



CCO Oregon Annual Conference: Coordinated Care and the Road Ahead

Tuesday, September 24, 2019 from 8:30am - 4:30pm
Salem Convention Center

8:30am Attendee check-in and exhibitor booths open

9:00am Morning plenary

Willamette B/C **Welcome and opening remarks**
Samantha Shepherd, Executive Director, CCO Oregon and Matt Sinnott, Co-Chair, CCO Oregon Board of Directors and Senior Director of Government Affairs and Contracting, Willamette Dental

Keynote: CCO 2.0 and the road ahead
Pat Allen, Administrator, Oregon Health Authority

9:50am Concurrent sessions - Round 1

Willamette A **Lessons learned: Community health information exchanges**
Erick Maddox, Reliance eHealth Collaborative and Michael Heidenreich, PacificSource Health Plans

Learn more about the health information exchanges in coordinated care including common use cases and workflows for a CCO. Presenters will discuss varied methods of clinical data exchange through the HIE employed to reduce missing patient information and resources spent acquiring records, improve results management, support decisions made at the point of care, and ultimately improve the transition and coordination. Discussion will include solutions to those challenges, including a current OHA initiative to reduce financial barriers.

Willamette B/C **Diabetes integration pilot for individuals with severe and persistent mental illness**
Harish Asok and Alexandra (Ally) Birch, Cascadia Behavioral Healthcare

Individuals with co-occurring severe persistent mental illness (SPMI) and diabetes encounter additional barriers to managing diabetes including medication complexity, access to health care, and stigma. Cascadia Behavioral Healthcare will deliver a fully integrated diabetes program for individuals with co-morbid diabetes/pre-diabetes and SPMI. Their objectives include: designing a diabetes management program that integrates behavioral, physical and oral health care; increasing patient engagement; and, improving diabetes management and health outcomes.

Croisan Creek A **Age-based care and community-based, integrated solutions (combined presentation)**

A. Safe housing: Aging-in-place and care coordination with social service contracts
Sam Engel, AllCare Health CCO and Howard M Johnson and Sharon Johnson, Rebuilding Together - Rogue Valley



Smoke Busters is a pilot project, which aims to improve the in-home environmental conditions of vulnerable populations. For the past several years, Southern Oregon has experienced extended periods of wildfire-created smoky conditions that range from “unhealthy” to “hazardous,” particularly for those with chronic lung conditions, such as asthma, bronchitis or COPD. During smoky days people are encouraged to wear face masks or stay indoors. However, in homes with less than adequate air filtration, remaining indoors may represent a health threat as well.

B. Purposeful intergenerational communities: Trauma informed solutions to social issues

Shelley Gillespie and Renee Moseley, Bridge Meadows

Without proper support and stable housing, highly emotional, complex family dynamics can further exacerbate trauma by perpetuating an intergenerational cycle of poverty. Bridge Meadows interrupts this cycle of instability and isolation. Working at the intersection of child welfare, affordable housing, health and aging, integrated onsite trauma informed services and therapeutic interventions improve health, housing stability, educational attainment, and social connection for residents of all ages.

Croisan
Creek B

The road ahead for community health improvement planning: CHIPs and the SHIP

Anona Gund and Christy Hudson, Oregon Health Authority; Darin Dale, Jackson Care Connect; Paul Lindberg, United Way Columiba Gorge; Angie Treadwell, Oregon State University Extension; and Maria Tafolla, Health ShareOregon; and, West Livaudais, Oregon Health Sciences University

With the majority of CCOs completing new community health improvement plans in 2019 and the changing landscape with CCO 2.0, there is a great opportunity to increase collaborative efforts. At the same time, OHA’s Public Health Division is developing the next State Health Improvement Plan (SHIP). This presentation will highlight CCO programs and efforts that improve collaboration and/or address the new 2020-2024 SHIP.

Croisan
Creek C

New payment models and social determinants of health: Are these evolving together? Lessons from the Community Health Center setting

Carly Hood Ronick, Oregon Primary Care Association and Fred Dolgin, Virginia Garcia Memorial Health Center

Community health centers were built on the connection between health and socioeconomic conditions, and have steadily improved the health of families and communities experiencing poverty. In 2012, many health centers in Oregon began entering new payment models in partnership with the Oregon Health Authority and the Oregon Primary Care Association. Virginia Garcia Memorial Health Center will share how they’ve harnessed the power of this new payment model to address the root causes of poor health. Attendees will learn about the evolution of measuring equity and social determinant efforts within the new payment model; the changes at one health center to move more upstream; and, expanded efforts to promote opportunities in CCO 2.0.

10:50am Break

10:55am Concurrent sessions - Round 2

Willamette A

Taking a public health approach: Providing oral health services in schools

Melissa Freeman and Tom Holt, Oregon Community Foundation; Linda Mann, Capitol Dental; and Trina McClure-Gwaltney, Mercy Foundation



The Oregon Children’s Dental Health Initiative is a five-year effort to expand access to dental prevention services in elementary and middle schools throughout Oregon. School-based dental health programs are an evidence-based, effective approach to improving dental health and promoting health equity. School-based dental health programs provide dental screenings, sealants, fluoride, and oral health education. These programs reduce dental pain and suffering and are a highly effective way to reduce states’ oral health costs, resulting in cost savings within two years. Learn more about building school based partnerships, data outcomes, and next steps to further success.

Willamette
B/C

[Panel management strategies to optimize member engagement with primary care](#)

Resa Bradeen and Jessica Young, Children’s Health Alliance and Children’s Health Foundation

As CCO/plan membership fluctuates, the role of proactive patient/panel management to rapidly onboard and deliver preventive and acute care in the primary care setting is increasingly critical. The Children’s Health Alliance will present key learning for member-to-PCP assignment and best practices for engaging members with Primary Care in order to achieve clinical care outcomes.

Croisan Creek
A

[FIT outreach to increase participation in colorectal cancer screening: BeneFIT study outcomes](#)

Amanda Petrik and Jennifer Rivelli, Kaiser Permanente Northwest Center for Health Research

A recent hybrid implementation-effectiveness study comparing the implementation and outcomes of two program models that health plans developed for a mailed fecal immunochemical test (FIT) intervention. The health plans mailed FITs to the homes of age-eligible Medicaid and Medicare health plan members overdue for colorectal cancer screening. Health Plan A used a collaborative approach of mailing co-branded introductory letters, FIT kits, and reminder postcards and relying on clinics’ standard procedures for ordering and processing completed FIT kits; Health Plan B used a centralized approach of mailing FITs directly to patients, processing them at a centralized laboratory, and delivering live reminder phone calls to patients who had not completed their FITs.

Croisan Creek
B

[Utilizing Community Health Workers to address the underlying causes of addiction](#)

Kate Gekeler, Northeast Oregon Housing Authority and Liberty Avila, Northeast Oregon Network (NEON)

The Pathways Community Hub model works with contracted partner organizations to employ Community Health Workers (CHWs) to work with vulnerable individuals and families. CHWs work to link community members with services that address identified needs. Utilizing a three-year grant from HRSA, NEON adopted the Pathways model, historically used with adults with chronic conditions, to those 14 years of age and older that are either misusing opioids or are determined to be at risk of misusing opioids. Our first project task was to define “at-risk.” Using our newly defined qualification standards, we enrolled community members in the Pathways Community Hub, essentially using the same intervention, but with a different target population.

Croisan Creek
C

[Prepared for high-quality patient care? Clinical orientation for new staff](#)

Sarah Deines, Anayeli Franco, Julia Solano, and Kira Pietras, Virginia Garcia Memorial Health Center

Medical staff are responsible for collecting and documenting up to 100 data points for each patient encounter. Despite the tremendous responsibility we place on our medical support staff, many do not have a consistent plan for training new staff to perform patient-centered, high-quality standard work. The original version of this training was developed by a training workgroup and focused on 10-day training program scheduled over a 4-week period for medical assistants and nurses on alternating months. This created challenges as new employees may not complete all sessions for two months after hire; resulting in continued reliance on peer-to-peer training in busy, understaffed



clinics. In 2018, the curriculum was transferred to Clinical Programs Managers, who redesigned the curriculum to align with organization-wide onboarding every other Monday.

11:55am **Networking lunch and plenary**

Willamette
B/C

CCO Oregon workgroups and programs

Facilitator: Samantha Shepherd, Executive Director, CCO Oregon

After getting your buffet lunch, please choose a table in the main ballroom. Tables will be labeled per CCO Oregon workgroup: Behavioral Health, Dental and Oral Health, Pharmacy, and Social Determinants of Health. Choose what interests you and meet colleagues from across Oregon addressing the same challenges as you. The time will be lightly structured, leaving ample space for networking.

U.S. Senator Jeff Merkley video address

Oregon State Legislative panel: Coordinated care and the road ahead

Senator Laurie Monnes Anderson, Chair, Senate Health Care

Representative Cedric Hayden, Vice-Chair, House Health Care

Representative Rob Nosse, Co-Chair, Ways and Means Subcommittee on Human Services

Representative Tawna Sanchez, Vice-Chair, House Human Services and Housing

Representative Anna Williams, Vice Chair, House Human Services and Housing

Representative Rachel Prusak, Member, House Health Care

Facilitator: Sean Kolmer, Co-Chair, CCO Oregon Board of Directors and Senior Vice President of Policy and Strategy, Oregon Association of Hospitals and Health Systems

1:50pm **Concurrent sessions - Round 3**

Willamette
A

Value-based payments and shared risk coordinated care projects (combined presentation)

A. Community-driven investments and community-shared risk

Keshia Bigler, Emileigh Canalas, and Mae Pfeil, Columbia Pacific CCO

In 2015, Columbia Pacific CCO (CPCCO) entered county-level collaborative gain/risk sharing agreements to build shared ownership and accountability for CPCCO's member health at the community level and to incentivize providers to work together to improve quality care and reduce avoidable costs and utilization. Since then, each county has created cross-functional Operational Workgroups funding a Complex Care Hub in Clatsop that featured a triage coordinator, a social worker, and a registered nurse to provide care coordination and a Community Paramedicine program in Columbia with local primary care clinics and community mental health providers. In 2019, based on clinical and cost data, each risk sharing group decided to focus on addressing substance use disorder.

B. CCO 2.0 policy and value-based payments

Chris DeMars, Director, Oregon Health Authority Transformation Center

Oregon has a long history of health system transformation, including substantial efforts to move away from traditional volume-based health care payments to payments based on value that support positive member health

outcomes and cost savings. The Oregon Health Authority's (OHA's) value-based payment (VBP) policies in the second iteration of the coordinated care organizations' (CCO) contracts, "CCO 2.0," beginning January 2020 and continuing through 2024, support the increased use of payment methodologies that emphasize the quality rather than quantity of services provided.

Willamette B/C

Technological approaches to coordinate care in and out of the clinic (combined presentation)

A. Virtual tools to help rebuild the medical neighborhood

Tanya Kapka, CareOregon and Swati Kumar, RubiconMD

CareOregon and RubiconMD partnered in 2017 to rebuild a medical neighborhood with help from technology. RubiconMD's platform allows primary care clinicians to submit online cases to a national network of specialists, with same day responses for expert opinions. EConsults can improve the quality of care in the primary care setting and solve specialty access challenges, especially for underserved patient populations. Furthermore, communication and patient-centered focus is retained within a trusted primary care team, especially important for socially complex populations who may have extra challenges getting to specialist visits in person.

B. Transforming a health plan with technology for integrated care delivery under CCO 2.0

LeRoy E Jones, GSI Health and Jonathan Weedman, CareOregon

CareOregon and GSI Health will discuss their partnership to optimize care management with the use of technology to address "rising-risk" populations. CareOregon's strategy identifies key medical, behavioral, and social factors using a uniform methodology and orchestrates workflows using integrated care teams across business lines and external community partners to manage care. As a result, care team members function at the top of their training or license with critical insights that help them understand why a member is rising- or high-risk and what specific issues they need to focus on individually and as a team to improve member health. Strategies for deploying the approach within the organization and into communities using centralized and federated care management and disparate levels of provider engagement—as well as overcoming provider resistance to accessing another system—will be discussed.

Croisan Creek A

Medication-Assisted Treatments (MAT): Programs and tools (combined presentation)

A. Bringing substance use disorder treatment into the primary care setting: Medication Assisted Therapy, a Track for Empowering Recovery Success (It MATTERS)

Ilana Hull, Dara Johnson, and Nicole Antoniadis, Providence Medical Group

Medication Assisted Therapy, a Track for Empowering Recovery Success (It MATTERS) is a joint effort of Providence Medical Group Milwaukie and Southeast Family Medicine Clinics, which are the two residency clinics of the Providence Oregon Family Medicine Residency. It utilizes a team-based approach in which medical providers, pharmacists, case managers, behavioral health integration (BHI) specialists and support staff each play an integral role in program development and operation. The program allows patients to access MAT within the primary care setting, which allows for increased privacy, less stigmatization and the ability to care for all of a patient's health care needs in one place. Discussion will include the program structure, including some initial data about our program participants, patient success stories, and challenges encountered during the first year.

B. Building Bridges: A Sustainable Model to Increase Successful Access to Services Across the Continuum of Care for MAT Patients



Alice Mollo-Christensen, Ben Schwartz, Recovery Works NW and Stacie Antoniadis, CareOregon

Part of Recovery Works NW's mission is to increase access to Medication-Assisted Treatment or Medication Supported Recovery programs. Their outpatient model is designed to fill the gap they've observed between residential treatment, daily dispense, and primary care. The Recovery Works NW team believes in innovative treatments to increase access to services, and create viable, replicable models to increase positive treatment outcomes. They aim to work with care providers, payers, and treatment programs to support the implementation of modular solutions that can significantly expand overall access to services beyond the direct scope of our own programming. The presentation will provide an overview of the current program model and review the successes and challenges encountered through various pilot programs and other endeavors as progress towards program goals continues.

C. Addressing addiction through Project ECHO: Innovative program offerings for various settings

Jonathan Robbins and Maggie McLean McDonnell, Oregon Health Sciences University

In 2016, Oregon began offering a Substance Use Disorders in Ambulatory Care ECHO program to build capacity to screen for and treat substance use disorders (SUD) in primary care. Building on that experience, this year Oregon has offered four addiction-focused ECHO programs. Two programs are designed to build knowledge and skills in diagnosing and treating substance use disorders (Substance Use Disorders in Ambulatory Care and Chronic Pain and Opioids in primary care). Two programs are designed to build systems to support clinicians in implementing best practices (Effective Systems for Treating Addiction in Primary Care and Substance Use Disorders in Hospital Care.)

Croisan Creek B

Outcomes and approaches to dental and oral health integration (combined presentation)

A. First Tooth Training impact on children's oral health assessments, fluoride varnishes, and other dental services

Sarah Bartelmann, Providence Center for Outcomes Research & Education (CORE) and Laura McKeane, AllCare Health

Early childhood caries (ECC) are one of the most common chronic conditions in children, and children from low-income families have decreased access to dental services. First Tooth is an oral health integration program designed by the Oregon Oral Health Coalition to reduce ECCs by training physical health and social service providers to incorporate preventive oral health services into other infant and child services. The objective of this study was to evaluate the impact of the First Tooth program on the use of oral and dental health services in AllCare Health member children up to 19 years of age. Integrating oral health assessments and fluoride varnish in primary care settings through First Tooth program has increased utilization of these services.

B. Health care transformation: Oral Health Integration Projects (OHIP) and learning collaborative

Aron Goffin, Multnomah County Health Department; Alyssa Franzen and Alexa Jett, CareOregon; and Kary Rapport, Neighborhood Health Center

CareOregon Dental has partnered with its Federally Qualified Health Center (FQHC) provider network to advance oral health integration. In 2017, CareOregon Dental launched the Oral Health Integration Projects (OHIP) strategy to increase dental utilization and advance oral health integration within physical and behavioral health. CareOregon's OHIP faculty team models interdisciplinary clinical and operational leadership, provides direct support to each project and presents on relevant topics during OHIP learning sessions. Through our unique partnership with the project teams we are viewed as collaborators, in addition to payer. We are aware that project sustainability is key for

improving health outcomes in our community, and strive to ensure projects are fully implemented. OHIP is designed to break down silos and strengthen interdisciplinary collaboration, leading to ultimate health care transformation.

Croisan
Creek C

Delivering quality complex patient care with team-based solutions (combined presentation)

A. Providing care coordination to a unique population

Tonya Fogleman, Jennifer Head, Andrew Nelson, and Heather Teters, The Summit Primary Care Team at Old Town Clinic (Central City Concern)

The Summit Team's patients often have advanced medical illness with several chronic and progressive diagnoses, and often have a hard time engaging in primary care and navigating various specialist appointments. Summit patients have the opportunity for longer appointments, increased care coordination, and health system navigation. Additionally, Summit patients often have additional challenges of substance misuse, behavioral health issues, housing insecurity, and/or legal concerns. Discussion will include how wrap-around services and very patient-specific care coordination is delivered, our efforts in advanced care planning, workflow and team communication, and case studies highlighting our experiences in both successful and unsuccessful care coordination endeavors.

B. Implementing evidence based behavioral health care in Oregon: The ACT Model

Heidi Hendrix, Oregon Center of Excellence for Assertive Community Treatment

The Assertive Community Treatment (ACT) model is an evidence based practice designed to work with individuals who have not engaged in traditional mental health services, who suffer the most significant functional impairment and have a history of high utilization of psychiatric hospitals or emergency rooms, history of criminal justice involvement, and history of homelessness. The ACT team is a multidisciplinary team that includes: a team leader (QMHP level mental health clinician), a licensed medical practitioner (psychiatrist or psychiatric mental health nurse practitioner), nurses, substance abuse specialists, supported employment specialists, peer support specialists, case managers and other mental health specialists. Key services include case management, counseling and psychotherapy, skills training and psychiatric rehabilitation services, medication management, crisis services, integrated dual disorder treatment, employment services and housing supports.

3:20pm Break with dessert

3:25pm Concurrent sessions - Round 4

Willamette
B/C

Developing coordinated care networks to address social inequities

David Caress, Unite Us and Nicole Friedman, Kaiser Permanente Northwest

Unite Us is an outcome-focused technology company that builds coordinated care networks of health and human service providers. The company empowers both medical and social service providers to work together, integrating health and social care. With Unite Us, providers across sectors can send and receive secure referrals, track every person's total health journey, and report on tangible outcomes across a full range of services in a centralized, cohesive, and collaborative ecosystem. This social infrastructure helps communities transform their ability to track outcomes, improve health, and measure impact at scale. Unite Us now powers 55 networks in over 23 states and is setting a blueprint for communities across the country.

Croisan

Improving access: Oral health as a social determinant



Creek A

Michelle Cady, Cornerstone Community Housing; Amanda Cobb, Trillium Community Health Plan; Karen Hall, Christain Hanson, and Kyna Knights, Capitol Dental Care

A strong commitment to serve Trillium members facing multiple health disparities created the opportunity for a unique partnership between Capitol Dental Care, Cornerstone Community Housing, Willamette Family, INC, Springfield Family Practice, and Trillium Community Health Plan. The goal of their partnership is to improve oral health access to Trillium members who struggle to navigate a broad range of complex issues which often leads to increased housing insecurity, eviction and ultimately homelessness. This session explores how this unique partnership was formed, data about the population served, impact, and transition into CCO 2.0.

Croisan Creek B

[The power of storytelling as a person-centered data collection method](#)

Nancy Knopf and Heather Oberst, Columbia Pacific CCO

In 2018, Columbia Pacific CCO engaged in a person-centered approach to completing its Community Health Assessment which uses a platform called SenseMaker for collecting stories from people across its three-county region. This equity-oriented, trauma-informed approach is highly participatory while producing results that are statistically significant across its three counties. When paired with traditional methods for assessing population-level data and community-based priority setting, the result is a rich analysis of complex community health issues which can then be used to make nuanced decisions. Discussion will include how results were integrated into the Community Health Improvement Plan, and how they will continue to use the tool for evaluation and planning.

Croisan Creek C

[Fostering Hope Initiative \(FHI\): Strong families, resilient neighborhoods](#)

Michael Rohwer, Curandi and Jim Seymour, Catholic Community Services

The Fostering Hope Initiative (FHI) was formed as an integrated response to social service, housing, and health needs of vulnerable individuals and families in eight neighborhoods. The presentation will share how building an integrated response system helps vulnerable individuals and families significantly reduce toxic stress, build family protective factors, and develop connections to social services, health care, and stable housing. FHI's neighborhood-based approach to addressing the social determinants of health using coordination adapted to the unique nature of the non-medical community presents opportunity for synergistic effects without formal relationships, and a natural platform for outcome-based payment strategies and community research.

4:25pm

Hit the road