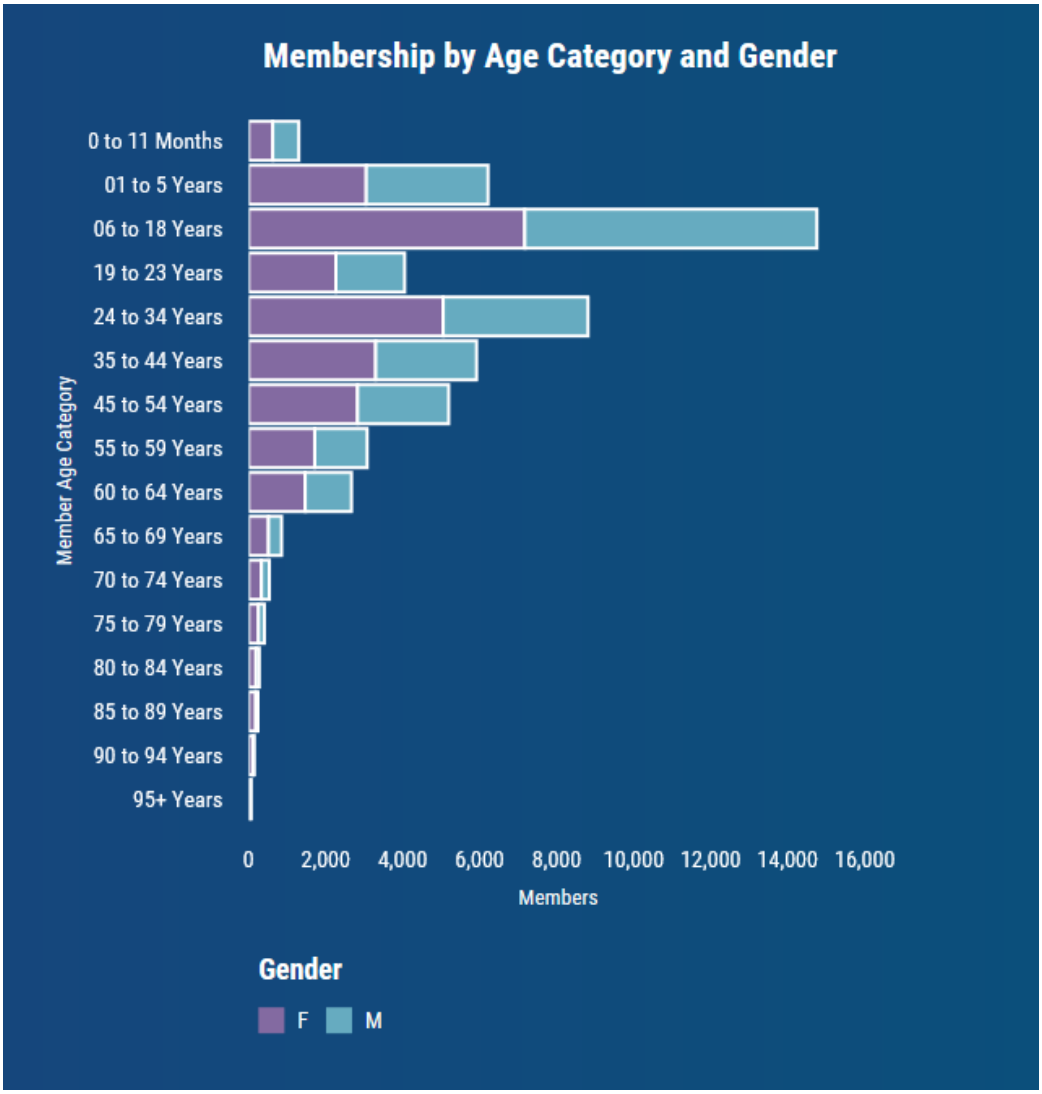
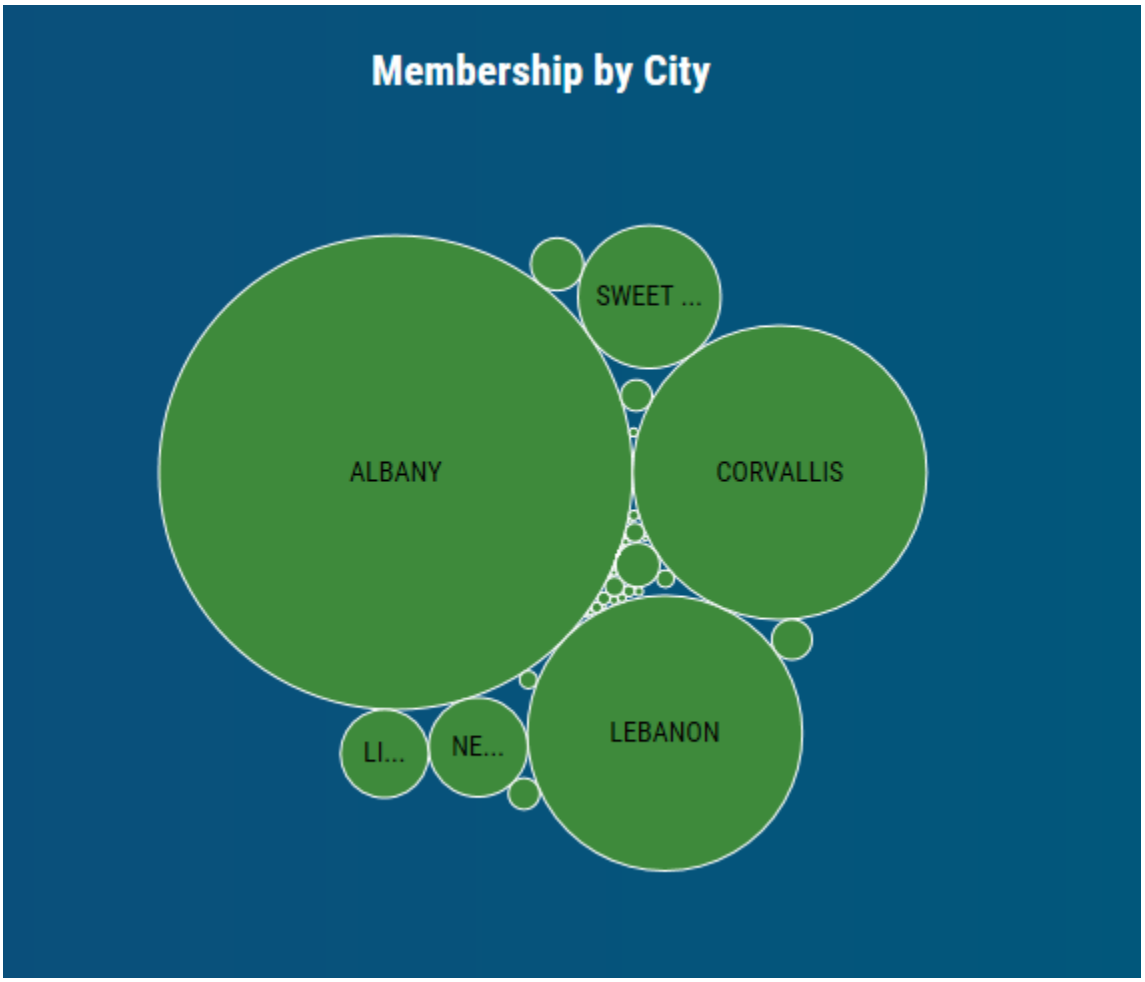
InterCommunity Health Network CCO

IHN-CCO
Operations Report
May 2018

IHN-CCO Total Enrollment

As of May 2018 54,514





Highlights

OHA announces public meetings to help shape the future of coordinated care

April 3, 2018
The Oregon Health Authority will hold three meetings at the end of April to gather public input about the coordinated care model and the state's Medicaid reforms.

Coordinated care organizations (CCOs) are the heart of the coordinated care model. CCOs were formed in Oregon in 2012 as part of the state's plan to improve the quality of health care and limit the growth in health care spending.

"We need to hear from OHP members, taxpayers and the public about what's working for them, and what needs more work so we can continue to transform the health system in Oregon," said Patrick Allen, OHA's Director. "We have more than five years of experience with the coordinated care model. We know that it has saved taxpayers money while improving care in some areas, but we also know there is a lot more work to do," he added.

CCOs are local organizations governed by community members. They bring together physical, mental health, addiction medicine, and dental health providers to coordinate care for people on

the Oregon Health Plan (Medicaid). There are now 15 CCOs in Oregon coordinating health care for nearly 1 million OHP members throughout the state.
New CCO contracts will start in 2020, but the state is gathering public input now to help inform these contracts. There are three public meetings in April:

- Portland – April 20, 9-11 a.m., Mercy Corps Northwest, 43 SW Naito Parkway
- The Dalles – April 21, 10 a.m. to 1 p.m., Wahtonka High School, 3601 West 10th Street
- Woodburn – April 28, 9 a.m. to noon, Legacy Health Wellspring Conference Center, 1475 Mt. Hood Ave.

Anyone is welcome, and advance registration is appreciated.

2014/2015 claw back

Transformation

Transformation Quality Strategy (TQS)
Background: The TQS has combined two CCO deliverables: the CCO Transformation Plan and Quality Assessment and Performance Improvement (CCO Quality Strategy). This streamlined approach aims to support health system transformation by providing CCOs with an opportunity to internally coordinate and align all of their transformation and quality work. The TQS template was developed to support: (1) sharing of CCOs' best practices; (2) advancement of CCOs' health transformation through aligned innovation and quality methods; and (3) state monitoring of CCOs' progress. Per Oregon's CMS 1115 demonstration wavier, Oregon is required to report to CMS on CCOs' health transformation activities, and the TQS allows us to satisfy this requirement. In addition, CCOs must submit a TQS to OHA per CCO contract. TQS submissions will be posted to the OHA website.

While the TQS is required per both the 1115 waiver and CCO contract, the 2018 TQS data-collection tool is considered a trial. OHA will convene a CCO TQS work group in April to provide feedback to OHA.

Staff submitted the 2018 contract requirement "Targeted Quality Strategy" on Marcy 15th. We are currently awaiting feedback before making available.

Delivery Systems Transformation Committee (DST)

The DST will release an RFP asking for Transformation Proposals on April 9, 2018. Successful proposals will focus on the following:

Key Outcomes Achieved: The pilot delivered on planned activities, measurable outcomes, and impacted the
following areas:
• Access to Healthcare
• Behavioral Health
• Child Health
• Chronic Disease Prevention and Management
• CLAS (Culturally and Linguistically Appropriate Services) Standards and Provider Network
• Decreased ED utilization for all IHN-CCO members
• Health Information Technology
• Integration of Care (physical, behavioral, and oral health care)
• Maternal Health
• Patient-Centered Primary Care Home (PCPCH)

• Provider Supports
• Social Determinants of Health (SDoH)
• Special Health Care Needs (SHCN)
• Value-based Payment Models

Health Improvement: The pilot had a significant impact in the health or healthcare for IHN-CCO members.

Health Equity: The pilot defined an approach for fair opportunities for members to be as healthy as possible.

Improved Access: The pilot activities resulted in improved access of healthcare; availability of services, culturally
considerate care, and quality and appropriate care to IHN-CCO members.

Transformational: The pilot activities created a newly imagined form, function, or structure of health care
delivery. The pilot created opportunities for innovation and new learning for the DST.

Barriers: The pilot identified and sufficiently explained barriers and how the barriers were overcome.

Partnerships and Collaboration: The pilot developed partnerships or collaborated with previously unrelated
organizations and/or resources. It established new connections within and between the healthcare delivery
system, the community, and community services.

Resource Investment: The pilot was a good use of funds; the pilot impacted a large number of IHN-CCO
members or strongly affected a high-need population.

Reduced Costs: The pilot has the potential to reduce costs or the pilot targeted an area of healthcare associated
with rising costs.

Sustainability: The activities and impacts of the pilot are self-sustaining. The pilot project or impact will continue
for at least a year. It would be beneficial to replicate this pilot in other organizations or programs.

High Dollar Cases: IHN-CCO has 0 cases over $300,000 as of April, 2018

2017 Metrics –

a. We have made great strides on the 2017 metrics since we last met, we have confirmed that we have met 12 of the metrics which supports us receiving our ful allotment of dollars back.

b. We know we did not meet
    a. ED utilization
    b. Diabetes