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Certification: I certify to the best of my knowledge and belief that this report is correct and complete for performance of activities for the purposes set forth in the award documents.

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INTRODUCTION

With generous support from the CMS Innovation Center, the Health Commons Project provides funding for five integrated interventions that together create a system of care for high-utilizing Health Share members. These five key interventions are:

1. **ED Guides,** a program that puts non-traditional health care workers in the emergency department to help patients with non-acute needs find the most appropriate place to get care;
2. **Standard Transitions**, which builds a standard discharge summary into each hospital's electronic health record. This project also creates standardized workflows to ensure that the primary care and inpatient care teams know exactly who is responsible for each step in the care process;
3. **C-TraIn,** a care transitions intervention that provides high-intensity support to high-utilizing patients who are discharged from the hospital. This program helps patients transition from inpatient to outpatient care, provides pharmacist support to increase medication adherence, and links patients to resources to meet psychosocial needs;
4. **Intensive Transitions Teams**, which provide transitions support specifically for patients who have had a psychiatric hospital admission, deploying mobile crisis support specialists who can meet patients at the hospital and then follow them throughout their transition to outpatient care;
5. **Interdisciplinary Community Care Teams,** provide multidisciplinary support to high-utilizing patients to help them build health literacy, address psychosocial needs, and overcome barriers to health. Within the ICCT program, there are four subprograms that have each hired outreach workers with specialized skill sets to meet the needs of the unique population served.
    a. **Health Resilience Program (formerly Community Care Program)** – This program is run centrally by CareOregon and has sixteen Health Resilience Specialists embedded primarily in primary care clinics across the community. One is embedded in a specialty clinic that serves patients with complex pulmonary conditions. One is paired with a Physician Assistant in a community setting.
    b. **Central City Concern Health Improvement Project** – This program employs five outreach workers, including a recovery specialist, a registered nurse, and a mental health professional who are embedded in a primary care clinic and serve patients experiencing homelessness.
    c. **New Directions** – This program employs two social workers embedded in a hospital emergency department who work with frequent ED utilizers with mental health challenges.
    d. **Tri-County 911 Service Coordination Program** – This program employs four social workers who work in the three counties with frequent 911 callers.

ACCOMPLISHMENTS IN THE LAST QUARTER

In the last quarter, the Health Commons project made exciting progress towards developing a new system of care for our highest-acuity Health Share members. The work of the individual interventions is highlighted below.

Grant-Wide Accomplishments

Building a Learning Community: This quarter we convened 202 community stakeholders at an all-day Learning Collaborative on November 5, 2014 titled "Looking to the Future." This collaborative event brought together people from all major facets of our health care and social service community. We reviewed the status of grant-funded interventions and of Health Share's programs to build collaboration for sustainability and innovation after the grant. By bringing this set of stakeholders together, this

collaborative provided an opportunity for community learning, engagement, and strategic alignment. The final agenda is attached as SD1_0985_10QR_PPMC.

Making Mid-Stream Corrections: All the grant interventions continue on the path of iterative learning and continuous process improvement to ensure the best use of resources and openness to continue to improve and grow in service to our population. Additionally, the PopIntel team continues to help the program teams refine their data collection forms and to provide just-in-time data analyses to inform sustainability. CORE continues to collect data and work on reports to provide quantitative and qualitative analysis for each intervention. One of the key ongoing learnings from CORE's work is how to provide meaningful evaluations, aligned with grant leadership, in collaboration with the various programs.

Ensuring Sustainability: As we enter the last six months of the grant, the sustainability conversations are more robust and yielding commitments. Sustainability pathway discussions continue for Tri-County 911 and New Directions. We anticipate having more information to report in the coming months. Below are the summaries of our sustainability success stories to date.

The Skin Care Clinic at Bud Clark Commons: The providers at the Skin Care Clinic have been tracking their encounters with patients, and at this point, given the encounters and the volume of patients, it has been determined that the program could sustain itself by billing for its services. We have initiated conversations with the FQHCs in the downtown region to see if one of them might be willing to sponsor the clinic, enabling them to bill for services and receive a wrap-around payment. The FQHC partners are interested, and we anticipate having a firm commitment next quarter.

Health Resilience Program: The CareOregon Health Resilience Program is in the final contract negotiations with Providence to continue to fund the program's staff located in Providence clinics after the grant ends as well as to expand to two additional clinics. The work that was successfully done to make the case to CareOregon last quarter to continue to fund and spread the program was valuable in the conversations with Providence as well. This work included: analysis of preliminary cost data, surveys of patients and providers, and qualitative work designed to tell the story of patients and providers touched by the program.

ITT: As noted in previous reports Clackamas and Washington Counties have already agreed to funding the program and will be keeping it in its current state. In Multnomah County the conversations continue about what form the program will take in the future, but Multnomah County has indicated that they will be sustaining the program beyond the grant.

Standard Transitions: Standard Transitions has met the original goals for the program roll out and is sustained in the organizations scoped for adoption. This program has met its sustainability goals. Questions remain about what will be next in this realm and who in the community will pick up this new work. The community conversation around a standard discharge documentation and follow-up process after a psychiatric hospitalization appears to be solidifying and the Health Commons Grant will aid in convening those conversations as appropriate.

CTraIn: CTraIn has been a springboard of learning for intensive work in the Care Management arena at both the locations where it is in operation and to our larger community partners. Through its touches to other programs, it continues to be a catalyst for both additional learnings and future collaborations with partners outside the intervention – as well as larger community

conversations. This program is currently in progress at two different entities – Oregon Health and Sciences University (OHSU) and Legacy Health System. Both organizations plan to sustain this program as a part of a larger Care Management operational restructuring.

Accomplishments of Each of the Individual Interventions

ED Guides: The ED Guide Program has finalized the training of two new team members, with a third to be hired in Q1 2015. Fully staffing the team has revitalized the group and prompted staff participation in improvement work, including monthly in-services, formal system for providing feedback to colleagues, and identification of opportunities to perfect this intervention. The program continues a healthy relationship with our CORE colleagues, supporting the efforts to generate our quantitative impact analysis report. To complement this report, the program leadership team is crafting a description of the qualitative impact of this work, in order to paint a comprehensive picture to stakeholders during reporting sessions. This qualitative report will include feedback from providers, caregivers, and community partners, as well as projected cost savings, and potential growth opportunities for 2015.

Standard Transitions: The Standard Transitions roll-out is continuing as planned at additional sites. Oregon Health and Sciences University (OHSU) is continuing efforts to move program roll-out beyond initial pilot sites. Their IT department is still working on the tracking and reporting piece for this intervention. Tuality is on target with their work toward implementation as well and organization around the process is still ongoing. Portland Adventist can now easily integrate the Standard Transitions form due to some enhanced Cerner functionality, so the initial barriers to their roll out have been lifted. They hope to begin mid-to-late first quarter 2015.

C-Train: In the last quarter, we continued to integrate care delivery and define roles and accountability across all sites. At OHSU, C-Train has continued to partner with social work to refine the role social workers play within the C-Train intervention now that New Directions and C-Train have been combined. At Legacy, C-TraIn programmatic discussions have continued and will be embedded in the organization's overall reorganization as part of transitional care.

Intensive Transition Teams: The ITT program has become a vital component to the regional system of care in mental health across all three counties. As new programs in acute care are developed ITT is seen as a necessary bridge program that can be used to help facilitate more effective transitions across settings. In Multnomah County a working partnership is in effect between the local ITT provider (Cascadia Behavioral Health) and the county as MH service funder. The Cascadia program has been working with Multnomah County to refine their in-reach strategy, striving to touch more individuals while in acute care to aid with these transitions. This model differs slightly from the other counties in that the referral and front-end contact is paramount and not contingent on a referral from a hospital social worker. The other county locations do more front-end screening for appropriateness to the ITT model. In both cases ITT remains a primary strategy for bridging from one care setting to another, though the model looks slightly different in Multnomah County than it does in the other two counties in the region. The ITT Steering Committee—comprised of ITT leadership and County leadership from all sites—continues to meet every other month to problem-solve and align practices. This group has agreed that continuing to meet after the grant in some capacity will be important. This may mean continuing their role as a steering committee for this service, or more broadly in their roles as local crisis systems.

Interdisciplinary Community Care Teams (ICCT) – Health Resilience Program (HRP): Last quarter, the Health Resilience Program expanded the peer program to include two new Peer organizations, and the

peer staff members are now attending weekly huddles with the program. Having the benefit of staff members with "lived experience" has been tremendously valuable and continues to inform the program's processes. Caseloads for the new Peers have grown quickly as a result of closer relationships with HRP staff. Additionally, our pilot project embedding an HRS in Hooper Detox Center in an effort to connect this group of high risk clients to both further treatment and primary care continues to evolve and help us identify large treatment gaps for the population with severe substance abuse. Our work with the Advanced Primary Care Collaborative also continues to evolve within the three pilot clinics; one team has incorporated a Peer Specialist.

In the last quarter, the Skin Care Clinic at Bud Clark Commons continued to serve the homeless population. We continue to learn about how to best serve a patient population experiencing chronic homelessness, drug/alcohol addiction, and behavioral health diagnoses. We successfully completed a video summarizing the work being done at the Skin Care Clinic that will aid sustainability conversations. The project team also initiated evaluation discussions with Providence CORE to analyze and review programmatic data to see what opportunities or lessons learned might be gleaned from the data.

ICCT – Central City Concern Health Improvement Project (CHIPs): During Quarter 10 the CHIPs team has been able to review its initial implementation of, and sought opportunities to optimize, the panel manager role which began in the previous quarter. This has resulted in improved panel management workflow, with refined internal communication pathways and role definition and improved visibility within the clinic. CHIPs staff underwent formal training in the Electronic Health Record's Care Planning module, which also received an update this quarter. With Care Planning now live, staff seek to complete care plans for all newly engaged patients. Focus was placed on refinement of program metrics and the Team Lead was able to represent the program at the Harm Reduction Coalition's National Conference in Baltimore. The CHIPs team has also forged ahead with new partnerships with the Old Town Clinic Pharmacy and IHART, Old Town Recovery Center's new patient-centered behavioral health home with primary care integration. CHIPs outreach workers are now empowered to use a Care Oregon-developed tool for connecting with patients about their medication regimens, caseloads are reviewed for timely MTM interventions, and the pharmacy collaboration has been solidified as part of regular meeting structure. Ongoing collaborations with specialty behavioral health programs, including cross-program representation, continue to be strengthened and supported.

ICCT – New Directions: A primary focus of New Directions during the past quarter remained the effective integration of the Emergency Department Information Exchange software (EDIE). EDIE continues to be implemented statewide to aid the collective community in managing the needs of patients who have 5 or more ED visits in the prior 12 months. One of the New Directions Social Workers has taken a leadership role in advancing the community roll-out of EDIE, with a specific focus on standardization of best practices, many of which have been learned as a result of CMMI grant funded programs. New Directions has also expanded outreach efforts to weekly drop-in sessions at the Portland Rescue Mission where Health Resiliency staff members also meet with patients. This expanded service has led to increased patient encounters and enhanced community relationships. Additionally, New Directions initiated a small pilot in OHSU's Emergency Department to provide support to uninsured patients who are presumptively eligible for Medicaid when they present to the ED. The intention of this pilot is to learn the experience of this patient population and identify what is needed to successfully connect them to primary care. Outcome data from CORE in the next quarter will be integrated into proposals for FY16 budget requests and the sustainability portfolio.

ICCT – Tri-County 911 (TC911) Service Coordination Program: Since the last report, we finalized and began sharing the Providence CORE evaluation report which highlights program positive impact on health outcomes and costs. Additionally, our program description, a critical part of our program "sustainability portfolio" was also completed and is attached as SD2_0985_10QR_PPMC. Both are expected to be added to the Health Commons Grant website in early 2015. Internal discussions with key county leaders resulted in a plan to begin formal outreach to financial stakeholders. Outreach to Health Plan leadership began this quarter and will continue into 2015; goals are to highlight TC911 project impact on members and secure funding after the grant ends. Outreach has required preparation of stakeholder-specific data, budgets, and proposals. TC911 continues to work on clinical and operational process improvements, including developing trauma integrated clinical supervision, streamlining documentation and data collection processes, and working in partnership with EDs to standardize care plan templates. Moreover, TC911 staff have been asked to participate in a county-wide *Home for Everyone* policy workgroup; this group has been appointed to make recommendations directly to the County Chair on future housing funding, policies, and practices throughout Multnomah County.

CHALLENGES EXPERIENCED IN THE LAST QUARTER

ED Guides: The ED Guide Program is fortunate to have very few challenges in the past quarter. As new team members are welcomed, the team has experienced the expected growing pains as roles shift and personality differences provide individual challenges. The team is planning an off-site retreat to foster collaboration, trust, and clarity of roles. The future of this program and the intervention will undoubtedly evolve, aided by our CORE and qualitative reports, thus creating a sense of ambiguity for the team about the coming year. Fortunately, this team is well versed in the ability to exist with this discomfort and not allow it to impact patient care.

Standard Transitions: Challenges remain for Standard Transitions in reporting and data collection at both Providence and OHSU sites due to the ability of providers to rename the template. The feedback continues to be that the form is both relevant and utilized in the majority of relevant discharges at both organizations. The ability to track the data reliably remains a key obstacle. It is unlikely either site will be able to resolve this issue in the time left on the grant. The renaming issue is a critical learning that will be shared with other groups within the grant to build expectations about process and appropriate template use upon roll-out.

C-Train: Challenges remain for C-Train around integrating at all sites with existing in-and-outpatient care teams. Both are continuing to iteratively shape and define the standard of transitional care for high risk patients through plan-do-study-act cycles for continuous refinement.

Intensive Transition Teams (ITT): The main challenges for ITT at this point are around the work occurring in Multnomah County. This is the largest county in the tri-county region and has by far the most psychiatric hospitalizations across more hospitals than the other counties. Given this ITT has struggled to engage a majority of discharges while still in the hospital. The county has provided additional support and oversight to the program to ensure that they are aware of hospitalizations early and the expectation is that these hospitalizations receive contact from ITT. This has stretched the capacity of the Cascadia ITT program and reshaped some aspects of the model compared to other counties. The grant has funded a position within Multnomah County to serve in as an Exceptional Needs Care Coordinator (ENCC) who was hired only recently but who will be an integral component of the ITT workflow. The grant data and IT support team has worked extremely hard to revamp tracking and reporting for this particular site through PopIntel, though the reports remain a work in progress as the County's priorities

change as they learn more about the nuances of the model. The grant leadership team will be meeting with Multnomah County leadership about their sustainability plans for this project and how/whether the Cascadia ITT program is part of their long-term population strategy.

ICCT – Health Resilience Program: Access to addictions treatment continues to be a challenge for HRP clients this quarter as in the previous quarter. Housing for homeless clients post hospitalization or AD rehabilitation is also a continuing theme. Capacity at all housing partners is an ongoing challenge. Our JOIN (a housing first organization) partnership is a way we are attempting to address and partner around housing issues. Finally, as our HRS team gets larger, we recognize the need for sustained and expanded focus on team support, training, and cohesiveness. More HRS staff make this more complex to maintain and manage. We have good systems and structures in place and continue to evaluate the best way to expand that support as our staffing model grows.

The main challenge for the Skin Care Clinic at Bud Clark Commons this quarter was to begin sustainability conversations with local partners. This included a discussion with multiple potential funders around what the funding model might look like and how the program is staffed.

ICCT – CHIPs: Recruitment of an experienced QMHP-level outreach worker has been more difficult than anticipated. Similarly, recruitment of an RN with strong social determinants of health focus and the ability to take on a medical consulting leadership role has been challenging. Role definition for the CHIPs RN continues to be subject to review and evolution, coinciding with broader clinic strategy around complex care management for the highest vulnerability population. Additionally, maintenance of the clarity of CHIPs' intervention within clinic-wide strategy for an extremely large population of patients meeting or approaching 'high utilizer' criteria (approximately 25% of the overall population, or 1750 individuals in need of complex care management) is an ongoing challenge.

ICCT – New Directions: Challenges continue to exist in identifying long-term case management resources for patients whose needs exceed those of a short-term case management model. These challenges represent gaps in the community and advocacy efforts continue to identify community-based solutions. Lack of housing and chemical dependency treatment resources in the community remain significant barriers to reducing avoidable ED utilization for many patients.

ICCT – Tri-County 911 Service Coordination Program: Securing future funding has been time intensive for staff. Furthermore, we continue to triage referrals; ongoing demand continues to remain greater than staff/program capacity to serve clients in the three counties.

SELF-MONITORING MEASUREMENT AND COST SAVINGS REPORTING

Self-Monitoring & Learning System: The self-monitoring team has continued to collect and aggregate program participation data, survey data, claims data for utilization and cost measures, and qualitative data for program improvement. We have updated our comprehensive self-monitoring data system with data from October, November, and December. This system includes historical and current claims data for all potential grant enrollees (the entire Health Share of Oregon population), member-level information such as coverage characteristics and demographics, and program information including enrollment histories and statuses for all grant programs operating in the community. These data have been used to produce updated numbers for our quarterly reporting, and are actively used internally to drive improvement within and across our various grant interventions. We also devoted significant energy to refining the data collection forms in PopIntel for both the ITT and the C-Train interventions in

order to more accurately reflect the programs' workflows. Our data in PopIntel also helps us provide just-in-time analyses to inform the programs' sustainability conversations.

We also continue to work on "sustainability portfolios" – more detailed impact evaluations for each program which include comparison groups and ROI estimates. Last quarter, we completed the evaluations for the ED Guides and "Tri-County 911" programs. This quarter, we have been working on the C-Train, ITT, Bud Clark Commons, and Standard Transitions reports, as well as a refresh of the ED Guides program report. Each report includes a description of the intervention, a claims analysis with a comparison group, and quantitative, qualitative, and/or patient-reported outcomes as they are available. These documents add to our quarterly "population monitoring" reporting and are used in conversations with our stakeholders regarding sustainability planning beyond the grant.

One of the key learnings to date is how to provide meaningful evaluation products while simultaneously maintaining alignment with grant leadership and collaborating with the various programs. Out of those experiences we've developed a methodology which includes early definition of key questions to align all stakeholders, and require grant leadership approval before time and resources are committed. We also do not complete evaluation work in isolation; we are educating the programs about the evaluation process and using their insights to inform hypotheses.

Early Findings on Cost Savings: Our cost savings goals are intended to be evaluated against a counterfactual of what would have happened in the absence of our program, which we operationalize through a propensity-score matched or comparison group. Our first analysis of the ED Guides program found improvements in connections to primary care and modest reductions in ED use among participants but no significant cost savings; however, we were able to identify an "optimization" path for the program by classifying the types of patients whom they impacted most. The program responded by re-tooling to better target those patients, and our follow-up analysis will determine if this response has improved the program's savings profile. Likewise, our analysis of the Tri-County 911 program showed significant program impacts, including savings in excess of program costs; these findings have been used locally to secure post-grant funding. Both reports are available on our project website.

Several of our other programs are showing signs of lower costs than their enrolled members had at baseline, but we are still in the process of formulating comparison groups to more confidently attribute these costs to program effects. We anticipate releasing reports for Ctrain, ITT, and Standard Transitions programs in the upcoming quarter, with the Health Resilience Program and Bud Clark Commons reports slated for the following quarter.

PLANNED ACTIVITIES FOR Q11

ED Guides

- Continue to refine documentation expectations
- Participate in teambuilding activities
- Prepare for CORE impact analysis report with ongoing team discussions
- Revisit agreements with community partners to meet current patient needs

Standard Transitions

- Continued engagement on program development at Tuality
- Continued engagement on program development at Adventist
- Continue to engage with OHSU as they move toward operationalization

- Begin exploring other system-wide transitions of care that might warrant on-going focus from Health Share following the grant period.

C-Train

- Continue cross-site learning opportunities.
- Continue sustainability conversations with OHSU and Legacy leadership
- Continue to use dashboards and other PopIntel data to identify best practices across nursing, pharmacy, and social work (for example, standards regarding who is the optimal client for this intervention, and who receives a home visit)

Intensive Transition Team

- CORE to continue claims analysis to assess ITT outcomes
- On-going review of updated PopIntel reporting (capturing # of in-hospital encounters and follow-up within 7 days of discharge)
- Continue intensive engagement with Multnomah County around shifting ITT's focus with their population to have a greater number of front-end touches in the hospital
- Continue discussions with Multnomah County and Cascadia about sustainability planning

ICCT – Health Resilience Program

- Initiate monthly Motivational Interviewing training with a local expert
- Plan a one-day training on the trauma intervention model, "Seeking Safety"
- Ongoing improvements to the Operational Dashboard
- Develop metrics to measure the effectiveness of Peer workforce

ICCT – Central City Concern Health Improvement Project

- Hire RN and QMHP to achieve 100% staffing
- Finalize sustainability and transition plan for CHIPs staff following completion of grant period
- Review implementation of care planning standards
- Strengthen outreach worker performance benchmarks
- Continue to seek improvement in panel management capacity and expansion of panel management tools

ICCT – New Directions

- Optimize EDIE integration into the OHSU ED and establish workflows to enhance care coordination in the ED
- Actively participate in community efforts to develop EDIE standards of practice
- Finalize Providence CORE evaluation report and develop sustainability plan

ICCT – Tri-County 911 Service Coordination Program

- Outreach to Health Plans and others benefiting from TC911 to secure funding
- Broadly share Providence CORE evaluation report and "Sustainability Portfolio," including upload to Health Commons website
- Work with county to expand technology supports for optimal program efficiency (e.g. Care Everywhere uploads, PreManage, Oregon Access)
- Identify and begin to address operational/logistical issues to support a student field placement in Fall 2015.

STORIES FROM THE FIELD

We have received feedback from our community partners that the discipline the grant has demonstrated around using data for continuous learning and process improvement has helped them push some of that discipline into their own organizations. The grant has also proved to our community partners that we can work together in serving an identified population. Modeling from the grant in both of these arenas is helping our community advance its transformation agenda significantly.

PULSE CHECK

We have nothing additional to report at this time.