CareOregon Annual Report **2017**

Strengthening our communities by making health care work for everyone

CareOregon®

Making health care work for everyone.

We develop all our programs with one thought in mind.

Will this improve the health of our members, their families, their communities?

Whether members are at the beginning of their lives, needing prenatal or early dental care. At the challenging stage where behavioral health, housing or care coordination support are key. Or near the end, when homebound, palliative or hospice care can bring comfort and security. We are here to make health care work for all.

Table of contents

President & Chief Executive Officer Eric C. Hunter works collaboratively with members, providers, staff, legislators and community partners to improve health equity and address the social determinants of health.

Improving lives

LETTER FROM THE CHIEF EXECUTIVE OFFICER

At CareOregon, our goal is to improve the lives of the people we serve. Every day, we strive to build stronger communities by making health care work for everyone.

Health is made up of many factors, not just physical wellness. To live a healthy and happy life, you need stable housing, nutritious food, exercise, and an emotional and psychological support system—all in addition to great health care. CareOregon's family touches each of these.

We serve as a catalyst for collaboration across our communities. Partnerships, integration, alternative payment models, grants and training all combine to help strengthen the delivery and community systems that support member health.

We celebrate diversity, inclusion and hope through unique member programs and staff engagement. And through creative problem solving, we search out ways to get member voices heard, ensure provider needs are met and make the community healthier.

This work brings us closer, day by day, to those we have the honor to serve.

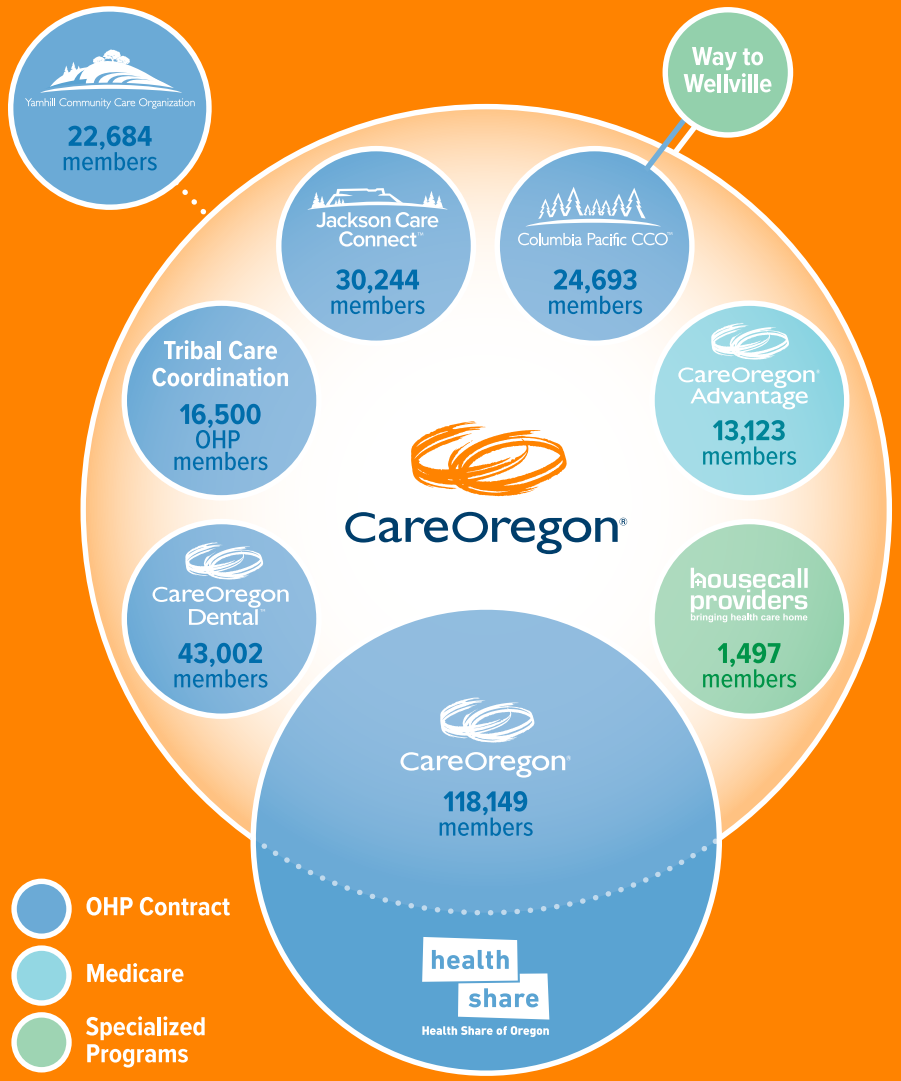
Eric C. Hunter
President & Chief Executive Officer
CareOregon

CareOregon's family

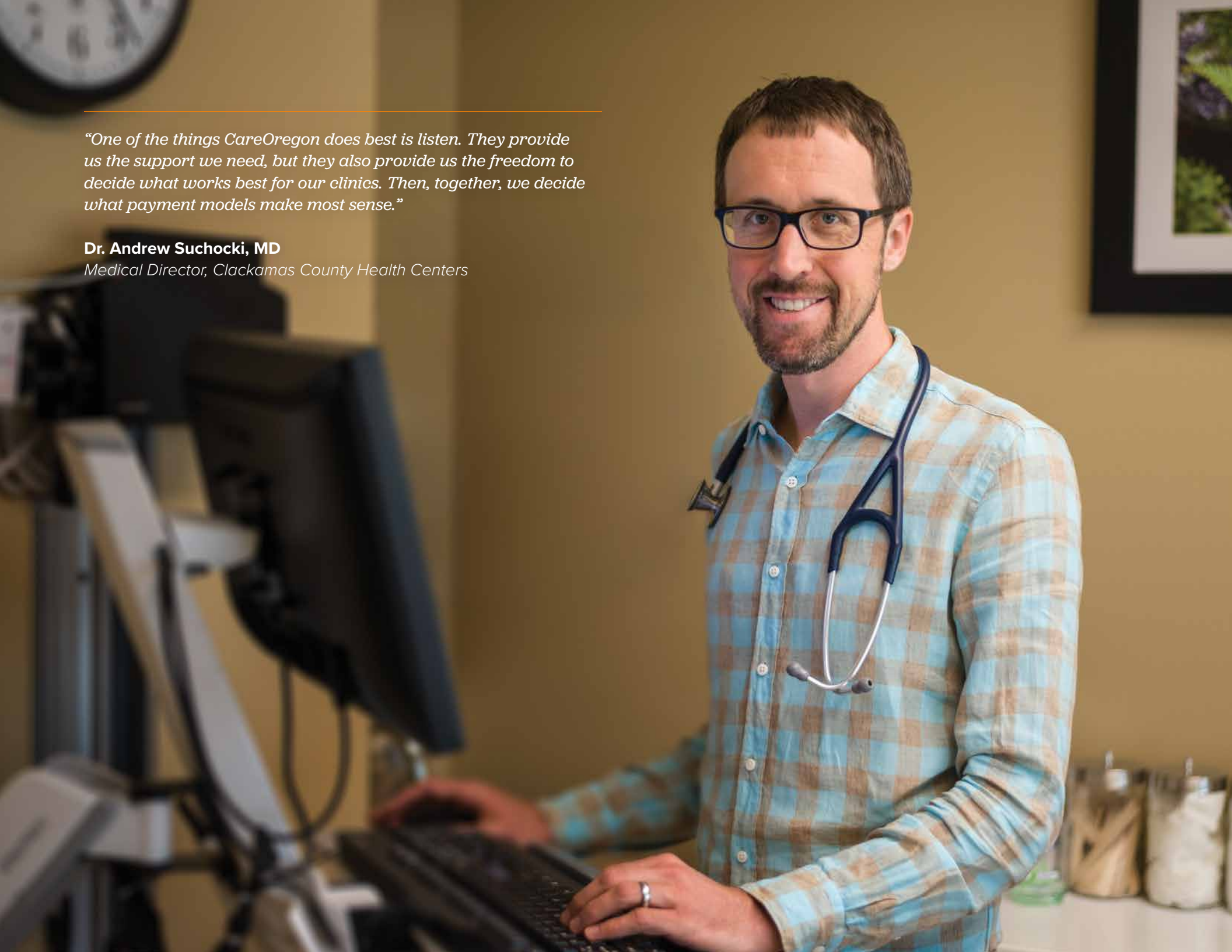
Founded in 1994 as a safety net for the recently formed Oregon Health Plan, CareOregon has been a nonprofit providing health plan services, education and community support for 24 years.

During that time, we've added to the family to meet our members' changing needs. While serving the largest number of Medicaid members in Oregon, we added Medicare—CareOregon Advantage—in 2006. In 2012, we helped form and support Coordinated Care Organizations (CCOs) and added CareOregon Dental. In 2017, we added in Housecall Providers and collaborated with the state's Nine Federally Recognized Tribes and the Oregon Health Authority to form Tribal Care Coordination. And throughout that time, we supported community needs with additional organizations focusing on population health.

Today, we are making strides in integrating physical, dental and behavioral health care and treating substance use disorder. The CareOregon family is working with our members, their providers and communities. We are committed to improving and protecting the health of all Oregonians, with a focus not just on health care, but on total health and well-being.



Members as of Dec. 31, 2017



"One of the things CareOregon does best is listen. They provide us the support we need, but they also provide us the freedom to decide what works best for our clinics. Then, together, we decide what payment models make most sense."

Dr. Andrew Suchocki, MD
Medical Director, Clackamas County Health Centers

Creating a foundation for health

PRIMARY CARE

From its inception, CareOregon's focus has been on primary care, and the importance of preventive and chronic care in improving health for the entire community. Dr. Andrew Suchocki, Medical Director of Clackamas County Health Department, has seen this demonstrated first hand.

"CareOregon is unlike any other insurance company I've encountered," says Dr. Suchocki, who's been part of CareOregon's extensive provider network for many years. "Their knowledge of primary care and the community, and their ability to bring health providers together, has improved care for all. Without them, our region would not have the successful health system that now exists."

Strengthening primary care through value based payments

"For more than 20 years, our philosophy hasn't changed, but over that time, how we ensure its success has evolved dramatically," says Mindy Stadtlander, CareOregon's Executive Director, Medicaid and Network Services.

In recent years, federal and state health agencies have called for a shift from fee-for-service to value-based payment models that reward providers for better health outcomes. Working in collaboration with its provider network, CareOregon has become one of Oregon's most innovative developers of value-based primary care reimbursement.

CareOregon's Network and Clinical Support Team began transitioning from fee-for-service to whole-health funding in 2015.

"One of the things CareOregon does best is listen," says Dr. Suchocki. "They provide us the support we need, but they also provide us the freedom to decide what works best for our clinics. Then, together, we decide what payment models make most sense."

"This is a collaborative effort, and we are developing it with our partners as we go," says Mindy. "Together, we're designing a system that reimburses innovative clinical delivery models, such as primary care homes and behavioral health specialists. Our value based payment model for primary care is based on what the clinics have identified as priorities, rather than us just telling them what we are going to do."

In 2017, CareOregon's alternative methods of provider payments increased to about 65 percent of payments across all types of services—primary care, hospital, and specialty. In addition, 6.5 percent or $33.5 million in payments were based on the key tasks of improving processes and meeting goals for quality of care, access to care, care coordination and behavioral health integration specifically in the primary care setting. These payment changes are partnered with practice facilitation and technical assistance aimed at helping primary care practices make this transition smoothly.

"This emphasis on collaboration gives providers ownership for improving primary care for their own patients, while strengthening health care across the state," says Dr. Suchocki.

"Our goal is to support the best possible health outcome for each member, and to financially recognize our providers' commitment to improving that care, so they can continue to invest in their care delivery," said Mindy.

Collaborating for better outcomes

Financial incentives aren't the only key to improving health outcomes.

"We hold regular learning collaboratives with our primary care network that allow clinics to share their barriers and successes," says Mindy. "In 2017, over 80 primary care practices participated in our learning collaboratives, and CareOregon's practice facilitators delivered more than 1,375 hours of technical assistance to them."

"CareOregon also is working with the providers to develop practices that fit the circumstances and needs of the individual clinics," said Dr. Suchocki. "For example, CareOregon provides practice coaching for primary care transformation training, medical home training, and health coach training to improve the care its members receive. When our organization was facing a variety of challenges, CareOregon helped catalyze change by providing a practice coach, and she was incredible. CareOregon is trained in the best coaching practices. They give us the support we need and then back away, but they are always there for you when you need them."

"This emphasis on collaboration gives providers ownership in improving primary care for their own patients, while strengthening health care across the state."

"Our work in this space has been so successful that we partnered with the University of California, San Francisco Center for Excellence in Primary Care (UCSF CEPC) to co-develop a national training for practice coaching for primary care," says Mindy. "A training that usually has a waiting list for participation. In 2017 this fruitful partnership trained 45 participants from all over the nation."

Enabling primary care innovation

Oregon is known nationally for its primary care delivery innovations. From one end of the state to the other, medical practices have experimented with services that don't adhere strictly to the traditional mode of acute care visits. This has resulted in ways to help patients get better faster, stay healthier longer, and lower costs for care.

But federal and state-defined payment systems are still largely focused on code-based treatments, rather than practices' innovative efforts to improve whole health. CareOregon has made strides in changing that.

"Our goal is to integrate innovative care and payment structure to ensure the best care for the members served by our partner Coordinated Care Organizations and our Medicare plans," Mindy says.

This includes:

- Strengthening primary care infrastructure
- Integrating dental and behavioral health with primary care
- Supporting the delivery of non-face-to-face visits
- Investing in system-level care coordination

Few of those practices are paid for under traditional fee-for-service payment. Or, in the cases when a service is paid for, it's not reimbursed at the cost of providing it.

"We know that the traditional fee-for-service payment structure is inadequate for the work we're asking primary care to actually do," Mindy says. "There's no code for panel management, for example, and we've all agreed that that's important. We've had to think differently about our payment structure, because clinically it's the right thing to do.

"We aren't stopping here," says Mindy. "We will continue in our efforts to strengthen, support and help resource primary care to deliver healthy outcomes." (See figures on right.)

"And we're happy to keep working together, at the clinic level and through collaboratives formed by CareOregon," said Dr. Suchocki. "Because, after all, it is really the patients who win."

CareOregon is moving quickly toward increasing payment for quality care—2017:

142,000
members were assigned to clinics that participate in our primary care payment model, behavioral health integration or enhanced support

71%
of our health care spend included alternative or population-based payments, already exceeding the Department of Health and Human Services target for 2018

35%
of our hospital payments included a risk-based total cost of care contract

88%
of hospital services included our transformation efforts, such as hospital-to-home transition

150+
clinics participated in alternative payment models over the past four years

102
primary care clinics participating in behavioral health integration with at least .5 FTE licensed behavioral health clinician onsite

100%
of the Coordinated Care Organizations associated with CareOregon received 100 percent of the quality pool dollars they were eligible for, based on their performance on 2017 Oregon Health Authority (OHA) incentive measures

Coming home to a new partner

HOUSECALL PROVIDERS

Gloria McClain (center) surrounded by her family and care team members from Housecall Providers.

CareOregon has been exploring various ways to enhance care options for our medically fragile and seriously ill members. And in 2017, we had the opportunity to bring the nationally known Housecall Providers into the family.

Demonstrating the value of home-based medicine

With home-based medical providers, Housecall Providers serves homebound and critically ill patients throughout their continuum of care—from primary and palliative care to hospice. In addition to outstanding care, Housecall Providers has proved itself to be one of the most cost-effective home-based medical organizations in the country. It has participated for five years in the Medicare Independence at Home national demonstration project, which includes 13 additional home-based medical practices around the nation that provide comprehensive primary care in the home. Results have been released only for the first two years of the pilot. In both years, Housecall Providers had the highest cost savings per patient among the demonstration sites.

Housecall Providers' Lead Care Coordinator Alicia Hanson says, "CareOregon patients have always had better access to community resources and support services than a lot of our other patients. Partnering with CareOregon, we are now able to access those services for the rest of our patients as well."

Collaborating for better care

Although Housecall Providers serve patients throughout the health care system, CareOregon is increasing its use of the program, particularly for members with advanced illnesses. CareOregon member Gloria McClain demonstrates the importance of this collaboration.

According to Gloria, the period before receiving support services from CareOregon was one of the loneliest and darkest times of her life.

"For a long time, I didn't think anyone was listening, and that is what scared me the most," says Gloria.

"No one knew my story, and I wanted others to know that you can get past hardships. No matter how many times you fall, you can get back up."

In 2017, Gloria—who is 68 and has chronic obstructive pulmonary disease (COPD)—became Housecall Providers' first palliative care patient not associated with its primary care program.

"Improving the quality of life for CareOregon members with advanced illness is without question one of the benefits of this new partnership," says Housecall Providers Clinical Operations Director Kristi Youngs.

Ensuring the right care at the right time

No one knows better than Gloria the importance of the right resource at the right time. For the last five years, she has relied heavily on the support of Heather Stoecklin, one of CareOregon's respiratory therapists.

"Heather was going to do everything that she could do to help me, because she saw my will to survive," says Gloria.

Another "angel" of her care team is Housecall Providers Registered Nurse Monica Ontiveros. Monica has been visiting Gloria at her apartment in North Portland since last December. Receiving medical care in the comfort and convenience of her home has meant that the energy she would normally spend getting to her appointments can now be used to engage with her community.

"I am able to go to my meetings, which is so wonderful because it gets me up and out and allows me to communicate with people of all walks," says Gloria.

Offering unique support systems

Palliative medicine focuses on providing relief from the symptoms and stress of a serious illness. By deeply exploring a patient's personal goals, the palliative care team helps match those goals with care options. In Gloria's case, this included asking Housecall Providers Palliative Care Spiritual Counselor Dean Yamamoto to baptize her.

"The job of a palliative care chaplain is to stay within the patient's spiritual frame of reference and to support whatever that might be," says Dean.

There was a time that Gloria thought she had used up all her chances. But the support of her family, community and her care team showed her how important it is that she carry on.

"I feel blessed every morning I take my first breath," says Gloria. "I no longer ask, 'Why me, why me?' I know now that it is so somebody else can know why."

Housecall Providers—2017

550+
new patients

1,900+
patients served

10,000
home visits

2,750+
care coordination calls per month

360
CareOregon members served across the continuum of care

Highest cost savings
year 1 and 2, in the Medicare demonstration project, **Independence at Home**

(Right) Naudia West, Housing Case Manager, and (left) Angie Hernandez, JOIN Retention Worker, were part of the cross-organizational team that helped Derek Romero obtain comfortable, safe, stable housing.

Strengthening communities in new ways

HOUSING PROGRAM

Stable housing is the foundation of both individual and community health and wellness. That's why CareOregon actively works with the community to help end homelessness in our service areas.

In 2017, CareOregon sponsored the Central City Concern's "Housing is Health" project by donating $4 million. CareOregon has also deployed housing case managers in buildings where our members struggle to navigate housing issues, including the threat of eviction. We help members reverse their current crisis, and we provide training on how to avoid future evictions. We are now focusing on the integration of housing support with clinical and disease-specific needs.

Helping one member at a time

Our member Derek Romero, a 50-year-old of Apache descent, demonstrated how his living situation and health were tied together.

Just a year ago, Derek had a great business in Hawaii, Ohana Bike Rental, a few feet from one of the most beautiful beaches in the world.

"I spent 10 years in Maui," Derek says. "Right there by the Kaanapali grocery store. I had a rental business for about eight years over there: mopeds and bikes. Did real well until this liver thing."

"This liver thing" was cirrhosis, diagnosed about eight years ago. It had been 10 years since Derek had stopped drinking, something often associated with the disease. But by early 2017, the doctor said Derek could no longer work.

His business was lost, along with his income and home. He spent nights on friends' couches in his old hometown of Portland and days looking for help, not knowing where it might come from.

Health begins with housing

45+
CareOregon members obtained housing through JOIN's efforts

$300,000
in housing security grants was raised

$4 million
was given to Housing is Health

44% cut in readmissions
in the first 30 days of leaving the hospital

It would have been easy to give up and grow bitter and depressed, but that's not Derek's way.

Derek sold the business and came home to Portland where he still had a small network of family and friends who might help.

"My main objective was to get somewhere warm before it got really cold here, and I'd have to leave Oregon because I couldn't handle that in the streets," Derek says. "That would put me behind on my liver specialist and on a transplant."

Recognizing individual needs

At OHSU Family Medicine at Richmond, Derek met Molly Dressler, a CareOregon Health Resilience Specialist. Molly's job is to look at the non-medical factors in a person's life that make healing difficult. Homelessness is a big one. Seeing that Derek was homeless, Molly contacted Naudia West, a CareOregon Housing Case Manager.

"Once I connected with Derek, we worked with Home Forward," Naudia says. "Due to his terminal illness, he was eligible to get on a priority wait list."

Now Derek lives in housing managed by Home Forward, formerly the Housing Authority of Portland. It's a small apartment, but Derek and his mother were able to find some furnishings from the Community Warehouse, and with the addition of a few items that honor his Native American heritage, Derek was able to make this new apartment feel like home. His companion is Rah-Rah, a terrier who has his own collection of outfits, including aloha shirts from his days as the "spokesmodel" for Derek's business in Maui.

Working together

Finding housing was a major step, but Naudia's work with Derek did not end there. Derek also benefited from a partnership to help formerly unhoused people successfully keep their new homes.

The partnership includes CareOregon, Portland/Multnomah County's Joint Office of Homeless Services and JOIN, a Portland nonprofit that helps homeless individuals and families transition out of homelessness into permanent housing.

Pam Hester, CareOregon's Health and Housing Manager, says that CareOregon and the Joint Office teamed up to fund a contract to expand JOIN's housing placement and stabilization work to some of CareOregon's members.

"JOIN provides housing retention services to more than 45 CareOregon members each year," said Pam. "While about 30 are placed by CareOregon's housing case managers, the other 15 are placed in Permanent Supportive Housing by JOIN's staff."

Angie Hernandez is Derek's JOIN retention worker. She says JOIN helps with the barriers that sometimes force newly housed people back out onto the streets.

Taking a holistic approach

"Once members are housed, sometimes there's a missing piece," Angie says. "As retention workers, we take a holistic approach with our friends that we work with."

In Derek's case, that meant finding an attorney to help when his Social Security application was rejected despite the terminal illness that made him eligible. For others, it might mean making sure that medications are taken as directed. Sometimes it's just coming over to keep them company, just to walk or talk.

"We just try to get people involved with the community, and to feel happy again and be able to go forward, not only with housing, but with their lives," Angie says.

Being involved with housing makes sense for a health plan, Naudia says. Without housing, getting treatment can be challenging. Without housing, Derek could not be on a waiting list for a possible transplant that could save his life.

"We just try to get people involved with the community, and to feel happy again and be able to go forward, not only with housing, but with their lives."

"That'd be the death notice for me because I'd just be terminal and have nothing to look forward to," Derek says. "With that transplant, I've got a chance to possibly live even to be 70 years old, 75."

Creating extended family

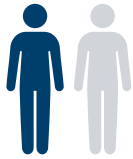
Ohana was the name of Derek's business, the Hawaiian word for family. It could be said that Derek has found a new family with his housing support team.

"They are life-changing," Derek says. "I actually fell into a web of lifesavers, and that's what these guys are. They're the web. If you get in it, you're in a beautiful place.

"They keep you up to where you're inspired to move forward, where the average person would probably just sit and sulk in depression," he says. "Once I found out I was dying, then I really started living, so life's a whole different scene for me than it was before. Every day could be the last day. Well, I'm ready. I'm going to actually host my own funeral. It's kind of neat. I've been putting it together now slowly. I'm going to get a recording out, and when my funeral comes, I'll be the one speaking for myself."

In the meantime, Derek's living a full life. Always out and about, riding buses and MAX trains all over. He's looking forward to the big powwow at Delta Park this summer, and Rah-Rah has his Pendleton jacket all ready to go.

Recuperative Care Program reduces hospital readmissions



Typically,
1 out of **2**
homeless patients are readmitted within 30 days discharge from the hospital

Fewer than
1 in **16**
CareOregon homeless patients are readmitted within 30 days after discharge from the **Recuperative Care Program**

To reduce readmissions and improve quality of experience, the Regional Care Team staff meets regularly to support members with multiple care needs.

Bringing compassion and coordination
REGIONAL CARE TEAM

Making health care work means meshing all the components of care into a smooth, easy-to-use, compassion-based process that works for members and providers alike.

Last Thanksgiving, one member's story dramatically reinforced the importance of creating our new Regional Care Team (RCT) based on high-touch, full-system coordination. A 56-year-old man who had lived on the street since age 9 found his way to a Providence hospital emergency room. Diagnosed with end-stage cancer, he was enrolled in the Oregon Health Plan.

Many care teams, including ours, swung into action. Providence assigned a case manager, Oregon Health & Science University (OHSU) assigned a social worker, and CareOregon provided transitional care and housing assistance. Housecall Providers, which joined the CareOregon family in 2017, supplied hospice services.

Retaining a member focus

Complex, end-of-life treatment can lose its patient focus as the health care system kicks into action. But thanks to CareOregon's burgeoning Regional Care Team and its resources, all care-givers collaborated to create a peaceful, caring, end-of-life experience for a man who hated living "inside."

"We've recognized the need for internal integration," says Jonathan. "We are collaborating on the best way to wrap members in a warm blanket of care."

"He wasn't eligible to go anywhere," said Jane Duck, CareOregon's High-Risk Populations Programs Manager for Population Health Partnerships. "He couldn't go to the shelter because [he had a] wound. He didn't qualify for a skilled or nursing facility, and he wouldn't have gone. He didn't want to be enclosed away from his support system on the street."

CareOregon arranged his stay in a close-in hotel so he could get to the shelter at meal time to see friends while he could still walk. Staff from CareOregon, Housecall Providers, Providence and OHSU coordinated daily visits to make him comfortable and arrange meals.

"It was phenomenal because we all worked so well together," said Jane. "Everybody was very sensitive to his needs, wishes and goals. It was a huge use of human resources, especially over the Thanksgiving holiday, but not in financial resources."

A few days later, he passed away peacefully and in comfort.

"We came together to make it possible for [this member] to stay warm, fed and have his wishes honored," says Housecall Providers Social Worker Youske Eto. "He died the way he wanted to, while being cared for by genuinely compassionate people."

RCT is a collaboration—2017:

4,000+
members served by Exceptional Needs Care Coordination

2,511 Medicare &
850 Medicaid
members served by Transitional Care & Outreach

26
Members received Eviction Prevention

2,287
members served by Health Resilience Workers

1,726
gaps in care addressed (125% > goal)

$6.6 million
cost reduction in pharmacy trend

66%
members served by in-clinic behavioral health integration (CareOregon)

4-Star Rating
achieved for Star readmission metric

4.5-Star Rating
achieved for Medicare Part D

Recognizing needs

The broad array of CareOregon resources brought to bear in this case—transitional care, hospice, housing, exceptional needs care coordination—all come under CareOregon's newly organized Regional Care Team.

"We provide so many services, from one-on-one health resilience to medication therapy coordination to chronic care support," says Jonathan Weedman, Director of Population Health. "We've recognized the need for internal integration. We are collaborating on the best way to wrap members in a warm blanket of care."

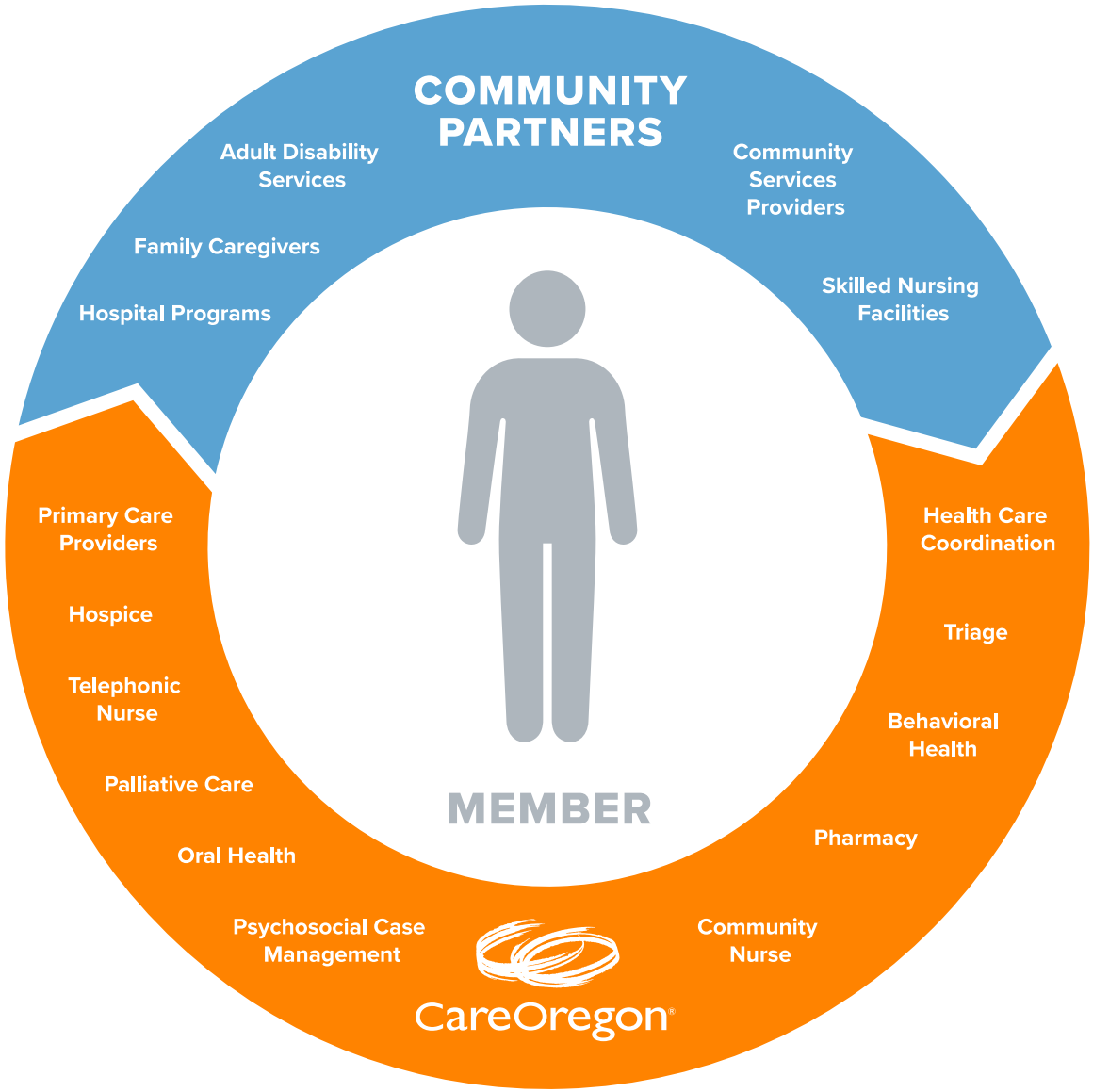
Staff from many departments have daily check-ins so they can get a 360-degree view of all the ways CareOregon touches members, from health resilience to housing. The goal is for departments to share a dashboard that collects this information so it can be seen at a glance.

"By integrating our own work, we can increase member and provider support without creating an overwhelming number of calls or questions," Jonathan says. "We have learned a lot in terms of working together, and we are very excited to move formally to the Regional Care Team structure. The pilot, which was developed in 2017, officially kicked off in January 2018, and will be fully implemented by the end of the year. By integrating our own work, we can increase member and provider support. We can also reduce duplication of work and improve member outcomes."

Demonstrating compassion

While cost and administrative efficiency are key goals, the true payoff is in quality member service. The member story we shared demonstrates how important that quality care is.

Compassion, effectiveness, efficiency, collaboration—these make up the foundation that is our new Regional Care Team.



CareOregon and its community partners working together to support members

When a member is supported by multiple departments and organizations, the Regional Care Team brings them all together to reduce duplication and waste, while improving the member's experience and strengthening health outcomes.

Member Jean Fitch believes behavioral health collaboration "literally . . . has kept me alive."

Combining all aspects of care

BEHAVIORAL HEALTH INTEGRATION

Coordinated Care Organizations (CCOs) were designed to integrate all aspects of health.

In 2017, Jackson Care Connect, our CCO in Southern Oregon, provided financial and technical support to help primary care clinics integrate behavioral health into their practices. This support is critical because 70 percent of primary health care visits have a psychosocial driver. In integrated clinics, 9 percent of Jackson Care Connect members (1,800) were seen by a behavioral health consultant.

Jackson Care Connect member Jean Fitch uses such a clinic, the La Clinica Wellness Center. The Medford-based clinic she visits includes primary care, mental health counseling and wellness services—including movement and nutrition classes—under one roof.

Jean has a history of complex health issues—trauma, chronic depression and seizures—as well as a history of injuries, including a major car accident. Because she was deemed uninsurable in another state, she spent eight to 10 years without any medical care before she learned about the Oregon Health Plan (OHP).

Collaborating to change lives

Once she was enrolled in OHP, Jean connected with Dr. Justin Adams as her primary care provider. Dr. Adams is also the Chief Medical Officer for La Clinica. Being able to call the Wellness Center her medical home has been "massively life changing" for Jean. "I can literally say this place has kept me alive," she says.

In addition to regular visits with Dr. Adams, Jean also sees a licensed clinical social worker and a wellness coach. "They work really hard at helping me stay out of the hospital," she says.

La Clinica used its integrated approach to address Jean's seizures, something she's lived with for much of her adult life. Jackson Care Connect covered seizure studies, and the team at La Clinica discovered a psychogenic component to her seizures.

She credits the team's honest, caring approach with helping her address them. The tools she learned, as well as the quality of care she is receiving, helped her decrease the number of seizures from 40–50 a day to about five a week.

Thinking about health in a different way

"It's kind of a collaboration that gets me involved," Jean said. "I have stakes in this. It's my life. It's my health, I should have a stake in it."

She has also taken advantage of La Clinica's classes in yoga, mindfulness, nutrition and stress release. She says the approach "has given me a way to think about health in a different way."

Through the nutrition classes, Jean has discovered ways to eat better and reduce inflammation, and she is now able to walk without pain for the first time in years. She has also lost 50 pounds, and her blood sugar, blood pressure and cholesterol numbers have all improved.

"So, the goal for everybody is overall general health...[and] to get to the point where you can manage whatever chronic issues you have," she says.

Through the wellness classes, Jean has discovered mindfulness as a means of coping with pain, depression and anxiety.

"I'm actually getting to where I can use specific tools that I've learned...I can work through it more from a behavioral standpoint," she says.

"It's kind of a collaboration that gets me involved. I have stakes in this. It's my life. It's my health, I should have a stake in it."

Building awareness

Another important revelation for Jean is getting a diagnosis of post-traumatic stress disorder. That diagnosis gave her a new perspective on her health.

"It feels less like I'm the crazy person. It's more like your life experiences are what has opened you up to this," she says.

Through the improvements Jean has made over the past couple of years with the help of her team, she has learned that she is a survivor.

"I had lost hope," Jean said. "I had lost energy. I had lost everything. And now I have the energy to work on it. I have tools to work on it."

"I am grateful that OHP exists. I am grateful that Jackson Care Connect and CareOregon put it together in the way that they do."

Behavioral Health Integration

70%
of primary health care visits to integrated clinics have a psychosocial driver

9%
of Jackson Care Connect members (1,800) in integrated clinics were seen by a behavioral health consultant

21.6%
of Jackson Care Connect members had at least one service treating a mental illness

Wellness center participants, like Diana Bartholic, learn how to manage pain with movement, meditation and education.

Looking beyond the CCOs

RESPONDING TO THE OPIOID EPIDEMIC

Strengthening communities sometimes means looking beyond our own neighborhoods to national issues like the opioid epidemic. Unfortunately, Oregon has more than its share of the problem.

In a recent Senate hearing, Gov. Kate Brown said, "In Oregon, I will soon declare addiction and substance abuse to be a public health crisis, in no small part because of the impacts of opioids. We have seen a 400 percent increase in opioid use disorder over a 10-year period from 2005-2015. Roughly one in 10 of our young adults, aged 18 to 25, have abused opioids. Every other day, on average, we lose one more Oregonian due to an opioid overdose."

Addressing the needs of our communities

CareOregon and its partner Coordinated Care Organizations (CCOs) work diligently to address this issue throughout the state.

One outstanding example is the work being undertaken by Columbia Pacific Coordinated Care Organization, part of the CareOregon family. The CCO staff, board of directors and multidisciplinary clinical advisory panel have partnered with physical and behavioral health care providers and the community to develop innovative programs to reduce and treat opioid use. They have also helped to mobilize the community around this issue.

"Overdose deaths from opioids in Clatsop, Columbia and Tillamook counties still exceed the average for the state of Oregon," says Dr. Safina Koreishi, Medical Director for Columbia Pacific CCO. "Over the last couple of years, we have made great progress on a variety of initiatives, including annual community-wide summits on opioid and substance use disorder, training on safe prescribing and difficult conversations for primary care providers, completion of regional prescribing guidelines and increasing the use of Naloxone by emergency responders.

Columbia Pacific CCO saw the following results in 2016-2017 compared to 2015:

257 fewer
people using chronic opioids

41% decrease
in the average opioid dose among chronic opioid users

63% reduction
in the number of patients on high doses (>90 MED)

>500,000 fewer
opioid pills prescribed in the region

"We have also worked with the community to start drug take-back boxes in pharmacies to help decrease the amount of unneeded opioid pills in circulation. All of this has been overseen by the Columbia Pacific CCO Clinical Advisory Panel, as well as the Northwest Regional Substance Use Steering Committee."

We address opioids and substance use through a trauma-informed lens to inspire collaboration and de-stigmatize addiction.

Columbia Pacific CCO has also partnered with local primary care and behavioral health clinics to support the development of increased medication-assisted treatment services for opioid addiction within the community.

"We hope to build on our progress to address opioids and substance use through a trauma-informed lens to inspire collaboration and de-stigmatize addiction in our communities," says Dr. Koreishi.

Dealing with underlying issues

- **Columbia Pacific CCO** has worked with providers in Tillamook, Clatsop and Columbia counties to establish a behavioral health-based wellness center in each of the three counties. These centers work with patients in small groups over a 10-week period. Participants learn how to manage pain through movement, yoga, meditation and education. The wellness centers are free to CCO members.

  The CCO has also launched a community education campaign to help people in pain "get their life back" by helping direct them to these wellness centers.

- **In Columbia County,** the CCO partnered with Columbia Community Mental Health to expand Pathways Substance Use Disorder Rehabilitation Center to include Bridge to Pathways, a medication-assisted inpatient detoxification program. Managed by a medical care provider, it is the only program of its kind in the region. Before Bridge to Pathways, patients had to search all over the state to find an available detox bed. CCO members are given priority status in this program.

- **Additionally, the North Coast Crisis Respite Center** is a partnership in Clatsop County that includes Greater Oregon Behavioral Health, Clatsop Behavioral Health, Columbia Memorial Hospital, Providence Seaside Hospital, Columbia Pacific CCO and the Clatsop County Public Health Department. The crisis respite center is a sanctuary for community members experiencing a behavioral health crisis, including substance use disorder.

All the CCOs within our CareOregon family are addressing substance use disorders through a wide variety of clinical and educational efforts. Working together, our goal is to shift this community crisis into a community collaboration for better physical and behavioral health.

Columbia Pacific CCO

- **Helped create 3 pain clinics, including:**
  - 10-week programs
  - Yoga, movement, meditation and education
- **Supported 16-bed respite center**
- **Partners with local providers to support medication-assisted treatment**
  - Support nine-bed medication-assisted inpatient detox
  - Support training of emergency responders administering Naloxone
- **Supports secure drug take-back locations**
- **Holds annual summit for approximately 200 community members, providers and partner organizations**

To help children avoid cavities, in 2017, our dental programs increased sealant placement.

Integrating oral health
DENTAL PROGRAMS

In 2017, CareOregon elevated oral health integration to one of our top priorities, establishing an Oral Health Integration Steering Committee. Physical, behavioral and dental integration is made easier by the fact that Executive Dental Director Alyssa Franzen and her team manage oral care throughout the CareOregon family of plans.

Together, this team helps the dental plans that contract with Columbia Pacific CCO and Jackson Care Connect develop oral health strategies and clinical integration, and lead CareOregon Dental, our Dental Care Organization serving the metro area. By working with CareOregon's medical and behavioral health teams, the leadership of each CCO and the Dental Care Organizations in various parts of the state, the Dental Department has been able to make oral health an integral part of whole health.

"Our goal is to demonstrate that oral health, behavioral health and physical health are equally important as they relate to an individual's total well-being," says Dr. Franzen.

Despite CareOregon's unique advantage, the task of integration is challenging. In 2017, CareOregon focused on three initiatives:

- Address oral health for CareOregon's youngest members, age 0–5
- Increase oral health awareness by pregnant women
- Improve navigation to oral health services

Improving oral health for our youngest members

To give our youngest members a good start with oral health, the Dental Department and affiliated CCOs adopted First Tooth—a statewide program to integrate oral health into physical health practices for children in their earliest years.

Oral Health Integration—2017

13,667
children age 0–5 had a dental visit

210
primary care team members trained in First Tooth

2,076
children age 0–5 received an oral health service in a primary care setting

1,100
women completed a dental visit during their pregnancy

"Most children see their pediatric doctors seven to 11 times in the first three years of life, and well-child visits are a great opportunity for oral health screens and interventions," says Alexa Jett, CareOregon Dental Innovations Specialist.

First Tooth trains and certifies physical health practitioners to evaluate the oral health of their young patients. They recommend interventions such as fluoride varnish, counsel parents on oral health and refer them to a dental home. When the provider has been certified, they can be compensated for oral health screenings for their Oregon Health Plan patients.

The Dental Department took First Tooth further than the state, expanding it from children 0-3, up through age 5. They include both primary care and dental innovations specialists in their training team to emphasize the importance of oral health to the child's physical health. Innovations specialists show primary care providers how to fit oral health into busy patient visits and make it easy to connect patients with their dental plans.

"It's a way that we've integrated health information as well, so we can cross the great divide of medical to dental," says Cathleen Olesitse, Oral Health Program Manager.

"We'll take it from there and ensure that the child's dental plan knows that this child exists, knows that this child got a fluoride or an oral health service in primary care," Alexa says. "Then the dental plan will do an outreach to get them to establish a dental home. It's an awesome opportunity to move toward that health home model, where it's not just medical, but you really look at the whole health of the person."

Integrating oral health into pregnancy care

In 2017, a cross-disciplinary team led by the Dental Department did the groundwork for increasing the number of women who receive oral health care during pregnancy. It's an objective that addresses oral and physical health for both mother and baby.

Having access to member physical health data makes it possible for CareOregon Dental to help obstetrics providers connect members with their dental plans. And that makes it more likely that the member will follow through and get oral health services during pregnancy.

"In 2018, we want to see a 5 percent increase in the number of pregnant women receiving a dental visit during the nine months before delivery," says Cathleen.

"Usually the mother is the most common primary caregiver. If she has a high bacterial load in her mouth, she will transfer that to the child. So, let's start by getting the mom healthy."

The team worked with women's health providers to develop specific steps to help clinics move forward. These efforts ranged from creating a member brochure to training obstetrics providers in how to explain to their patients the importance of oral health care.

Dental Care Organizations can reach out on their own to pregnant OHP members. But the patient is much more likely to respond positively if the obstetrics provider has already shared the importance and safety of oral health during pregnancy, Cathleen says.

Additionally, CareOregon Dental accepted grant requests from Federally Qualified Health Center medical clinics that want to expand oral health services for mothers, infants and toddlers. Beginning in 2017 and into 2018, the Dental Department accepted grant applications. These ranged from embedding a dental hygienist in a maternity clinic to providing mobile dental equipment for outreach at scattered health clinics and Native American cultural events.

Making oral health access easier

Adding an oral health referral form to the provider portal and improving website communication were important parts of the initiative to improve oral health navigation and communication in 2017. Perhaps an even greater component is an intentional, well-designed shift in thinking.

"The intent of that navigation and communications initiative was to ensure that every single communication, whether in writing or verbal, has an oral and behavioral health component in it," Cathleen says. "If there is any way during a member touch that we can include oral health information, navigational services, care coordination, that opportunity is to be taken."

"It is definitely a culture shift," Dr. Franzen says.

It's similar to the process a few years ago by CareOregon, the CCOs and the state to consider behavioral health and physical health as co-equal.

"Now we're really trying to highlight the importance of oral health in a not dissimilar manner—that oral health is equal to behavioral health and physical health, and it relates to your overall health," she says.

Additionally, we want to include all the elements of health—physical, mental and oral—when addressing the important components of social determinants of health.

"When one of our staff is working with a member on social determinants of health—food insecurity, housing instability and all those things—they need to take the opportunity to make sure their behavioral health and their oral health are considered," Cathleen says.

Because CareOregon's staff is responsible for our own Dental Care Organization (DCO), CareOregon Dental, and for working with the DCOs serving Jackson Care Connect and Columbia Pacific CCO, we have an opportunity to collaborate with dental organizations across Oregon.

The Dental Department worked with a cross-disciplinary work group accountable to the oral health steering committee. Together, we developed and led clinical integration initiatives between medical and dental care, starting with pregnant women and 0- to 5-year-olds.

CareOregon Dental also has maintained the highest sealant performance among all of Health Share of Oregon's dental plans since the Oregon Health Authority established this goal two years ago.

CareOregon Dental DCO—2017

$2 million
allocated to clinical integration projects

25,524
members had a dental visit

4,167
children got dental sealants

302
members received care coordination services after a dental-related ED visit

Philip Archambault Sr. was one of the many elders and Tribal members who spent days sharing their stories and wisdom with our staff.

Walking alongside Oregon's Tribes

TRIBAL CARE COORDINATION

CareOregon was honored when the Nine Federally Recognized Tribes of Oregon recommended that the Oregon Health Authority (OHA) contract with us to provide care coordination services to American Indian and Alaska Native (AI/AN) Tribal members on Oregon Health Plan (OHP) open card.

Becoming kindred

Over the past few years, the Tribes have wanted more of a relationship with CareOregon, according to Sharon Stanphill, Health Operations Officer, who oversees the health system for the Cow Creek Band of Umpqua Tribe of Indians.

"It is more than obvious to the Tribes that CareOregon is kindred to us," says Sharon. "CareOregon is just the partner we've been waiting for."

Together, CareOregon, Tribal Leaders, the Native American Rehabilitation Association of the Northwest (NARA) and OHA worked to develop a culturally appropriate, statewide telephonic program for over 16,500 Tribal members on OHP open card. The CareOregon Tribal Care Coordination program launched on Aug. 1, 2017; in February 2018, an additional 1,600 Tribal members, formerly with FamilyCare, became eligible for this program and joined the other Tribal members in working with CareOregon.

Walking together

Tribal Care Coordination supports members as they navigate chronic health conditions, establish primary health care homes, find specialty providers, access transportation for appointments or access durable medical equipment. Tribal Care Coordination services can also help Tribal members maneuver through the health system in general by identifying what is working well

Tribal Care Coordination

496 calls

- **40%** of calls for dental access
- **50%** of calls from AI/AN OHP members who are not part of the Nine Federally Approved Tribes of Oregon

388 cases opened

331 members

from an estimated **70+** different tribes

Data from Aug. 1, 2017 to Dec. 31, 2017

Federally Recognized Tribes of Oregon

1 *Burns Paiute Tribe*

2 *Confederated Tribes of Coos, Lower Umpqua and Siuslaw*

3 *Coquille Indian Tribe*

4 *Cow Creek Band of Umpqua Tribe of Indians*

5 *Confederated Tribes of The Grand Ronde Community*

6 *Klamath Tribes*

7 *Confederated Tribes of Siletz Indians*

8 *Confederated Tribes of the Umatilla Indian Reservation*

9 *Confederated Tribes of Warm Springs Reservation*

for the member or advocating alongside the member to remove barriers. The care coordination provided by our Tribal-specific clinical team is available at no cost for Tribal OHP open-card members.

"I'm really impressed that CareOregon staff came to our homelands searching to get to know us and understand our Tribal members' needs," said Sharon. "We sat down, shared a meal, talked about how we do things and how CareOregon could deliver services to our members. They really got to know us as individual Tribes and by coming to our homeland and meeting our staff, we knew we were going to get the attention and benefits our Tribal members would need."

Removing barriers

Sharon shared an experience of a Cow Creek Band of Umpqua Tribe of Indians' family, and how Tribal care coordinators helped the family work through a challenge. This family drove two hours with their very sick grandchild to have a scheduled diagnostic appointment. The child had no food or liquid in preparation for the treatment, adding to the pain he was already experiencing.

"When they arrived, it was discovered that the prior authorization hadn't been obtained prior to the appointment being made, and thus the procedure was going to have to be canceled," said Sharon.

"In the past, the family would have turned around and driven two more hours home without having the crucial service," Sharon says.

Instead of returning home, the family was advised to contact CareOregon's Tribal Care Coordination program. The Tribal care coordinators worked together, advocated alongside the family, and were able to obtain the appropriate approvals for the child's procedure to move forward that same day.

By the end of 2017, the Tribal Care Coordination team began receiving more repeat referrals from patients who had been assisted in the past, and many are calling back for support with more complex health care needs. By engaging with patients long-term, this team is demonstrating to Tribal members that they are an accessible and trustworthy resource that truly coordinates their health care needs.

Learning from the Tribes

The Tribal Care Coordination team shared that they have found opportunities to serve the health care of Tribal OHP members in a deeper and more meaningful way.

CareOregon staff members were thankful to have cultural competency training organized by NARA and the Yellowhawk Tribal Health Center. They learned from Tribal community members about the history of indigenous peoples, and the difficulties they have faced historically and continue to face. During this training, CareOregon staff also learned about historical trauma, intergenerational trauma and how resilient Tribal people have been and continue to be.

While visiting CareOregon for a celebration of Native American Heritage Month, NARA Chief Operating Officer Michael Watkins, a citizen of the Confederate Tribes of The Grand Ronde Community, told staff, "Everything you learned in school about Indians — throw it out the windows, because it wasn't true."

Understanding spirituality's role in health

NARA's Cultural Director and Hunkpapa Lakota Elder Philip Archambault Sr. talked about the differences in spiritual backgrounds between Native Americans and non-Tribal members, and emphasized that spirituality is a key part of health for indigenous people.

"Our sweat lodge is our church, where we go to pray…[and to] develop your mind and the positive aspects of your life."

He shared that up until legislative changes in 1978, American Indians were denied their religious beliefs by law, which had a significant impact on the physical and mental health of the Tribal members. The forced boarding schools, where cruelty was common, was another factor for many Elders. Understanding the historical and intergenerational effects is key to health care.

"I'm really impressed that CareOregon staff came to our homelands searching to get to know us and understand our Tribal members' needs."

Health and well-being for Tribal members requires that they live in harmony with Mother Earth, says Philip.

"Understanding, at least in part, about the role that spirituality, a connection to the environment, and the history of abuse that is integral to many Tribal members' lives, has helped us as we talk to Tribal Care Coordination users about their health and needs," says Philip. "Our goal is to respect Tribal medicine and traditional beliefs, as we integrate them with available health systems."

"I feel good being here with you because you want to help our people," said Philip to CareOregon staff. "You have to live by good values—mental, physical and spiritual—and then you can be proud."

CareOregon's staff is indeed proud and honored to walk alongside the Nine Tribes of Oregon, NARA, and all of the Tribal OHP members. We are committed to serving, identifying and removing barriers, as well as advocating alongside all Tribal members with a goal of providing the best possible service to Tribal Care Coordination users.

It was our great privilege to have met and learned from Philip Archambault Sr, who passed away in July. We will honor his memory by putting his wisdom into practice with each member we work with through the Tribal Care Coordination program.

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Financial Summary 2017

To ensure our ability to meet the needs of our members and their families, in both good times and in lean, CareOregon has carefully maintained a prudent level of reserves over the years. In 2017 we experienced a significant rise in the acuity of our membership, as well as medical cost trends exceeding the rate of increase in Medicaid and Medicare funding. Yet CareOregon remains a source of stability amid this turbulent landscape. We will continue to improve the cost effectiveness and quality of health care and to tightly manage administrative costs, enabling CareOregon to strengthen the communities we serve in 2018 and beyond.

196,000
MEMBERS

$1.036 billion
TOTAL REVENUE

$485 million
TOTAL ASSETS

Community Investment 2017

Over the past two years, CareOregon has invested more than $20 million in Oregon communities through grants, sponsorships, improvements in provider capacity and social services. By investing in programs such as preventive care, access to healthy food and stable housing, safe neighborhoods and more, we are helping to improve health outcomes for our members and create healthy environments for all Oregonians. And by empowering people to get healthy and stay healthy, our Community Investments are reducing health care costs now and in the years to come.

	COMMUNITY DIRECTED GIVING	PROVIDER CAPACITY & OUTCOME-BASED PAYMENTS
CareOregon	**$3.9** million	**$1.3** million
Columbia Pacific CCO	**$950** thousand	**$867** thousand
Jackson Care Connect	**$436** thousand	**$1.4** million

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