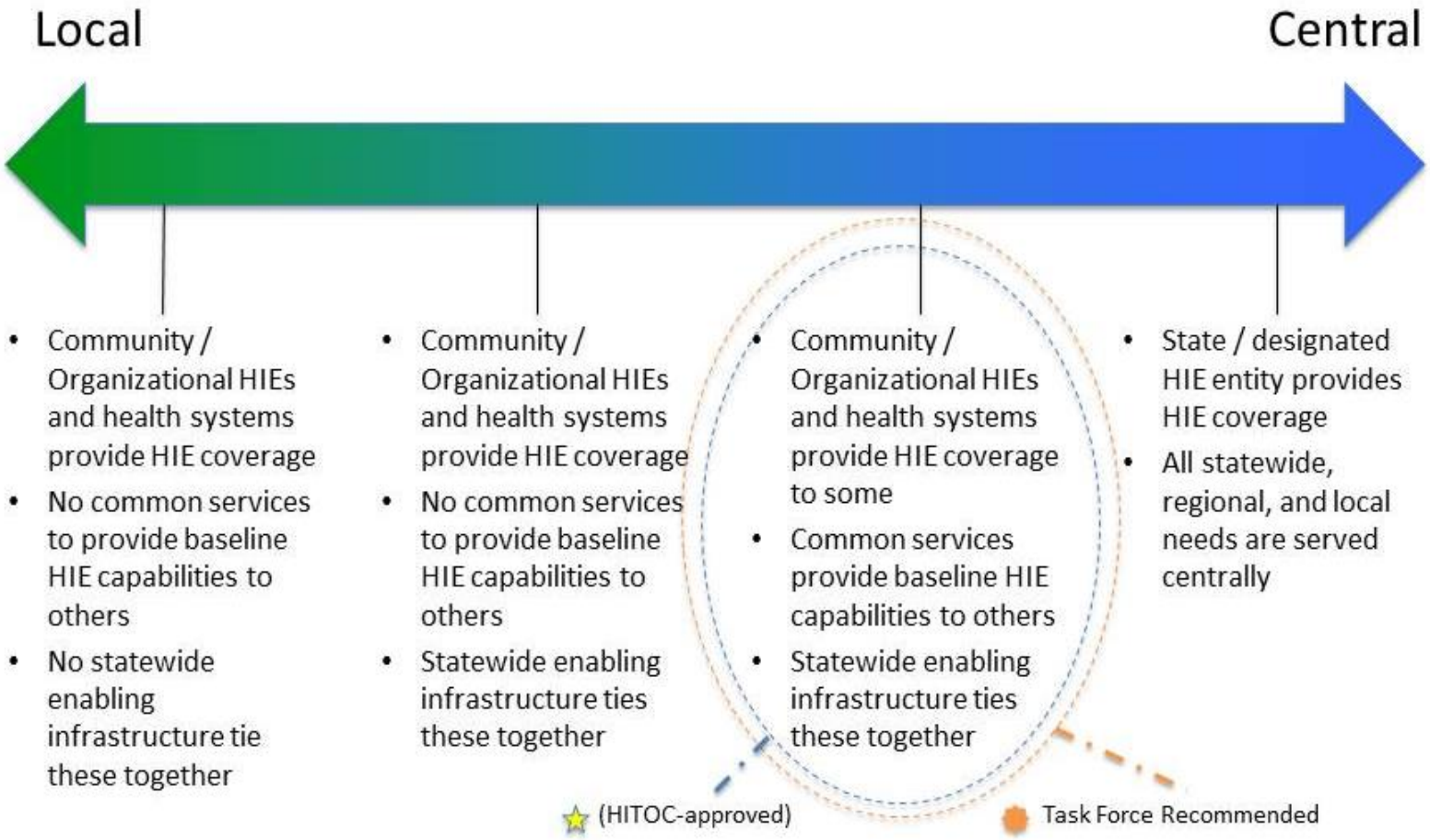
Approaches to Statewide HIE Coverage



- State partnership model with governance over "network of networks"

New CMS HIE Funds – OHA Approach

Oregon intends to explore using new federal funds to:

1. Support care coordination across Medicaid providers, including supporting proposed housing and corrections initiatives in Oregon's proposed 1115 waiver demonstration by
   - supporting the costs of an HIE entity (e.g., regional HIEs) to onboard providers
2. Support Oregon's Medicaid providers, with or without an EHR, including:
   - behavioral health, long-term care, corrections, and other social services, to connect to HIE entities.
3. Ensure HIE entities in Oregon are able to support OHA's Medicaid objectives by setting criteria that entities would need to meet to be eligible for funding

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CMS Guidance (2016) on HIE Funds

State Medicaid Directors Letter on HITECH funding:

- 90% federal matching funds for activities to promote HIE to enable eligible professionals (EPs) to meet meaningful use
- Support for any Medicaid provider to connect to HIE entities or other interoperable systems:
  - behavioral health, long term care, corrections, etc.
- Support for HIE entity costs for onboarding (e.g., interface, data agreements, etc.) – could also apply to onboarding to:
  - public health systems,
  - a statewide provider directory
- Funds cannot support:
  - the provider's costs for onboarding (e.g., EHR vendor costs)
  - operational costs or to purchase EHRs

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HIE Onboarding Program – Next steps

Health Information Technology Oversight Council endorsed concept June 9, 2016

OHA next steps:

- Establish a process and forum to determine criteria
  - Convene small stakeholder work group to help OHA staff develop the concept
  - Continue to socialize concept and gather input
  - Report back to HITOC and other stakeholders
- Formalize strategy, in partnership with stakeholders
- Submit a concept to CMS for discussion and ultimately approval

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Behavioral Health Scan

- Coordinated Care Model relies on HIT infrastructure to share data across provider types
- Limited types of behavioral health providers are eligible for the EHR Incentive Program
  - Lower rates of HIT adoption
  - Lack of data
- Scan will
  - Provide information about adoption, barriers, plans, and priorities
  - Highlight areas of needed support for OHA to consider
  - Potentially inform policies

Health IT Oversight Council – Membership and Next Steps

Oregon Health Authority

HITOC responsibilities

- Make recommendations related to Health IT to the Board to promote health system transformation
- Regularly review and report to the Board on:
  - Status of the Oregon Health IT program and other OHA health IT efforts
  - Efforts of local, regional, and statewide organizations to participate in health IT systems
  - Adoption and use of health IT among providers, systems, patients, and other users in Oregon
- Advise the Board or the Congressional Delegation on federal law and policy changes that impact health IT efforts in Oregon

OHPB responsibilities

- HB2294 (2015) moved HITOC under the Health Policy Board
  - The Board is responsible for chartering HITOC, appointing members and determining terms, and
  - Ensuring that there is broad representation on HITOC of individuals and organizations that will be impacted by the Oregon HIT Program
    - Experience, knowledge, expertise in health care delivery, health information technology, health informatics, and health care quality improvement
    - Other priorities for membership (cross-section of care delivery perspectives, consumer advocates, behavioral health, dental, diverse geographical representation, etc.)
- Board considers HITOC recommendations and takes action as appropriate
- Board reports and refers HIT issues to HITOC as needed

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HITOC Membership

Name	Title	Organizational Affiliation	Location	Term
Maili Boynay	IS Director Ambulatory Community Systems	Legacy Health	Portland, OR	3
Robert (Bob) Brown* (vice-chair)	Retired Advocate	Allies for Healthier Oregon	Portland, OR	2
Erick Doolen (chair)	COO	PacificSource	Springfield, OR	4
Chuck Fischer	IT Director	Advantage Dental	Redmond, OR	3
Valerie Fong, RN	CNIO	Providence Health & Services	Portland, OR	2
Charles (Bud) Garrison	Director, Clinical Informatics	Oregon Health & Science University	Portland, OR	4
Brandon Gatke	CIO	Cascadia Behavioral Healthcare	Portland, OR	3
Amy Henninger, MD	Site Medical Director	Multnomah County Health Department	Portland, OR	2
Mark Hetz	CIO	Asante Health System	Medford, OR	4
Sonney Sapra	CIO	Tuality Healthcare	Hillsboro, OR	3
Greg Van Pelt	President	Oregon Health Leadership Council	Portland, OR	2

**Bob Brown will be stepping down when a replacement is found*

Gaps to fill:

- Consumer/advocate
- Underserved areas: Rural/frontier, Tribes, small/unaffiliated provider
- Social services, long term supports/services
- Health information exchange
- Supplemental behavioral health perspective

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HITOC timeline:

- Call for nominations – targeted to fill gaps - October
- Proposed members for Board approval – December
- Behavioral Health HIT Scan – early 2017
- Annual report – summer 2017
- HITOC: Strategic Plan Update – mid/late 2017

- Coordination through Board liaison

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Learn more about Oregon's HIT/HIE developments and Subscribe to our email list!

www.HealthIT.Oregon.gov

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