Oregon Health Policy Board

AGENDA

March 4, 2014
Market Square Building
1515 SW 5th Avenue, 9th floor
8:30 to 11:30 a.m.

Live web streamed at: OHPB Live Web Streaming

#	Time	Item	Presenter	Action Item
1	8:30	Welcome, call to order and roll **Action item:** 2/4/14 minutes	Chair	X
2	8:35	Director's Report and welcoming Zeke Smith and Lisa Watson	Tina Edlund, OHA	
3	8:50	Overview of OHPB's 2014 work plan	Jeff Scroggin	
4	9:15	Oregon Insurance Division presentation: • Rate review overview • Cost, Utilization, & Quality Metrics	Laura Cali	
5	9:45	Proposed Measurement Framework: Initial Quarterly Dashboard	Gretchen Morley	
	10:15	Break		
6	10:30	Transformation Center update: • CCO Transformation Plans milestones report • Transformation Funds	Cathy Kaufmann	
7	11:00	Legislative update: summary of February session	Courtney Westling	
8	11:15	Public testimony	Chair	
	11:30	Adjourn	Chair	

DRAFT

Next meeting:
April 1, 2014
1:00 to 5:00 p.m.
Market Square Building
1515 SW 5th Avenue, 9th floor

Oregon Health Policy Board
DRAFT Minutes
February 4, 2014
1:00 - 3:30 p.m.
1515 SW 5th Avenue, 9th Floor

Item
Welcome and Call To Order Interim Chair Mike Bonetto called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present. Mike Bonetto was asked by the Governor to fill in intermittently as Chair of the Board; Dr. Carla McKelvey was asked to fill in intermittently as Vice-Chair. Two new members will be joining the Board for the March meeting, once they have gone through Senate confirmation in February. Tina Edlund and Leslie Clement were present from the Oregon Health Authority (OHA). **Consent Agenda:** The meeting minutes from January 7, 2014 were unanimously approved.
Director's Report – Tina Edlund Tina reviewed current enrollment numbers for the Oregon Health Plan. Projected enrollment by the end of 2014 was 240,000 enrollees. Currently, 180,000 employees have been enrolled in OHP. Legislative session began February 3: 1. One of OHA's key bills is the creation of the Temporary Medical Insurance Pool (TMIP), which covers high-risk individuals who need continuing coverage. The ultimate goal is to have TMIP enrollees end up in the private market. 2. The Basic Health Plan provides a framework for those that might go between Medicaid coverage and up to 200% of poverty. The goal of the Basic Health plan is to reduce constant coverage churn. Advocacy organizations have asked the legislature to direct OHA to conduct a study on the impacts and costs of creating the Basic Health Plan in Oregon. 3. There is a bill sponsored by Elizabeth Steiner Hayward that, if passes, would direct OHA to apply for a waiver from the federal government to allow OHA to use money from the children's health insurance program (CHIP) to subsidize coverage so children can go into the exchange, along with their parents, rather than be in the CHIP program. It would also create a choice for the parents, if they wish to leave their children in CHIP. Tina also covered summary documents for transformation funds and community mental health programs. The legislature set aside $30 million in transformation funds for CCOs to propose innovations they could use the funds for, which were administered through the transformation center. The legislature also set aside $40 million for investments in community mental health programs throughout the state. The Addictions and Mental Health program used an RFP approach to award those dollars to communities throughout the state. View Health System Transformation Fund Proposal Requirements Summary here, starting on page 27 View 2013-2015 Mental Health Investments Summary here, starting on page 31
Workforce Committee Update: Projections of Provider Demand 2013-2020 – **Peter Graven, Center for Health Systems Effectiveness** **Jo Isgrigg, Oregon Healthcare Workforce Institute** **Lisa Angus, OHA** There is a workforce related concern about access to care for newly insured Oregonians. OHPB requested the Office for Oregon Health Policy & Research, Oregon Health & Science University, the Center for Health System Effectiveness and the Oregon Healthcare Workforce Institute to project future demand while adjusting for potential changes related to health care transformation.

The study used unique data from Oregon-specific sources, including Oregon's All Payer, All Claims database and the Oregon Health Care Workforce Licensing Database, to identify utilization by type of health insurance coverage and to allow for the estimation of clinician demand at the state and county level.

View the Workforce Report – Projected Demand, 2013-2020 here.
View the Workforce Committee Presentation here

Health System Transformation: Quarterly Progress Report – Lori Coyner, OHA

Lori reviewed the fourth quarter report which included data from January through September 2013. March 31, 2014 is the last day CCOs can submit claims for 2013 and during April, the final CCO metrics for incentive payments will be completed. Performance incentive payments will be distributed in June.

Oregon and CCOs are assessed annually on 33 measures. Financial penalties are imposed to the state if quality goals are not achieved. Next steps will be to continue to aggregate and produce state-level data for each of the state's 33 performance measures. CCO-level progress reports will be prepared and publicly reported on performance metrics, including quality, utilization and cost data. Performance metrics by race and ethnicity will be prepared and publicly reported for 2013 calendar year. Full data for calendar year 2013 will be included in the next report.

View Oregon's Health System Transformation Quarterly Report, presentation here
View the Health System Transformation Quarterly Progress Report here

2014 Work plan: Direction, Calendar, Next Steps – Diana Bianco, Artemis Consulting

Diana Bianco with Artemis Consulting appeared before the Board to help facilitate a discussion in response to recommendations that were sent to the Governor in December 2013 and how the 2014 work plan, direction, calendar and next steps will address and implement the recommendations.

The policy staff at OHA developed a list of high level deliverables:

- Dashboard & Framework – presentation to Board in March 2014
- Rate Filing Metrics – presentation to the Board in March 2014
- Sustainable Rate of Growth work group – will begin nomination for members in late February
- Primary Care Infrastructure – short term technical advisory group to convene May or June
- Alignment of Metrics and Reporting – end of May
- CCM Alignment Accountability workgroup – draft charter, appointing work group, end of April
- The All payer database technical advisory group will be appointed in April

The board discussed the structure of the work around developing and implementing a sustainable rate of growth methodology and mechanisms to hold entities accountable to those rates. Questions were raised about what the Board's role would be in that work and what information would be needed to provide ongoing input and guidance.

The board also discussed an enhanced rate review process that would include a small set of metrics from the dashboard and measurement framework for informal inclusion in 2015 rate filings. OID will present initial quality, cost and utilization metrics at the March Board meeting.

Adjourn

Next meeting:
March 4, 2014
8:30 a.m. to 1:00 p.m.
Market Square Building
1515 SW 5th Ave, 9th Floor
Portland, OR 97201

ACA Enrollments

(as of 2-27-2014)

Determinations through Cover Oregon:

- 38,806 — Private/QHP
- 84,991 — Medicaid/OHP
- 123,797 — Total
- ~35,000 additional people determined eligible for private insurance, but have not yet picked a plan

Oregon Health Authority "Fast Track" enrollments:

- 128,434 — Oregon Health Plan

Total enrollments:

- 252,231

Oregon Health Authority

JOHN A. KITZHABER, MD
Governor

January 30, 2014

Oregon Health Policy Board
500 Summer Street NE
Salem, OR 97301

Dear Oregon Health Policy Board members:

Thank you for your recommendations to align Oregon's health system transformation with the Affordable Care Act (ACA) implementation. It's imperative we transform care for all Oregonians and your recommended strategies build on our triple aim goals of better care, better health and lower costs that we have begun to implement in the Oregon Health Plan with Coordinated Care Organizations. I look forward to your progress in advancing the recommendations contained in your final report, which represent fundamental next steps for Oregon's continued health system transformation evolution.

As you further develop and advance your recommendations, I would like the Oregon Health Authority, the Policy Board and the Oregon Insurance Division to consider how these strategies could be implemented. The recommendations could include any additional legislative or regulatory actions necessary to ensure the strategies you have outlined can contribute to creating a more effective, efficient health care system. These recommendations should be completed no later than December 1, 2014.

Thanks for your leadership over the past several years, Oregon has made significant strides in reforming its health care delivery system and much of that progress has resulted from your hard work and recommendations. Across the state, communities have begun transforming to deliver more effective, efficient care. We have an amazing opportunity to leverage your efforts to ensure that every Oregonian has the opportunity for better health and better care at a lower cost.

Sincerely,

John A. Kitzhaber, M.D.
Governor

SPK/gg

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AllCare Health Plan

AllCare's transformation funds will support their *Stewards of Change* Initiative. AllCare believes there is surplus funding throughout the social and health care system that is lost through duplication of services, delivery of unnecessary services, and safety issues that lead to avoidable poor outcomes and low quality care. Much of the surplus is currently absorbed in unnecessary costs by large hospitals and health systems that provide patient care that could instead be diverted to lower cost settings.

Building upon their innovative payment model for patient-centered primary care homes, they will adapt that model to achieve similar financial and clinical integration among their partners. Innovative payment methodologies and delivery models will support integrating physical health, mental health, dental health, and addiction recovery into non-hospital-based systems and into lower cost, preventive settings. These health care services are further enhanced through the support of community services and public health.

They will focus these efforts on high-cost and high-risk Oregon Health Plan members, and expect this model of collaboration and use of lower-cost settings to benefit all Oregon Health Plan members.

They will establish four committees for different provider types that will develop cost savings initiatives, quality measures, and tiered payment structures for shared risk that can transform their financial and clinical models.

AllCare physicians have developed a new payment model that leaves the current system in place, while adding financial incentives for providers who meet certain objectives. For example, providers can increase their compensation by remaining open to new Medicaid patients. Some of the metrics that will be used to measure success include reducing the cost of hospital-based services and calculating the percentage of Oregon Health Plan members who rank their experience with the AllCare Health Plan as "high."

The Stewards of Change Initiative will also improve community services by funding the addition of more mental health and addiction counselors and community health workers. AllCare's vision of adding social services to individual care plans can easily be adapted by other communities.

Cascade Health Alliance

Cascade Health Alliance is using its transformation funds to establish five projects.

Implementation of a health information exchange (HIE) system: Benefits of such an exchange will include increased care team communication through connection to the regional Jefferson Health Information Exchange; improved experience and care coordination for patients in multiple care settings; reduced hospital readmissions; and efficiencies that arise from the use of advanced HIE systems.

Youth crisis respite and residential program: The first youth crisis respite program in Klamath County will be a short-term residential program that offers care for youth experiencing transient psychiatric crises. Previously, youth patients who could not stay with their family or foster care homes had to travel out-of-area services. This youth crisis respite will reduce trauma for the children and cost for county youth mental health services while providing more efficient and effective care in the community.

Traditional health care worker and non-emergent medical transportation: Four traditional community health workers will be connected with the non-emergent medical transportation system. They will interact with and provide assistance to users of in-home care and high utilizers of health care, such as those who visit the emergency department frequently or those who could benefit from better care management.

Mobile crisis team: A Klamath County mobile crisis team will provide on-site, face-to-face therapeutic response to individuals experiencing a behavioral health crisis. The team replaces the current high-cost, emergency crisis response model. The team will be able to assess, treat, and stabilize the situation and reduce immediate risk and threat of harm. Providing intensive treatment in the community, not as an ER admission, allows for safer and more effective treatment.

Care coordination program: Electronic health record systems will be used to improve care coordination among the many providers who interact with a patient, including primary care physicians, specialists, nurses, mental health, substance use providers and technicians. Incorporating electronic health records allows CHA to coordinate with providers and access up-to-date information on members; establish consistent treatments; easily transition members to other care settings; share lab and other reports; and provide more efficient and effective care.

Columbia Pacific CCO

Columbia Pacific CCO will primarily use their funds primarily to improve the delivery and integration of clinical care for members by focusing on three key areas.

Clinical interventions and improvements: Informed by their multi-disciplinary Clinical Advisory Panel (CAP), these projects will focus on clinical interventions.

- Implementing a CCO-wide opiate-prescribing and alternative pain management program that provides patients with chronic pain a tightly integrated team-based treatment program, which includes medical care, behavioral therapies, physical and movement therapy, relaxation and stress management, and education.
- Establishing ten detox beds.
- Creating crisis respite and safe holding capacity and recommendations for sustainable funding.
- Reducing inappropriate emergency department visits and hospital admissions for high-utilizers.

Medical home capacity building, provider training, and infrastructure improvements: Focusing on the PCPCH model, these projects will enhance population management, integration, and local access to service for both primary care and behavioral health clinics.

- Continuing the Primary Care Learning Collaborative: Provide technical assistance, training and other clinic support, building on previous CareOregon grants to expand and extend the learning collaborative to include behavioral health provider agency representatives interested in the PCPCH model.
- Training providers on medication assisted therapy, trauma-informed care, and SBIRT or SMART training to achieve screenings and outcomes benchmarks, and offering pharmacy supports for drug therapy coordination,
- Create PCPCH incentive payment models that reward providers for health outcomes.
- Building short-term residential crisis respite programs for individuals undergoing psychiatric crises who would otherwise remain in more expensive acute psychiatric beds.
- Implementing telemedicine for key specialty areas and diagnoses, and increasing the health care workforce capacity (primary care, behavioral and oral health and specialty providers) to accommodate the anticipated CCO membership growth.

Community development and partnerships: Provide wrap-around services and programs that support and enhance other efforts, including clinical capacity building.

- Healthy Homes Demonstration Pilot: Use the trained Community Action Team in Columbia County to assess and diagnose health risks in the home, and help arrange for funding for home rehabilitation in order to improve health.
- They will also select a community to participate in a community-wide Resilience Trumps ACEs training, which addresses the adverse effects that prolonged childhood trauma can have on brain development and offers hopeful behavioral health interventions for community members.
- The CCO will use the community health assessments from each county to address the identified health needs, which will likely include obesity, health education, prevention, and wellness activities.

Eastern Oregon CCO

Eastern Oregon CCO will establish its own grant-making process, which will fund community projects that contribute to better health outcomes. Providers and community partners will submit project proposals, all which must show how they meet a demonstrated need of EOCCO members.

EOCCO will use the same grant process that OHA designed for awarding transformation funds. They will work in close partnership with the OHSU Center for Evidence-based Policy to manage the grant application and evaluation process, as well as set minimum and maximum grant request thresholds.

The goal is to implement effective, successful, and financially sustainable community projects that decrease costs, improve patient care, or improve access to preventive care. Likely projects include:

- Funding to assist Patient-Centered Primary Care Homes in achieving higher tier status
- Investments in telemedicine
- Integration of mental health providers into the primary care setting
- Employing community health workers in hospitals to reduce inappropriate ER use
- Alignment between EOCCO, schools, and public health

EOCCO will utilize an advanced analytics and actuarial team to track data and evaluate outcomes.

FamilyCare

FamilyCare CCO is using innovative systems as the foundation to better quality care and healthy individuals. Carrying this systems approach forward, FamilyCare will implement a multi-tiered investment strategy with five interrelated components.

The Integrated Patient/Provider Organized Delivery System (IPPODS) model is member- and provider-centered, and provides a more direct, hands-on and technological approach to care. Teams of care professionals will help manage groups of providers based on region, specialty or patient population (such as diabetes as a specific condition, or particular geographic area). Simultaneously, FamilyCare will establish a "hub" of professionals focused on member services, such as Care Management or Referrals and Authorizations, who will be able to communicate with the teams in real time to coordinate care and connect members and providers to a wide range of services and professionals.

To provide members with greater options for Patient-Centered Primary Care Homes (PCPCHs), FamilyCare will provide technical assistance to small practice groups with technology investments and systems necessary to achieve PCPCH recognition status.

FamilyCare will invest in its IT infrastructure to create a more accurate and better integrated system through assessing use of electronic health records and identifying barriers. Then, it will support its contracted providers' use of electronic health records and information exchange.

To emphasize the importance of nutrition within the communities served, FamilyCare will hire a nutritionist. This directly ties into the nutrition and chronic disease elements of the Community Health Improvement Plan designed by FamilyCare's Community Advisory Council. The nutritionist will work with providers to share best practices for nutrition improvements through counseling and training, and will oversee a rotating panel of OSU graduate students interns on nutrition within clinicians' practices.

Finally, FamilyCare will invest in community education through a number of innovative pilot programs, with guidance from the Community Advisory Council. Often with partnership from community-based organizations, these programs will be distributed throughout the service region and will all be scalable, so that they may be added to additional regions following a thorough testing period.

Health Share of Oregon

Health Share of Oregon will focus on five priority areas that contribute to a regional system of care and promote the triple aim of better health, better care and lower costs. All the projects are focused on improving quality of care through patient education and coordinated care. These projects align with their transformation plan.

A Transformation Oversight Committee will oversee the projects, authorize task forces or work groups for specific initiatives, and monitor milestones, deliverables, and metrics that demonstrate transformational achievements.

Priority 1: Strengthening Primary Care Capacity

1) Develop an Advanced Primary Care (APC) practice model. This supports multi-disciplinary teams in delivering coordinated care to patients with complex, chronic diseases.

2) Expand primary care capacity through implementation of telementoring (e.g., ECHO), which combines telehealth technology and case-based learning. Primary care providers will be trained by specialists and other providers to learn how to offer specialized care and co-manage Medicaid patients with complex health care needs.

Priority 2: Enhancing Community Health Integration

1) Expanding the Healthy Homes Asthma program: Conduct home visits to improve prevention and care for families with asthma patients.
2) Participating in the Future Generations Collaborative, which brings together Native community-based organizations, the Native community, and government agencies to improve the health of urban Natives.
3) Establishing chronic-disease self-management programs in supported housing environments to assist adults with chronic conditions in better managing their own care.
4) Developing Health Share's Community Health Improvement Plan through implementation of the Community Readiness Model.

Priority 3: Engage Members

With Community Advisory Council members and key stakeholders, develop a pilot program that will develop a patient-centered approach for assigning new members to PCPCHs based on the patient's values, preferences, and expressed needs. Additionally, implement outreach strategies for who are difficult to engage members, and identify other best practices for new patient PCPCH enrollment .

Priority 4: Improving Community Care Coordination through Information Sharing

A stakeholder group will gain consensus on information sharing needs and processes. Sharing health information across providers can increases efficiency, care management, and safety, but must be done in a manner that is appropriate, meaningful, and secure.

Priority 5: Leveraging Health Information Technology

Health Share will use a portion of its allocated transformation fund to cover initial investment required to purchase and implement key technologies to support strategic priorities. Final determination of selected technology investments will occur by June 2014.

InterCommunity Health Network CCO (IHN-CCO)

InterCommunity Health Network CCO will establish a regional health information data solution. A single data repository will aggregate data from multiple providers and health care systems. It will be used to assess current capacity, engage community partners, and perform system inventory. In the future, this system will provide a foundation for, among multiple other potential outcomes, developing a shared information model, creating standards and supports mechanisms, tracking metrics data and reporting.

The Regional Health Information Exchange will be developed by IHN in collaboration with several organizations and stakeholders. Participating organizations must accept a data use agreement and have the capacity to effectively store and manage electronic health care data in order to guarantee the highest level of security prior to exchanging sensitive health information.

This project supports region-wide care and community-based population health, supporting transformational projects through the use of shared information and advancements in technology, improving patient engagement, assisting with care and disease management, and enhancing partnerships between providers.

Over the course of the project timeline, IHN will design data sharing agreements, select vendors, establish infrastructure and supports, test scripts, integrate member and provider information, test the systems, provide outreach, and conduct training.

Jackson Care Connect

Jackson Care Connect will use its transformation funds with input from its Clinical and Community Advisory groups. Over the past year, these groups have helped Jackson Care Connect develop and implement innovative ideas, learning activities, and community partnerships. This funding will contribute to three projects that are tied together with overarching systems management and will result in shared learning.

Jackson Care Connect will hire a Portfolio Manager to support educational and facilitation needs, including management of the transformation fund projects.

The first project is an investment in data sharing and health information technology (HIT) improvements. This will increase data sharing between organizations already using electronic health records and better integrate behavioral health service organizations and social support services into the system. They will also connect to the surrounding region, in partnership with other CCOs and hospitals, through participation in the Jefferson Health Information Exchange.

The second project will support Patient-Centered Primary Care Homes (PCPCHs) in capacity building and other support for current PCPCHs and for small clinics interested in becoming PCPCHs. Establishing a local learning collaborative will offer peer support, cross-learning, and exposure to different clinical care models to help bolster the PCPCH system. It can also be tailored to local community needs. In partnership with others, they will develop a sustainable PCPCH payment model to support recognized clinics in maintaining their team-based, multi-disciplinary, integrated care delivery model.

Their third project is improving care coordination, specifically integration of behavioral and physical health, and coordinated care for high utilizers. In partnership with others, they will develop a system integration model that will inform integration activities locally and statewide, and will support participating organizations with small stipends for their time and dedication.

PacificSource Central Oregon CCO

PacificSource Central Oregon CCO will use their funds in eight key domain areas that were identified in a strategic planning process completed in early 2013. They will fund a number of projects in these eight key domain areas that include: prevention and population health; health system integration; care coordination for patients with complex medical needs; information technology systems and CCO infrastructure; workforce development; member engagement and activation; alternative payment methodologies; and research and evaluation.

They will use a transparent portfolio management model to fund and oversee projects. This process includes member engagement, and screening and assessing procurements for project proposals through a public, community RFP process. CCO committees and councils will help with the evaluation, support collaboration, and inform final funding decisions in partnership with a newly formed Grants committee, the Operations Council, the Community Advisory Council, and the Clinical Advisory Panel.

Example initiatives include:

- A maternal and child health initiative, leveraging a public health and primary care partnership to enhance access to targeted services for high-risk OHP maternity members
- A pediatric complex care coordination initiative that embeds a nurse care coordinator in its three largest pediatric practices and development of a community-wide strategy for high-risk pediatric populations through the existing Program for the Evaluation of Development and Learning
- Two chronic pain initiatives
- A community-wide care coordination strategy for adult patients with complex health care needs (Bridges Health)
- Integration of behavioral health into primary care and primary care into behavioral health settings (the latter for members with severe and persistent mental illness)
- Increased capacity for behavioral health in primary care, including expansion into pediatric, neonatal intensive care and internal medicine settings including involvement in a bi-state alternative payment study (SHAPE in Colorado)
- A community-wide effort to standardize transitions in care between regional emergency departments and long term care facilities
- Trial alternative payment methodologies involving global risk agreements in acute mental health and with a targeted Medicaid population within one large clinic system

PacificSource – Columbia Gorge CCO

The PacificSource Columbia Gorge CCO will use their transformation funds across five key portfolios that were selected in partnership with the Columbia Gorge Health Council (CGHC). Each of the areas of the portfolio management model will be overseen by a decision-making group made up of stakeholders responsible for maintaining financial viability of the portfolio, evaluating and monitoring opportunities and performance, and for making all decisions in a structured way.

To measure the appropriateness of projects and to set consistent expectations within each portfolio, the Columbia Gorge region adopted nine measurement areas: cost, health outcomes, incentive measures, member activation (knowledge and skill for self-management of care), member experience, health promotion, equity, determinants of health, and efficiency & effectiveness. Each proposed project will be assessed and approved through the RAPID (Recommender, Approver, Performer, Input, Decision Maker) model.

Each portfolio has a number of proposed or in-process projects. Thirty-five percent of the funds will be reserved for additional projects as new information is available in early 2014.

Project areas include:

- High-performing health care system: Drives change within the health care eco-system by reducing costs and improving efficiency, effectiveness and member experience. Facilitating PCPCH integration and adoption, integrating dental health into the system, creating a standard release of information form, and supporting alternative payment methods.
- Working across social and organizational cultures: Bridge cultures to increase effectiveness, address equity issues, decrease cost, and improve member experience, knowledge, skills, and education. Potential projects include outreach to high utilizers, training providers in care management techniques, medical interpreter training, and addressing the results of the Oregon Equity and Inclusion grant.
- Engaged members: Member outreach focused on patient activation supporting more effective use of the health care system. Proposed projects include enrolling patients in the Persistent Pain Education and Opiate Reduction program; promoting maternal and child health through Text4Baby; and enrolling members through an improved on-boarding process.
- Community well-being: Improve long-term health within the larger community through education, health promotion, and addressing the determinants of health. Proposed projects include integration with the Early Learning Hubs, reducing childhood obesity through a Community Action Plan, and identifying and addressing community-wide needs through a comprehensive health system and community assessment.
- Information solutions: Investing in health information technology to improve information exchange capabilities. Projects include investing in clinical information aggregation, and creating capacity for integrated social service referrals.

65% of funding will be spread across five key portfolios; 35% will be reserved until early 2014 when results and further information becomes know.

PrimaryHealth of Josephine County

PrimaryHealth of Josephine County is using its transformation funds on seven core projects, which will improve the coordination of care, access to primary care, and the CCO's health information technology network.

Enhanced Care Delivery System Pilot: Sponsor an Enhanced Care Delivery System Pilot at the Grants Pass Clinic, a multi-specialty clinic which houses 56% of PrimaryHealth's primary care assignments. It will help improve quality and health outcomes, lower cost of care and increase patient satisfaction.

Maternal Medical Home: Work with Women's Health Center of Southern Oregon to develop a maternal medical home, where pregnant women can receive care that extends beyond the traditional obstetrical care model. It will improve birth outcomes by increasing compliance, education, and outreach, and focusing care management resources on those women at highest risk for poor birth outcomes.

Support for Patient-Centered Primary Care Homes: Support the development and effectiveness of patient-centered primary care homes (PCPCHs) through alternate payment methodologies; pay for performance bonuses; and the provision of additional staff positions. Fostering the success of PCPCHs will help PrimaryHealth improve outcomes for all of its members.

PrimaryHealth Information Technology: Increase capacity for quality and outcome reporting by enhancing its health information technology (HIT) systems through better software and additional staff. This will guide transformational efforts and help demonstrate through data whether transformational changes in the system have created the desired improvements.

Network Health Information Technology: PrimaryHealth will solidify its connectivity to the regional Jefferson Health Information Exchange (HIE). This will allow community providers to coordinate care more effectively and efficiently and may connect to other regional platforms in the future. This project will allow PrimaryHealth to: Gain access to clinical data from contributors to the HIE; improve its ability to manage quality and cost by enhancing communication channels across the care team, reducing duplicated tests and directing patients toward more appropriate care settings and services; manage hospital readmissions by addressing the major risk factors affecting 30-day readmission; and improve the patient experience by ensuring they are seen by the right provider, at the right time to keep them healthy and manage their chronic health conditions.

Education to Support Transformation: Support necessary education to train personnel on the innovative care concepts and tools used in care transformation.

CCO Staff to Support Transformation: Lastly, employ individuals charged with monitoring, participating in, and facilitating transformational efforts.

Trillium CCO

Trillium Coordinated Care Organization is using its transformation funds on a project called the *Shared Care Plan*. The plan will address problems of limited communication and fragmented patient information by linking individuals on a member's care coordination team virtually – including the member. This virtual link will allow teams to share information about the member and their care, even if the team is in different organizations or locations. The *Shared Care Plan* will help Trillium integrate and coordinate care for its 50,000 Medicaid members, ensuring higher quality health care and a better patient experience.

Trillium's three goals for the *Shared Care Plan* are to enhance and facilitate health information Exchange; improve care coordination and disease management to ensure improved outcomes for quality measures; and engage members in their care and well-being. It will also help further integration of physical and mental health and support the development of patient-centered primary care homes.

A secure web-based platform called Care Team Connect (CTC) will help convene a patient's team of providers across the health delivery network. It also combines risk assessments, a workflow engine and a secure data exchange to achieve robust care coordination.

The *Shared Care Plan* focuses on three main areas: care coordination and quality, patient activation, and health information exchange. It is a comprehensive coordinated care model tool that will allow Trillium to better manage the care of all its members, specifically those with a high need for patient-centered and preventive care coordination.

Umpqua Health Alliance

Umpqua Health Alliance plans will use its transformation funds on a wide range of small projects. The projects include:

- An expanded care clinic to help address the needs of the CCO's high utilizers by providing high quality primary care services. The clinic will coordinate physical, mental and dental health services, along with addiction and nurse case management services.
- Expanding the number of patient-centered primary care homes, with a focus on smaller and more rural practices.
- Collecting population metrics. Using its patient-centered electronic health record system will help support data collection. Electronic health records will also create opportunities for providers to be prompted to perform services for the patients who need them.
- Co-location of addiction services. By co-locating physical health services and addiction services, problems can be addressed at the time that an addiction is noted. By co-locating these services, UHA will increase the number of patients who see addiction counselors.
- Wellness services. Using its community health improvement plan, they will develop wellness programs, such as improved nutrition and exercise.
- Non-Emergent Medical Transportation is new to UHA and expected to be part of its provided services in July 2014. UHA plans to meet with area vendors to plan how to best serve its members' transportation needs.

Many of these projects are already in motion and will be launched by July 2014. This delivery timeline will allow for a full year of transformation in this biennium with the newly implemented projects.

Western Oregon Advanced Health

Western Oregon Advanced Health will use its transformation funds for four distinct projects, each of which is designed to support the triple aim and WOAH's transformation plan.

WOAH's first project will deliver a robust health information exchange, which will support health system transformation. They will expand on the region's existing efforts, which have been developed over the last three years through an informal association known locally as the Bay Area Community Health Information Alliance (BACHIA). The project will help BACHIA advance the planning, development, and implementation of the health information exchange. The critical needs that these funds will specifically be used for include a variety of highly specialized technical consulting services including planning, technical assistance, HIE vendor oversight, quality and analytics, clinical transformation, and replication and policy development.

The second project involves improving WOAH's advanced health analytics, supporting its strategic mission to meet and exceed Oregon's CCO incentive measures, while at the same time improving health outcomes and reducing costs. The analytic tools are based in part, on risk stratification, and will assist their providers to make the transition from symptom-driven care, to forecasted care that is coordinated, preventive, and assisted by advanced care coordinators and case managers.

The third project WOAH will undertake is establishing a system of Medication Therapy Management. Certain prescription medications for mental illness are known to contribute to the development of diabetes. This initiative will help track and care for patients who have been diagnosed with mental illness and are taking those medications.

Finally, WOAH will use their remaining transformation funds to retain its contracted personnel who support the above projects, along with the portfolio of projects that are currently included in their Transformation Plan.

Willamette Valley Community Health

Willamette Valley Community Health's primary goals are improving access to care, better coordinating care, and making care more cost effective. They will use their transformation funds on four projects.

The first project is a community health information sharing initiative. To resolve fragmentation of information in the health care system, this initiative will make pertinent patient information available to community health providers. The plan will be scaled to include all patients in the community, not just Oregon Health Plan members.

Second, WVCH will improve patient outcomes through development of its patient-centered primary care home program. By adopting the core concepts of the model across its provider network, they will be able to increase the quality of care that their members receive. Eventually, they hope that patient-centered primary care homes can become part of robust "health care neighborhoods," which will be able to truly connect communities of patients, providers, and local organizations to improve overall community health.

The third project will help WVCH ensure that children with complex medical conditions are receiving comprehensive care. Almost 14% of children in their service area have special health care needs, and those children interact with multiple parts of the health care system. This project will develop a centralized care coordination system for children that crosses physical, mental and children's health services. Children and families with the most complex needs will be assigned a Family Support Coordinator to help coordinate the child's care.

Lastly, they will use transformation funds to collaborate with the early learning education system. Through partnership with its local Early Learning Hub, they can collaborate to help parents, providers and early learning providers to improve the well-being of children from conception to kindergarten.

Yamhill

The Yamhill coordinated care organization's transformation plan will guide its transformation fund projects. It has eight initiative areas, all which help in achieving Oregon's triple aim of better health, better care and lower costs. Their eight projects focus on coordinated primary care, population health, chronic pain management, and health information exchange and data coordination. Funds will also be used to develop an alternative payment model.

One of Yamhill CCO's main goals is to improve primary care and care coordination. They'll work on this through their population health management initiative. The program helps patients who frequent the emergency department by connecting them with primary care services and other community resources. This provides alternatives to high-cost health care settings. The program also focuses on care coordination between delivery settings. Increasing access to primary care is part of this work.

Yamhill CCO is also working to ensure all providers are certified tier 3 patient-centered primary care homes. Additionally, they are developing maternal medical homes for all OB/Gyn providers. These initiatives will help members get appropriate care, while also decreasing costs by more efficiently utilizing the CCO's provider network.

Yamhill will also be working to provide timely primary care access to all of its members. They'll do this by expanding the CCO's primary care provider teams, which are comprised of physicians, advanced practitioners and (non) traditional health care workers. The team makes sure that the full spectrum of a patient's care is coordinated and focused on prevention. Additionally, this initiative will be used to fund the start-up of a bilateral integration care model, which helps coordinate physical and behavioral health care by placing primary care physicians into mental health clinics and behavioral health specialists into physical health settings. Bilateral integration will foster timely patient-centered care in a single setting.

In addition to improving primary care and making sure patients are treated in a timely and effective manner, Yamhill CCO is using their transformation fund dollars to system improvements. A large portion of their funds will be used to develop a viable alternative payment model; improving and supporting local health information exchange tools; and to improve data coordination across the CCO.

Oregon Coordinated Care Organizations
Transformation Plans Milestones and Benchmarks

Areas of Transformation 1-3……2-21

Areas of Transformation 4-6……..22-34

Areas of Transformation 7-8……..35-45

Information primarily obtained from CCO transformation amendment documents with clarifying and supporting material from Transformation narratives and abstracts. Some Milestones and benchmarks appear differently between documents. Full plan materials available at:

http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/Oregon-CCO-Transformation-Plans.aspx

Area of Transformation	**1. Developing and implementing a health care delivery model that integrates mental health and physical health care and addictions and dental health, when dental services are included. This area of transformation must specifically address the needs of individuals with severe and persistent mental illness.**		**2. Continuing implementation and development of Patient-Centered Primary Care Home (PCPCH).**		**3. Implementing consistent alternative payment methodologies that align payment with health outcomes.**	
CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
AllCare	• 10% improvement over 2012 Baseline measurement of Members with SPMI and diabetes who have claims/encounters processed (appropriate Current Procedure Terminology (CPT) codes) for HgbA1C and LDL laboratory tests.	• 20% improvement over Baseline measurement.	• 60% of Members in Jackson, Josephine and Curry counties are assigned to a PCPCH (4% increase from December 2012) with at least one PCPCH visit; and • 5% reduction in ED utilization over 2012 utilization Baseline.	• 70% of Members in Jackson, Josephine and Curry counties who are assigned to a PCPCH have at least one PCPCH visit. • Contractor ensures an 8% reduction in ED utilization over 2012 utilization Baseline.	• An 8% increase in the rate of PCP visits/1000 members from 2012 visit levels with resulting ED cost savings to be shared with PCP or PCPCH	• A 12% increase in the rate of PCP visits/1000 members from 2012 visit levels with resulting ED cost saving to be shared with PCP or PCPCH
Columbia Pacific	• Co-location of behaviorists working with addictions treatment and Primary Care Providers (PCP) in at least three major clinics in the Service Area with a focus on the Members with Severe and Persistent Mental Illness (SPMI) having one or more co-morbid conditions in addition to a mental health diagnosis. • Develops an alternative pain management model for piloting in at least one clinic in its Service Area.	• Reaches a reduction in number of opioids prescribed for Members using standardized benchmarks and improvement targets or, if unavailable, reduction specifications mutually agreed upon by the parties. • Improves Member depression and SBIRT screenings and referral for services reflected in the established CCO benchmarks and improvement targets.	• PCPCH Learning Collaborative is formed, training is completed and practice coaches deployed. • Standardized utilization and medical cost reports developed and deployed to at least four PCPCH clinics for identification and intervention with high-risk patients.	• 70% of Members are enrolled with PCPCH Tier 3 clinics.	• Capitation payments for mental health and addictions treatment implemented with all relevant Providers. • At least one primary care clinic selected for an Alternative Payment Methodology.	• 80% of Members receive care from Providers with integrated capitation for mental health and addictions services. • At least one primary care clinic receives alternative incentive payments from Contractor, with an additional 3 primary care clinics engaged in the process of establishing integrated capitation

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	• Partnerships with social services and school-based providers initiated to provide addictions screening and intervention for adolescents.	• Increases integrated care management services provided to the Members with SPMI as described in (1) above.				methods for mental health and addiction services.
Eastern Oregon CCO	• Develops criteria for triggering Intensive Case Management for Members and referrals for Members identified as high risk and needing collaborative mental health, physical health and addictions care coordination and Intensive Case Management. • Early Assessment and Support Alliance, Assertive Community Treatment, Supported Employment and associated wrap around programs available to all Members in all 12 counties. • Contract with medical clinics in at least three counties as voluntary early adopters. • 1:1 ratio of case rate based contracts with social and medical detox Providers.	• 1:1 ratio of case rate based contracts with social and medical detox Providers. • Contract with all three existing residential addictions Providers per the jointly defined payment model established at February 2013 meeting • Complete contracts with the remaining nine counties for outpatient behavioral health and addictions integration.	• At least 25 % of Members will be assigned to a certified PCPCH at any tier level (a 21% improvement over current level). • Seek agreement with and implement Alternative Payment Methodologies in at least three certified PCPCHs. • Identify and seek approval of PCPCH certified Providers on technical assistance tools that will assist them in meeting quality outcomes. • Identify and seek approval of PCPCH certified Providers on how Contractor can assist with Member	• At least 50 % of Members will be assigned to a certified PCPCH at any tier level. • All PCPCH certified Providers contracted using consistent Alternative Payment Methodologies. • Consistent technical assistance tools made available to PCPCH certified Providers. • Consistent Member engagement tools made available to PCPCH certified Provider	• Number of Primary Care Providers, Provider payments, and the number of Members served by clinics that are piloting Alternative Payment Methodologies tracked. • Number of hospitals and Provider payments that are piloting Alternative Payment Methodologies tracked. • Implement Alternative Payment Methodologies for Providers who become PCPCH certified such as modified FFS payments, PMPM chronic disease management payments, P4P bonus payments and a shared savings program.	• Measure effectiveness of efforts to transform payment delivery. • Measure outcomes of Providers who have moved to Alternative Payment Methodologies.

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
	• Contract with all three existing residential addictions Providers per the jointly defined payment model established at February 2013 meeting. • Complete pilot contracts with at least three communities as optional early adopters for outpatient behavioral health and addictions integration.		engagement.		• Annual review of PCPCH payment methodologies to determine effectiveness conducted; including growth in the number of certified PCPCHs, growth in enrollment and Member engagement, and improvement in value-based performance measures. • Identify and seek approval from Participating Providers on Alternative Payment Methodologies to be piloted with Providers, certified PCPCH clinics, and hospitals. • Alternative Payment Methodologies via contract amendments pilot begun, in compliance with OHA reimbursement requirements and Oregon Association of Hospitals and Health	

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
					Systems (OAHHS) recommendations for payment of Type A and Type B hospitals. • Capitation payment system implemented with a least one primary care clinic. • Capitation payment system implemented with at least one Type A hospital. • Actuarial-based process for cost-based payments that is not solely financially based implemented. • Contractor, with the help of OHA and OAHHS, will develop a sound rationale for continuation of cost-based payment (or equivalent financial support) for hospitals, Provider based clinics, Fully Qualified Health Clinics, and Rural Health Clinics utilizing variables such as demographics,	

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
					geography, and financial factors. • Contractor, with the help of its hospitals and OAHHS, will develop a rural hospital, value-based dashboard (with performance metrics) that will be used to award shared Contractor savings to hospitals. • Contractor, with the help of its hospitals and community CAC, will support a community-based health care delivery model that sustains access to local services and repurposes current infrastructure and staff as needed.	
FamilyCare, Inc.	• Collaborate with dental services Providers to determine appropriate risk analysis protocols and establish data collection process, by July 2014. • Collaborate with dental	• Collect information on 80% of qualifying Members' dental care needs. • Offer Services Coordination for 80% of qualifying members' dental care needs.	• Identify barriers to clinics achieving Tier 3 status, by October 2013. • Implement payment model to contracted PCPs to encourage PCPCH status, by July	• 50% of Members are assigned to a Tier 2 or Tier 3 PCPCH (20% currently assigned to a PCPCH).	• Develop a policy to consistently apply Alternative Payment Methodology to various Participating Providers, by July 2014. • Review and assess	• Alternative Payment Methodology offered to Participating Providers other than contracted PCPs, which include financial incentives for meeting certain outcome

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
	services Providers to establish appropriate care management process, by July 2014. • Offer SBIRT training to all contracted PCPs, by December 2013.	• 50% of contracted PCPs will be trained in SBIRT.	2014		Participating Provider contracts to determine if Alternative Payment Methodology is appropriate for that Provider type, by October 2013. • Survey Participating Providers to determine level of interest in accepting Alternative Payment Methodology, by December 2013.	measures.
Health Share of Oregon	• 10% decrease in hospitalization rate for Members with SPMI. Baseline and method of calculation to be determined and mutually agreed upon by Contractor and OHA.	• 20% decrease in the hospitalization rate for Members with SPMI. Baseline and method of calculation to be determined and mutually agreed upon by Contractor and OHA.	• 75% of Members receive care in a Tier 3 PCPCH (current percentage unavailable in transformation materials)	• 90% of Members receive care in a Tier 3 PCPCH	• Alternative Payment Methodology Policy that standardizes and aligns Provider payment models across all Contractor Risk Accepting Entities (three entities for mental health care and four for physical health, as described on p. 55 of Contractor's Transformation Plan) (RAEs) defined and established. • Budgeted Medical Loss Ratio for all RAEs	• Alternative Payment Methodology Policy that standardizes and aligns Provider payment models across all Contractor Risk Accepting Entities (RAEs) established and defined. • Budgeted Medical Loss Ratio for all RAEs established • A portion of any surplus from the Global Budget available to

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
					established. • A portion of any surplus from the Global Budget available to Contractor after all settlement processes have taken place distributed to Providers that comprise the RAE network • Any distribution to Providers of any surplus from the Global Budget made available to Contractor after all settlement processes have taken place is based on Alternative Payment Methodologies aimed at improving quality and reducing costs aligned with the OHA CCO quality incentive metrics	Contractor after all settlement processes have taken place to Providers that comprise the RAE network distributed. • Any distribution to Providers of any surplus from the Global Budget made available to Contractor after all settlement processes have taken place is increasingly based on Alternative Payment Methodologies aimed at improving quality and reducing costs aligned with the OHA CCO quality incentive metrics. • Baselines and specific increase from prior year to be determined and mutually agreed upon by Contractor and OHA.
Intercommunity Health Network	• Ensure policy, procedure, data systems and coordination operational for	• 8% increase over Baseline in Member participation in H2H Care Transition Pilot.	• Contractor develops data reports identifying Members who have	• Non-emergency ED utilizing Members will be redirected to the	• Bundled payment software and begins bundling payment to a	• Utilization data on related services from Participating Providers

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
	all aspects of the H2H Care Transition Pilot. • Ensure 40% of eligible Members participate in H2H Care Transition Pilot; of those Members, 75% will not readmit to inpatient for the same diagnosis within 30 days.	Baseline and method of calculation to be determined and mutually agreed upon between Contractor and OHA. • 10% decrease from Baseline in H2H Care Transition Pilot Members' readmission rates to inpatient for same diagnosis within 30 days. Baseline and method of calculation to be determined and mutually agreed upon between Contractor and OHA.	utilized the ED more than six times in the prior year or for non-emergency purposes.	PCPCH; reduction in ER usage by this group of Members by a measurement factor of 20% attained.	small set of SHS specialist Participating Providers implemented.	who are not included in the model to those that are being bundled compared. • Work on non-SHS Participating Provider contracts to implement performance based Reimbursement initiated.
Jackson Care Connect	• Implement sustainable funding mechanisms for interdisciplinary community care teams that are tied to behavioral health, primary care, hospital, and oral service providers. • Support existing interdisciplinary community care team and expand to include at least 2 more clinics or high-utilizer stakeholder groups. • Commonly agreed-upon	• Interdisciplinary community care team is embedded in at least 4 settings of care and procedures are in place to specifically address needs in SPMI Members. • Broad community-based plan to change local prescribing patterns of opioids and pain medications planned and developed.	• Contractor corroborates that existing PCPCH clinics are maintaining or improving current Tier standing. • Primary Care administrators group created to develop PCPCH locally, with unique strategies developed for small, private practices. • Strategies and incentives for small,	• At least 60% CCO Members paneled to PCPCH Tier 1-3 clinics (currently 41% of Members paneled to PCPCH Tier 1-3 clinics).	• Baseline knowledge of health outcomes across mental, physical and oral health developed to utilize in Alternative Payment Methodologies. • Alternative Payment Methodologies that are locally appropriate, and align payment with health outcomes among Providers identified.	• Implementation strategies with key stakeholders on Alternative Payment Methodologies that align payment with health outcomes and incent the PCPCH model of care facilitated.

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	definition of high utilizers adopted and utilized by interdisciplinary community care team. • Baseline data showing utilization patterns and associated costs is established, maintained, and shared across community care team members. Data shows SPMI population and allows for targeted interventions. • Jackson County Mental Health assists Contractor in development of guidelines for community outreach workers and community care team members to work effectively and safely with SPMI population. See description of culturally appropriate and stigma reducing project in Benchmark #7. • Hospital discharges for Members with mental health diagnosis are coordinated with outpatient service Providers and include care plans.		private clinics developed in partnership with administrators group, clinical advisory panel, and Contractor staff. • Relationship strengthened across primary care, specialty, and emergent Providers. • Training on PCPCH practice guidelines developed and implemented in at least 2 new Contractor clinics.		• Opportunities and strategies for developing risk sharing pools and multi-payer alternative payments explored. • At least 1 Alternative Payment Methodology selected for implementation.	

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	• Facilitate development of Memoranda of Understanding (MOU) between physical health, mental health, and addictions service Providers to manage timely and appropriate transitions of care. • Facilitate implementation of community opioid prescribing guidelines. • Capture Baseline data for current prescribing and utilizing patterns of pain and psychotropic medications. • Encourage use of Prescription Drug Monitoring Program by local prescribers. • Completes analysis of an alternative pain management model for piloting in at least one clinic in the Service area. • Creates and implements peer to peer education and dialogue aimed at changing prescribing patterns of					

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	opioids. May include a report card or other mechanism allowing prescribers to view and compare data on prescribing patterns. • Provides for co-location of behaviorists and addictions Providers in at least one major clinic in the Services Area. • Initiates partnerships with social services and school-based Providers to provide addictions screening and intervention for adolescents. • Includes oral health service Providers in opioid prescribing workgroups. • Coordinates activities with existing Opioid Prescribing Group achieved through Clinical Advisory Panel.					
Pacific Source Community Solutions	• Workteam members are identified and charter established by the end of the 2nd quarter 2013 via CGHC; • Workteam project plan	• Increase number of integrated co-location sites in Central Oregon Service Area from 5 to at least 9, including more complete integration at the primary	• Assessment of community PCPCH certification opportunities in partnership with Central Oregon Health Council	• Increase the number of Members attributed to PCPCH clinics by 5%. Baseline and method of measurement to be determined and	• APM recommendations embedded into 2015 CCO provider contracts. Central Oregon and Columbia Gorge Health Councils establish a	• Alternative Payment Methodology (APM) work groups are established to develop recommendations on payment

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	reviewed and approved by CGHC by the end of the 3rd quarter of 2013; • At least 4 integrated co-location sites in the Columbia Gorge Service Area are available to the Members by end of June 2014.	SPMI site. • Annual review of number of co-location services completed; includes report of scope of services and Member experiences to determine whether additional sites are required to meet Benchmarks.	completed. • Number of Members assigned to a PCPCH clinic in places as endorsed by Central Oregon Health Council increased.	mutually agreed upon by Contractor and OHA. • Increase the number of Members attributed to PCPCH clinics by 10% or achieve at least 85% PCPCH enrollment. Baseline and method of measurement to be determined and mutually agreed upon by Contractor and OHA.	formal process to evaluate the ongoing impact of reimbursement changes in relation to overall CCO outcomes, and make changes as necessary.	methodologies. APM work group recommendations endorsed by Central Oregon and Columbia Gorge Health Councils.
Primary Heath	• Super utilizers identified though encounter data analysis. • Establishes Baseline of healthcare utilization by super utilizers • Community outreach workers hired to assist small caseloads of identified super utilizers with effective navigation of the health care system and improved personal health and wellness. Community health workers will focus on assisting Members to obtain	• Total health plan utilization by identified super utilizers shows reduction of per member per month costs of at least 5% from the Contractor developed Baseline measurement.	• Contractor assists in infrastructure building, support, and education to expand the PCPCH model to alternate care sites which will target maternity care and community mental health settings. • PCPCH focused learning collaborative in Josephine County to enhance and build upon the skills of existing and prospective PCPCH's continues.	• Community Based Learning Collaborative that supports the ongoing development of PCPCH's/Medical Homes continues. • Medical home model expanded to non-traditional settings as evidenced by PCPCH Certification of at least two alternate or non-traditional care sites.	• Incentive based payment model expanded to other PCPCH clinics in the Contractor's network of Participating Providers.	• Incentive based payment model with at least one PCPCH clinic in the Contractor's network of Participating Providers

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	the right care in the right place at the right time. • Community outreach workers integrated with the health care team, including existing PCPCH's with a focus on the PCPCH currently under construction within the adult mental health facility. Community outreach workers will also work collaboratively with agencies such as Choices Counseling Center (CD) and Options for Southern Oregon (CMHP), and dental Providers. Integration will include a plan for effective communication with each part of the care team. • Community outreach workers to assist Members with setting and evaluating incremental health improvement goals. • Initial reduction total plan costs from contractor developed Baseline measurement attempted by July 1, 2014 along with		• Dashboard of metrics that are mutually agreed upon as important indicators of population health developed and distributed. • Expansion of PCPCH to new traditional and/or non traditional clinic sites support continued (i.e.PCPCH in specialty clinic sites).			

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
	improvement in health plan utilization patterns.					
Trillium Community Health Plan	• A depression screening protocol will have been developed and incorporated into all patient centered primary care homes (PCPCH) and contracted behavioral health agencies. 80% of Members served in PCPCHs will be screened by these Providers with an appropriate follow up response commensurate with the level of depression identified.	• Depression screen is fully implemented in the primary care and behavioral health system and all Members have been screened for depression. 1-2 other protocols will be developed and implemented by 7/1/2015. Potential areas have been identified and priorities will be established by committee.	• 65% of plan PCP's will be practicing in a recognized PCPCH (current percentage unavailable in transformation materials)	• >85% of plan PCP's will be practicing in a recognized PCPCH (current percentage unavailable in transformation materials)	• Capitation arrangement with ER physicians • Methodology established for providing Bonus payments to PCP groups that reduce ER visits. • Case rates for behavioral health Providers.	• Reduction in the amount paid to and the services provided by ER physicians. • Reduction in the number of ER visits/1,000 Members by at least 2%. Baseline to be determined and mutually agreed upon by OHA and Contractor. • 30% (by dollar amount) of payments made to behavioral health Providers will be through case rates.
Umpqua Health Alliance	• Transformation Workgroups and Teams established. • Recommendations for the Integrated Pilot Model focusing on strategies to improve coordination of services for Members with SPMI completed • Business plan describing the integrated system	• Number of Care Plans and ICT meetings for 20 SPMI Members participating in the Pilot Model improved. • Attain 45% of SPMI Members participating in the Pilot Model in Tier 2 or 3 PCPCHs (current percentage unavailable in transformation materials)	• Contractor ensures that 20% of Members are served in Tier 2 or 3 PCPCH (current percentage unavailable in transformation materials). • Contractor ensures that an additional 20% of Members are served in	• Contractor ensures that 30% of Members are served in Tier 2or 3 PCPCH • Contractor ensures that an additional 25% of Members are served in Tier 1 PCPCH	• 5% of Primary Care Provider (PCP) payments will be attributed to achieving scoring & metrics committee measures and goals	• 10 % of PCP payments will be attributed to achieving scoring & metrics committee measures and goals

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	recommendations with a specific focused plan for Members with SPMI and a plan for implementation completed		Tier 1 PCPCH			
Western Oregon Advanced Health	• 5% Improvement over Baseline number of SBIRT and Clinical Depression screened patients. Baseline and method of calculation to be determined and mutually agreed upon between Contractor and OHA.	• 10% Improvement over Baseline number of SBIRT and Clinical Depression screened patients with minimum score of 20%. Baseline and method of calculation to be determined and mutually agreed upon between Contractor and OHA.	• 10% Improvement over Baseline of members enrolled with a PCPCH.	• 100% of Members enrolled with a PCPCHs by 12-31-2014	• Develop and introduce Primary Care Provider (PCP) Dashboards for selected indicators (e.g., patient retention), as the first step in a sequence of events that will ultimately link Alternative Payment Methodologies with quality outcomes	• There will be a 2% reduction in total cost PMPM in the first one half of contract year 2015, when compared the first one-half of 2013. At the same time, there will be no decrease in quality assurance measures, between baseline and 06-15-2015, as measured by OHA-established incentive metrics.
Willamette Valley Community Health	• Meets OHA improvement target for this SBIRT screenings Benchmark. • For percent of Members served in clinics with embedded behaviorists – Contractor establishes Baseline, plan and target for engaging additional clinics • Contractor reporting on this	• Meets OHA improvement target for SBIRT screenings. • Attains 65 Percent of Members served in a PCPCH with embedded behaviorists • Contractor meets OHA performance target percentage of members 12 and up screened for	• 85% of Members are enrolled in Tier II or Tier III PCPCH Clinics (currently over 2/3 of members enrolled in Tier II or Tier III PCPCH clinics)	• 90% of Members are enrolled in Tier II or Tier III PCPCH Clinics.	• 15% of Participating Providers are participating in POP program.	• 20% of Participating Providers are participating in POP program.

Area of Transformation	**1. Developing and implementing a health care delivery model that integrates mental health and physical health care and addictions and dental health, when dental services are included. This area of transformation must specifically address the needs of individuals with severe and persistent mental illness.**		**2. Continuing implementation and development of Patient-Centered Primary Care Home (PCPCH).**		**3. Implementing consistent alternative payment methodologies that align payment with health outcomes.**	
CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
	Benchmark includes these measures to validate effective implementation of its service model: o proportion of billings for mental health vs. health and behavior codes o # of service units per Member per 3 months o length of sessions o Primary Care Provider (PCP) satisfaction • Contractor ensures depression screening implemented by PCPCHs serving 80% of Members age 12 and up.	depression.				
Yamhill County Care Organization	• SBIRT training provided and incorporated into patient flow in all PCPCH settings. • SBIRT training provided and incorporated into patient flow in both emergency departments; Contractor determines how Emergency Department coding will be	• 33% of adult Members with severe and persistent mental illness enrolled in behavioral health services at Yamhill County Health and Human Services are assigned to an on-site PCP. • Improved health status reflected in aggregate	• Baseline established for each PCP practice of percentage of their newly assigned Members they see within 90 days. • Contractor sends monthly reports of Members assigned, but	• 3% increase of its total membership being seen within 90 days of PCP assignment over its established Baseline total membership.	• One to two Alternative Payment Methodologies with high volume Providers that are related to defined outcomes piloted. • Targeted Benchmarks studied and refined.	• One or two Alternative Payment Methodologies that meet targeted health outcomes implemented.

Area of Transformation	**1. Developing and implementing a health care delivery model that integrates mental health and physical health care and addictions and dental health, when dental services are included. This area of transformation must specifically address the needs of individuals with severe and persistent mental illness.**		**2. Continuing implementation and development of Patient-Centered Primary Care Home (PCPCH).**		**3. Implementing consistent alternative payment methodologies that align payment with health outcomes.**	
CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
	captured in the OHA measure; Contractor determines whether SBIRT in mental health can be captured in the OHA measure. • Adequacy of Addictions & Drug treatment capacity to allow rapid access to treatment assessed; Contractor expands capacity if needed. • Non-Traditional Health Workers (NTHWs) and other outreach mechanisms used to assist medical Providers in successfully linking referred individuals with treatment. • Behaviorists are funded, hired, trained and employed by Willamette Valley Clinics, Chehalem Medical Clinic, Virginia Garcia and Physicians Medical Center, Providence Medical Group. • PCPCHs qualifying at Tier 3.C.3 (PCPCH Measure) have behaviorists included in their team;	PCPCH measures for this subset of the Virginia Garcia Memorial Health Center (VGMHC) population reached.	without a visit, to Providers.		• Methodologies to meet targets adjusted.	

Area of Transformation	**1. Developing and implementing a health care delivery model that integrates mental health and physical health care and addictions and dental health, when dental services are included. This area of transformation must specifically address the needs of individuals with severe and persistent mental illness.**		**2. Continuing implementation and development of Patient-Centered Primary Care Home (PCPCH).**		**3. Implementing consistent alternative payment methodologies that align payment with health outcomes.**	
CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
	• Contractor reports on measures to validate effective implementation of its service model: o **proportion of encounters for mental** health vs. health and behavior codes o # of service units per Member per 3 months o Average length of sessions. • PCP satisfaction • Inclusion of options for depression screening and follow-up in PCPCH collaborative; • Availability of evidence-based treatment (medications as first-line intervention only for serious depression in adults). • PWS positions are funded, hired, trained and employed by Contractor's subcontractor(s) or providers to support Members with mental health and addiction challenges.					

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
	• PAM training completed and coaching is underway. • Project evaluated and target # of PWS needed, funding mechanism that Contractor will use, and # of Members to be served is determined. • PCP services are funded, hired, trained and employed by Contractor's subcontractor(s) or providers and fully integrated into mental health clinics. • Service system integration is established through policies and procedures and integrated medical team. • Integrated-coordinated electronic health care recording, e-prescribing and information sharing practices established and functional. • Reception-scheduling and billing practices are in place. • Continuum of preventive and health promotion services offered to Members according to the					

Area of Transformation	**1. Developing and implementing a health care delivery model that integrates mental health and physical health care and addictions and dental health, when dental services are included. This area of transformation must specifically address the needs of individuals with severe and persistent mental illness.**		**2. Continuing implementation and development of Patient-Centered Primary Care Home (PCPCH).**		**3. Implementing consistent alternative payment methodologies that align payment with health outcomes.**	
CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
	severity of the condition/risk factors. • Integrated coordinated care teams created for all Members with Serious Mental Illness (SMI) involved in Community support services, chemical dependency treatment, courts or enhanced outpatient services, or who are experiencing chronic pain, HIV & or Hepatitis C. • PCPs participate in weekly treatment team meeting for ACT/EASA/Residential clients. • PCPs participate in monthly psychiatry team meetings regarding coordination of care. • Baseline and targets for health status and other PCPCH measures established for SMI Members.					

Area of Transformation	**4. Preparing a strategy for developing Contractor's Community Health Assessment and adopting an annual Community Health Improvement Plan consistent with SB 1580 (2012), Section 13.**		**5. Developing a plan for encouraging electronic health records; health information exchange; and meaningful use.**		**6. Assuring communications, Outreach, Member engagement, and services are tailored to cultural, health literacy, and linguistic needs.**	
CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
AllCare	• Completed CHIP for Josephine, Jackson and Curry counties submitted	• Strategies to implement CHIP and update as appropriate defined.	• A 10% increase over eligible Greenway EHR users sharing data across care settings as measured by the number of data exchange transactions per Participating Provider, compared to Baseline of a 2013 report of Greenway data exchange transactions.	• 20% increase over the 2013 Baseline of eligible Greenway EHR users sharing data across care settings as measured by the number of data exchange transactions per Participating Provider	• 20% improvement over Baseline number of Members aged 6-18 from the 2012 834 file who have received an annual well child check up from PCPCH or PCP.	• 30% improvement over Baseline number of Members aged 6-18 from the 2012 834 file who have received an annual well child check up from PCPCH or PCP.
Columbia Pacific	• Comprehensive CHIP for Contractor's Service Area completed, including identified strategies to reduce health disparities based on Community-identified priorities.	• Process of implementing CHIP priority strategies engaged throughout Service Area.	• Inventory of Participating Provider capabilities related to meaningful use, adoption of Care Accord, Care Everywhere or other HIE technology between physical and mental health Providers completed. • Baseline percentage of primary care clinics sharing any portion of the medical record with other Providers defined.	• At least two clinics in its Service Area supported with attaining Stage 1 HIE meaningful use standards, or moving from Stage 1 to Stage 2 HIE meaningful use standards. • Appropriate Contractor representatives participate in the OHA statewide HIE development process and help establish HIE Benchmarks.	• Community-specific definition of, and standards for, cultural competence developed. • Cultural competence policy and registry of vital documents for meeting cultural competence standards created. • Appropriate Benchmarks for Community specific improvements throughout its Service Area defined.	• Cultural competence policy and in process with Community-specific improvement Benchmarks implemented. • Member materials registry populated with 80% of vital documents translated into predominant languages or meet "Plain English" standards.

Area of Transformation	**4. Preparing a strategy for developing Contractor's Community Health Assessment and adopting an annual Community Health Improvement Plan consistent with SB 1580 (2012), Section 13.**		**5. Developing a plan for encouraging electronic health records; health information exchange; and meaningful use.**		**6. Assuring communications, Outreach, Member engagement, and services are tailored to cultural, health literacy, and linguistic needs.**	
CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
Eastern Oregon	• 100 % of Contractor's counties will have or be participating in an established local CAC and R-CAC with persistent, regular meeting times, as determined by the committee members. • 100% of CAC's will have a complete Community Needs Assessment analysis and proposed CHIP. • Contractor's CHIP will be submitted to OHA by 6/30/2014. • 100% of CACs will have implemented CHIP in their respective county and begin tracking outcomes.	• 100% of local counties will have or be participating in active CACs with consistent regular meetings and an established structure including, but not limited to, a mission, vision, goals and appointed leadership positions. • 100% of CACs will have implemented or be participating in a CHIP in their respective county, actively track outcomes measurements and begin making necessary changes and improvements, and provide an annual progress report.	• HIE steering committee established by mid-2013. • HIE strategy and plan will be determined in 2013. • Member access provided to health information through an online Member customized portal.	• Contractor agrees to participate in OHA's upcoming process to assess the next phase of statewide HIE development (including assessing the scope, financing and governance of statewide HIE services). In particular, Contractor will make appropriate executive and staff resources available for an interview with an OHA consultant, and will participate in a brief series of stakeholder workgroup meetings if requested by OHA. After the OHA process concludes and the next phase of statewide HIE services are defined, Contractor will update the HIE component of this transformation plan at the next update cycle. • Strategy and plan developed by the	• Health Literacy and Cultural Competency Policy adopted, and 10% of consumer materials have been revised accordingly. • 70% of county and/or regional demographics reports have been completed. • Cultural and linguistically appropriate training developed and Contractor leadership (10% of staff) has successfully completed training. • Interpreter certification options have been assessed and compiled into report; decision has been made to determine next steps.	• 60% of consumer materials have been revised according to Health Literacy and Cultural Competency policy. • All county and/or regional demographics reports have been completed and disseminated to 80% of Participating Providers. • 95% of staff has completed cultural and linguistically appropriate training and processes implemented to ensure ongoing and new hire training incorporating key elements of the training. • Final benchmark developed according to interpreter certification decision based on summary report (See Milestone 4).

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
				steering committee implementation begun. • Number of Members that access the online customized portal measured.		
FamilyCare, Inc.	• Work with Community partners to gather Member community health data, by September 2013. • Review and assess data to develop a Community Health Assessment (CHA), by October 2013.Present CHA to Community Advisory Council (CAC), by October 2013. • Draft CHIP for CAC review, by October 2013.CAC adopt CHIP by December 2013.	• CHA that informs the CAC in their work to adopt a CHIP developed.	• Work with OHA to develop a statewide Health IT solution, by July 2014. • Assess current Participating Provider use of Electronic Health Records via survey, by December 2013. • Identify barriers to Participating Provider use of Electronic Health Records and health information exchange (HIE), by December 2013.	• A majority of Participating Providers use Electronic Health Records and exchange health information electronically.	• Assess Medicaid portion of website to determine compliance with ADA requirements, by December 2013. • Conduct Member survey and review CHA to identify potential gaps in language or culturally-specific delivery of materials, by July 2014.	• Members will have access to culturally-specific materials (such as the handbook, welcome letter and wellness materials) electronically on Contractor's ADA compliant website.
Health Share of Oregon	• First CHIP draft presented to CAC by January 2014. • Contractor reports to OHA on progress accomplishing CHIP strategies by July 1, 2014	• Second CHIP report submitted to OHA by July 1, 2015, including progress report on elimination of three identified health	• Contractor collaborates with Oregon Health Information Technology Exchange Council (O-HITEC) and	• 15 % of Members are receiving care in multiple healthcare settings whose EHRs successfully connect across Participating	• CCWG conducts Cultural Competence needs assessment, agrees on uniform performance standards for functions associated with providing	• All affiliate organizations have implemented strategies to address poor performance in areas identified in

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
		disparities by 2018.	OCHIN to encourage greater adoption of certified EHRs and active participation within EHR Meaningful Use stage 2 among Participating Providers. • Contractor collaborates with its delivery systems that have implemented Epic's EHR to standardize their configurations of Care Everywhere and optimize its use. • Providers use of Secure Provider-Provider and Provider-Patient Messaging encouraged as such capabilities are seamlessly available within their respective EHRs. • In collaboration with OHA and Oregon's Health Information and Technology Oversight Council (OHITOC), the other	Providers' EHR implementations, and that no more than 10% of Participating Providers' fail to so connect during EHR implementations. Baselines and method of calculation to be determined and mutually agreed upon by Contractor and OHA. • 20 % of Participating Providers are exchanging secure EHR messages	culturally competent Member-centered care, (Communications, Outreach, Member Engagement and services) and ensures that affiliate organizations have developed plans to address areas of poor performance. .	the Cultural Competence needs assessment and have reached minimum standards in all areas of performance identified as weak

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
			CCOs, and their partners, Contractor considers leveraging a3rd party Health Information Exchange (HIE) Gateway to facilitate the seamless exchange of Personal Health Information (PHI) between dissimilar EHRs; at its discretion • An EHR acceptable to OHA and OHITOC, the other CCOs, and their partners is implemented.			
Intercommunity Health Network	• Community Health Assessment Plan (CHIP) completed.	• Health improvement measured against the CHIP Baseline and results of health improvement efforts reported to the Community.	• Roadmap for implementing Health Information Technology (HIT) in its Service Area developed. • Case management staff provided access to evaluate and educate Participating Providers. • Epic Care Link usage between Contractor and a select	• Shared Electronic Health Record system established for Participating Providers and partners to access in its Service Area, to enable a "community care plan".	• Online learning and resource center offered in multiple languages. • Community education campaign offered in culturally and linguistically appropriate ways. • Education campaign targeted for community and faith-based organization, and local schools.	• 100% of Contractor staff and PCPs are aware of the online learning and resource center and have knowledge of its purpose. • Participants in focus groups indicate awareness of the community education campaign and knowledge of its purpose through a measurement tool.

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
			Participating Provider panel piloted.			• 35% of those surveyed indicate awareness of the community education campaign and knowledge of its purpose.
Jackson Care Connect	• CAC engaged in the Community Assessment and Improvement Plan process. • CHA completed through guidance of CAC and adopted by CCO Board of Directors. • CHIP completed and approved by 7/1/14; CHIP includes identified strategies to reduce health disparities based on Community-identified priorities. • 2014 strategic priorities and annual Contractor board retreat are guided by CHA and CHIP findings. • CHIP is tightly integrated with the work related to Member engagement (Benchmark #6) cultural Competency of Providers	• CHIP priorities and data inform Contractor strategies.	• Assessment completed of Providers' deployment of meaningful use and existing needs, conducted in partnership with Jefferson HIE. • Mental health and addictions service Providers included in all appropriate health information planning efforts. • Contractor contributes to analysis of regional HIE scope of work and business plan being conducted by Jefferson HIE. • Contractor plan adopted to increase communication of health records and	• Contractor contributes to effort to establish a regional health information exchange solution that includes mental health, physical health, and addictions service Providers.	• CAC Practice Administrator's Group, CAP and Board of Directors are actively engaged in improving delivery of culturally competent care. CAC specifically reflects demographics of Members and is a central component of process for review and/or design of materials. • County-wide assessment conducted in coordination with CAC and Practice Administrators'' Group to inform creation of a Cultural Competency plan that includes: a. Selection and utilization of a Cultural Competency Assessment tool that is appropriate for Jackson County. b. Assessment of existing Contractor communications with revisions made as necessary Appropriate communication	• Baseline understanding of health disparities county-wide developed, Cultural Competency assessment completed, includes culturally specific Member engagement and communication strategies included in the QI Plan.

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
	(Benchmark #7), quality improvement plan (Benchmark #8), and high utilize strategies (Benchmark #1a).		patient information across Participating Providers. • Closed loop referral process implemented in partnership with Jefferson HIE. • Ongoing coordination and engagement conducted with state HIE development.		materials are shared widely with Providers. c. Identification of populations in Service Area, their cultural needs, and specific disparities. Will be included in CHA. • Tools identified for effective Member communication in collaboration with CAC and CAP. • Community level Baseline data collected regarding health disparities in year 1, as identified in CHA. Data gaps will be identified. • Education on "Unconscious Bias" conducted for Contractor Board of Directors, CAC, CAP and offers this education to Provider network. • QI plan with Cultural Competency Action Steps developed, including specific strategies for improving outreach, communications and Member engagement based on a Member definition of cultural competence.	
Pacific Source Community Solutions	• Central Oregon: CHA and CHIP updates standardized considering the	• Central Oregon: Annual update of CHA and CHIP are completed on an	• Central Oregon: Neutral Central Oregon HIE	• Central Oregon: Functional community patient record	• Written self-assessment completed to identify at least two (2) areas to improve	• Improvements on at least two (2) areas identified in self-

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
	community partner agencies' community health assessment and plan needs. • Columbia Gorge: First CHA and CHIP updates completed.	ongoing basis. • Columbia Gorge: Annual update of CHA and CHIP are completed on an ongoing basis.	governance entity formed by the 3rd quarter of 2013, with participation from the region's largest providers. • Central Oregon: Business plan and financing plan formalized for a comprehensive community HIE strategy by end of 2013. By July 2014, all providers participating in regional HIE governance will have interfaced their electronic health records to the HIE platform. • Central Oregon: Contractor efforts connected with this Benchmark result in documented high levels of information exchange between Electronic Medical Records, and high provider participation levels have enabled.	(continuity of care document) produced. • Columbia Gorge: Contractor monitors progress and demonstrates improvement in basic HIE functional areas such as: distribution of lab and other results, exchange of information for referrals, provider participation rates, and notification of hospital admissions.	Member communications with particular focus on Hispanic/Latino and Indian/Alaska Native (AI/AN) populations; Contractor outlines system requirements necessary to implement recommended changes.	assessment completed, ensuring communications meet the unique language, racial, ethnicity and cultural needs of our Members. Baseline, method of measurement, and improvement areas to be determined and mutually agreed upon by Contractor and OHA.

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
			• Columbia Gorge: Current capabilities assessed and consensus built among the Columbia Gorge stakeholders on a vision for HIE infrastructure, Milestones and Benchmarks. • Columbia Gorge: Contractor creates and implements elements of a community HIE development plan with specific goals for each HIE functional element.			
Primary Health of Josephine County	• CHIP is completed and approved, and includes identified strategies to reduce health disparities based on identified priorities.	• At least one CHIP priority strategy is implemented.	• PCPs' deployment of meaningful use and existing needs assessed. • Analysis of regional Health Information Exchange (HIE) competed with plan for increasing communication of health records and Member information	• 5% increase from its assessed Baseline of PCP clinics sharing a portion of health information securely, in real time attained. Baseline and method of calculation to be determined and mutually agreed upon between Contractor and OHA.	• Baseline Cultural Competency assessment of Member communication tools and current methods of engagement conducted. • Cultural Competency action plan with the help of the CAC created to include at a minimum: o Identification of Contractor's "vital documents"	• Contractor identifies policies and standard operating procedures are in place. • Document registry is in place, with 100% of "vital documents" translated into predominant languages and available to all Participating

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
			across PCPs. • Benchmark of the % of PCP clinics that are able to share a portion of the health record securely in real time measured.		o Identification of documents or standard operating procedures that may need revision or development based on the CAC's Cultural Competency assessment, such as a Cultural Competency policy. o Creation of a document registry Completed Cultural Competency assessment in coordination with its CAC.	Providers. • Standard operating procedures made available for coordination of interpreters, distribution of Member materials, and translation of materials.
Trillium Community Health Plan	• Adoption of collaborative CHA/CHIP in 2013 by Contractor Board of Directors, Lane County Public Health, and PeaceHealth/Sacred Heart Medical Centers.	• Adoption of collaborative CHA/CHIP in 2013 by Contractor Board of Directors, Lane County Public Health, and PeaceHealth/Sacred Heart Medical Centers.	• Shared care plan system links Contractor, contracted PCPCHs and behavioral health Providers. .	• Shared care plan system links Contractor, contracted PCPCHs, behavioral health Providers, specialists, community health workers, and selected social service agencies	• Complete assessment of Contractor Member materials and outreach efforts for language and literacy appropriateness, and implement any necessary improvement plans in order to achieve Benchmark.	• 90% of Contractor communications and outreach materials are available in formats appropriate for Members for whom English is not their primary language, and for those with low literacy levels.
Umpqua Health Alliance	• Contractor reviews CHA • Community Health	• CHA reviewed and initial CHIP action plans completed.	• 60% of Members are assigned to Providers that meet EHR	• 70% of patients are assigned to practices that meet EHR	• Barriers to Member engagement indentified.	• Action plan to address barriers to Member

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
	Improvement Plan (CHIP) completed. • Initial CHA and CHIP action plans developed.		meaningful use standards (current percentage unavailable in transformation materials). • Douglas County Health & Social Services has access to physical health records for 25% of Members (current percentage unavailable in transformation materials).	meaningful use standards • Douglas County Health & Social Services has access to physical health records for 35% of Members	• Member engagement methods reviewed and prioritized in conjunction with the CAC • Literacy and linguistic needs assessment completed in coordination with CAC	engagement and health literacy developed and implemented.
Western Oregon Advanced Health	• The Community Health Assessment (CHA) will be completed by 03-31-2013.The Community Health Improvement Plan (CHIP)will be completed by 08-31-2013	• The CHA will be updated by 03-31-2015.The CHIP will be completed by 07-01-2015	• 10% Improvement over Baseline proportion of providers using EHRs. Baseline and method of calculation to be determined and mutually agreed upon between Contractor and OHA after survey.	• 20% Improvement over Baseline. Baseline and method of calculation to be determined and mutually agreed upon between Contractor and OHA.	• If disparities among groups are identified at baseline derived from Consumer Assessment of Health Providers & Systems (CAHPS) Composite:, the disparity will be decreased by half (e.g. If 90% of all Member respondents respond that they are always or usually available to get the information that they need, but only 70% of a specific group respond this way, the gap of 20% will be decreased to a gap of only 10% by 2014.)	• Minimum Score of 85% with no statistically significant differences among groups by race, ethnicity, or disability status.

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
Willamette Valley Community Health	• Contractor finalizes CHIP	• Effectiveness of CHIP-driven interventions measured.	• 60% of Participating Providers have demonstrated compliance with Meaningful Use standards for Electronic Health Records (current percentage unavailable in transformation materials).	• 75% of Participating Providers have demonstrated compliance with Meaningful Use standards for Electronic Health Records.	• 85% of non-English speaking Members receive Contractor informational communications in their primary language.	• 90% of non-English speaking Members receive Contractor informational communications in their primary language.
Yamhill County Care Organization	• CAC will utilize a modified Mobilizing for Action through Planning and Partnerships (MAPP) process for the CHA and development of an annual CHIP. • CHIP will be reviewed and adopted by the Contractor Board by July 1, 2014.	• CAC will compile a report for Contractor regarding the progress of the specific measures that were to be addressed as a result of the CHA/CHIP process at the completion of the first year of the CHIP. • MAPP process will be followed so that a CHA is performed every five years by the CAC, with annually reported updates.	• Initial engagement of at least 50% of Participating Providers identified by The Advisory Board Company (owner of Crimson Care) to begin implementation of the Crimson Population Risk Management Tool.	• 50% of Participating Providers are participating in Clinical Data Exchange with Crimson Population Risk Management Tool.	• Enrollment data collected and assessed to determine the cultural composition of Members as well as literacy levels as a Baseline measurement. • The CAC reviews enrollment data and assesses the preferred spoken and written languages of Members, persons eligible for Medicaid or underserved populations. • The CAC researches best practices when determining a method to use for assessing the literacy levels of Members with the possibility of engaging Members in a focus-	• Performance assessed with the same methodology as the cultural composition and literacy Baseline determination to show that communication tools are culturally and linguistically appropriate for its Members.

Area of Transformation	**4. Preparing a strategy for developing Contractor's Community Health Assessment and adopting an annual Community Health Improvement Plan consistent with SB 1580 (2012), Section 13.**		**5. Developing a plan for encouraging electronic health records; health information exchange; and meaningful use.**		**6. Assuring communications, Outreach, Member engagement, and services are tailored to cultural, health literacy, and linguistic needs.**	
CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
					group or in-person interviews. • Recommendations provided from that assessment to Contractor Board and CAP.	

Area of Transformation	**7. Assuring that the culturally diverse needs of Members are met (Cultural Competence training, provider composition reflects Member diversity, non-traditional health care workers composition reflects Member diversity)**.		**8. Developing a Quality Improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes.**	
CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
AllCare	• Improvement of 15% over the 2013 survey derived Baseline percentage rate of cultural diversity program completion by PCPs, PCPCHs or OBs.	• Improvement of 30% over the Baseline percentage rate of cultural diversity program completion by PCPs, PCPCHs or OBs	• Identification process established and Baseline developed identifying those Members who are pregnant and need substance abuse intervention. .	• Appropriate referrals for 15% of pregnant Members with substance abuse issues obtained.
Columbia Pacific	• High frequency users of the ED, acute and other high cost services identified that could be diverted to PCPs through non-traditional workers or other outreach strategies. • Written plan to improve delivery of culturally competent care by Participating Providers completed. • Clinic-specific opportunities and pilots using navigators, peer support, community care teams or other non-traditional health workers identified.	• 5% reduction in the per member per month cost of care for identified high-cost, high-utilizer Members\ compared to the Baseline for identified high-cost, high-utilizer Members who were not assisted by non-traditional health workers. Baseline and method of calculation to be mutually agreed by the parties. • Contractor Quality Improvement (QI) plan includes specific targets and strategies for cultural competence, diversity and health literacy trainings, clinical practices and workplace norms	• Written QI plan developed with specific thresholds for reductions in disparities for: access to preventive care and screenings, childhood immunization rates, overweight and obesity, tobacco use, preventable hospital admissions or readmissions, and mental health and addictions screenings and treatment completed by May 30, 2014.	• QI plan developed collects data and implements strategies to address two priority areas of improvement for disparities reductions throughout its Service Area.
Eastern Oregon	• 100% of provider surveys	• 100% of clinic profiles will	• Data collection	• Reliable and accurate

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
CCO	determining which providers serve the majority of Spanish-speaking and culturally diverse populations completed. • Health literacy and Cultural Competency Training developed and piloted in three clinics. .	be developed and utilized in coordination of care for Spanish-speaking Members. • 75% of Participating Providers and clinic staff have completed training and processes have been developed for continuing education	methods developed and existing methods used to confirm demographic data has been collected on 30% of Members. • Standards for data collection and sharing will be established and operational for the Oregon Medicaid population. • Health literacy and cultural competency training and development will be completed in three clinics. o Data collection process using the health assessment is established, staff is trained and data is systematically captured in the Contractor operating system (confirmed by audit process) o Audit process demonstrates that race, ethnic, linguistic, disability, health	demographic data on 70% of the population collected. • Standards regarding data collection and sharing for the Oregon Medicaid population are sustained. • 75% of Participating Providers and clinic staffs have completed health literacy and cultural competency training, and processes have been developed for continuing education. • o Audits demonstrate data collection via the health assessment is sustained. o Audits process demonstrates that Contractor is meeting benchmarks to address race, ethnic, linguistic, health literacy, disability barriers identified in the health assessment. o Defined quality

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
			literacy barriers identified in the health assessment are addressed. o Specific quality indicators to measure Member engagement, access to care, use of services and cost of care are defined, Baselines are identified and Benchmarks for 7/1/15 are established.	indicators on Member engagement, access to care, use of services and cost of care meet benchmarks.
FamilyCare, Inc.	• Collect Member data on preferred language via survey, by December 2013. • Collect Participating Provider data on languages spoken, by December 2013. • Work with OHA to identify barriers to providing race and ethnicity data on Member enrollment files, by December 2013.	• Contractor is able to identify the race and ethnicity of a majority of Members and Participating Providers, in order to better assist Members in accessing appropriate health care providers.	• CHA will identify potential areas of disparity, based on race or ethnicity and linguistic needs, by July 2014. • Member survey identifies potential areas of disparity, based on race or ethnicity and linguistic needs, by December 2013.	• Contractor Quality Improvement plan will include metrics for identified disparities in access, quality, experience and outcomes.
Health Share of Oregon	• CAHPS Cultural Competence Item Set Baseline to be determined	• 2% improvement in CAHPS Cultural Competence scores. Baseline and	• Top chronic condition identified within each REL category. Baseline	• QI plan implemented that addresses top three identified REL

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
	and mutually agreed upon by Contractor and OHA.	method of calculation to be determined and mutually agreed upon by Contractor and OHA.	utilization and prevalence rates identified for each condition. • Contractor QI plan developed and submitted to OHA.	category conditions and associated reduction activities are initiated. • Contractor reports to OHA Baseline utilization data and prevalence data and Contractor fully implements an ongoing QI program to include Community Needs Assessment findings; Provider education and engagement; and Contractor attainment of a 10% improvement over Baseline utilizing Minnesota methodology in ongoing measurements of reduction in identified disparity conditions. Baseline and method of calculation to be determined and mutually agreed upon by Contractor and OHA.
InterCommunity Health Network	• Process for delivery and documentation of trainings that focus on but are not limited to health equity,	• 100% of Contractor employees and Participating Providers have completed annual	• Member ethnicity data gathered either from state data or by Member contact.	• Any disparity in access based on ethnicity identified.

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
	health literacy, cultural competence, cross-cultural communication, working with non-traditional health care workers in clinical teams, diversity, and cultivating a diverse workforce developed. • Identified staff and Participating Providers have received trainings focused on topics identified in this Benchmark.	trainings that assist in assuring that the culturally diverse needs of Members are met.		
Jackson Care Connect	• Environmental analysis to identify Baseline status of culturally competent care delivered by Participating Providers conducted (see Benchmark #6). • Strategies to reduce stigma and improve Cultural Competency among PCPs caring for patients with behavioral health problems and/or SPMI identified. • Cross training program for PCPs on behavioral health issues, with a special focus on culturally competent	• Community and Provider outreach plan developed targeting increased Cultural Competency and improved quality of care by PCPs for Members with SPMI or other behavioral health diagnosis.	• Understanding of local health disparities developed, shared and adopted by Contractor. Will be informed by CHA (Benchmark #4) and Cultural Competency assessment (Benchmark #6) • Quality standards identified that are locally appropriate and specifically address health outcomes, quality of care, workforce, language access, and reduction of	• Process and accompanying data established to identify quality measures that link health outcomes to health disparities and implementable action plan developed to address selected QI areas.

Area of Transformation	**7. Assuring that the culturally diverse needs of Members are met (Cultural Competence training, provider composition reflects Member diversity, non-traditional health care workers composition reflects Member diversity)**.		**8. Developing a Quality Improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes.**	
CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
	care for Members with mental health and/or addictions disorders researched and developed. • Education on "unconscious Bias" provided to Contractor Board of Directors, CAC, CAP and this education offered to Provider network. • Targeted training provided to Providers engaged in working with "high utilizers" (Benchmark #1). • Specific strategies for cultural trainings, health literacy, and workforce development included in Contractor QI plan.		health disparities. • At least four metrics are identified, calculated, and incorporated into the QI plan that link health disparities to health outcomes. • Contractor puts into place a plan to address selected QI areas.	
Pacific Source Community Solutions	• All appropriate and essential partners throughout CCO engaged to organize a committee to review, define and set Community adopted standards to be established and approved by Central Oregon and Columbia Gorge Health Councils.	• At least 50% of Provider sites, or the number of sites serving a minimum of 60% of Members, meet standards for continuing education on topics related to health equity, health disparities, health literacy and/or cultural competency. Contractor will specify which Benchmark measure will	• Written self-assessment of system data gaps completed; At least 2 operational or system changes to improve granular data collection, reporting and analysis related to language, race and ethnicity are completed. Quality Improvement plan	• 3 high priority changes implemented as per Quality Improvement plan and based on self-assessment and input from Health Equity Task Force.

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
		be used once agreed upon by Health Councils.	focused on eliminating racial, ethnic and linguistic disparities is adopted.	
PrimaryHealth of Josephine County	• Contractor ensures environmental Cultural Competency assessment identifies Baseline status of culturally competent care delivered by Participating Providers (see Benchmark#6). • Strategies to reduce stigma and improve Cultural Competency among PCPs and ancillary Providers caring for Members with behavioral health conditions and/or SPMI identified. • Contractor researches and develops a cross training program for PCPs, ancillary Providers and community outreach workers on behavioral health issues, with a special focus on communications, Member engagement, and culturally competent care for Members with mental health and/or addictions	• Community and Provider outreach plan developed targeting increased Cultural Competency and improved quality of care by PCPs for Members with SPMI or other behavioral health diagnosis.	• Specific goals developed and a strategy implemented for improvement on these metrics by July 1, 2014. OHA provided with an update to this Benchmark including the goals and improvement strategy by July 1, 2014.	• Remeasurement of selected metrics conducted that will demonstrate improvement of specific goals.

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
	disorders . • Potential for grant funding researched to support educational program. • Cultural Competence policy which specifically addresses cultural trainings, health literacy, and workforce development created (Benchmark #6).			
Trillium Community Health Plan	• Assessment of contracted Provider system completed to determine baseline level of Provider diversity and cultural competency training standards.	• Percentage of under representation of gender and cultural/language diversity of staff reduced at the Provider and front office role by 25%. Baseline and method of calculation to be determined and mutually agreed upon by OHA and Contractor.	• Complete analysis and identification of disparities related to ACA conditions and development of priority improvement plans.	• Reduction by 30% of disparities identified as priority for improvement. Baseline and method of calculation to be determined and mutually agreed upon by OHA and Contractor.
Umpqua Health Alliance	• Appropriate Culture of Poverty curriculum selected. • Training schedule for Providers and Contractor staff created. • At least one Culture of Poverty training session held by June, 2013	• 30% of Contractor staff and 20% of Provider staff will receive Culture of Poverty training.	• Racial, ethnic and linguistic disparities in Douglas County identified. • Access, quality of care, experience of care for Members with disparities assessed.	• QI plan to address the identified disparities for its specific population developed.
Western Oregon	• If disparities among groups	• 10% Improvement over	• 5% Improvement over	• 10% Improvement over

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
Advanced Health	are identified at baseline, the disparity will be decreased by half (e.g. If 90% of all Member respondents respond that they are always or usually available to get care as soon as they thought they needed, but only 70% of a specific group respond this way, the gap of 20% will be decreased to a gap of only 10% by 2014.)	Baseline with minimum score of 85%. The 10% improvement over Baseline will be achieved after the disparities groups are identified at Baseline. Thus the gap of 20% will be decreased to a gap of only 10% by 2014 and achievement will be reached with a minimum score of 85%.	Baseline of children receiving a developmental screening by 36 months, with any difference/gap in percentage screened decreased by half. Baseline and method of calculation to be determined and mutually agreed upon between Contractor and OHA. • 5% Improvement over Baseline of members receiving a colorectal cancer screening, with any gap/difference in percentage screened decreased by half. Baseline and method of calculation to be determined and mutually agreed upon between Contractor and OHA.	Baseline developmental screening with minimum score of 50%, with no statistically significant difference in screening rates for rural zip codes. Baseline and method of calculation to be determined and mutually agreed upon between Contractor and OHA. • 10% Improvement over Baseline colorectal cancer screening with minimum score of 61.34%, with no statistically significant difference in screening rates for rural zip codes. Baseline and method of calculation to be determined and mutually agreed upon between Contractor and OHA.
Willamette Valley Community Health	• Centralized cultural competence training offered to all Participating Providers on an annual basis	• Centralized cultural competence training offered and all Participating Providers who do not attend	• OHA improvement target for this Benchmark met.	• Contractor meets OHA performance target for this Benchmark for all Members.

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
		requested to submit an attestation declaring that they have received cultural competency training from an alternative source.		
Yamhill County Care Organization	• MAPP process for CHA applied; Contractor provides Baseline population data to the CAP in order to determine the culturally diverse needs of the Members. • Cultural diversity training provided to staff and Participating Providers on an annual basis. • Attempts to attract Providers and NTHW whose cultural composition reflects Member diversity documented.	• Member data assessed to determine any shifts in cultural makeup of the Member population. • 100% of staff will have participated in at least one formal cultural competency training. • 50% of Participating Providers will have participated in at least one formal cultural competency training. • Contractor ensures that percentages of Participating Providers and NTHW cultural composition will closely match the cultural composition of the Member population as is feasible for its Service Area.	• Contractor Board and CAP reviews survey results of first CAHPS, Contractor provides individual Providers with survey results, and Contractor identifies focus areas and the 2015 Benchmark improvement goals set for those areas. The 2014 survey will form the Contractor Baseline. • Baseline rate of preventive care visits in groups with identified disparities for current year. 2015 Benchmark set by comparison of this year's data using available historic data. • Baseline rate of preventive measures such as cancer screenings for SPMI members this year set. Comparison of this	• Contractor attains improvement in scores of focus areas reflected in this year's CAHPS survey, as defined during analysis of previous year's survey. • Rate of increase identified for preventive care visits in groups with identified disparities, compared with the goal determined after analysis of 2014 data • Rates for measures of quality improvement in preventative measures for SPMI members set to the Benchmark after analysis of 2014 baseline data. • Rates for measures of quality improvement in adult quality of care set to the Benchmark after

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CCO	**Milestones (2014)**	**Benchmarks (2015)**	**Milestones (2014)**	**Benchmarks (2015)**
			year's data with available historic data will inform setting of Benchmark for 2015. • Baseline rate of specific measures of adult quality of care, such as the diabetes care elements of HgbA1c and LDL cholesterol determined. Disparities identified using Contractor specific data. Comparison of this year's data with available historic data will inform setting of benchmark for 2015. • Baseline rate of specific measures of pediatric care such as developmental screenings determined. Disparities identified using Contractor specific data. Comparison of this year's data with available historic data will inform setting of Benchmark for 2015.	analysis of 2014 Baseline data. • Rates for measures of quality improvement in pediatric care set to the Benchmark after analysis of 2014 baseline data.

Bill #	Name	Description	Status as of 2/28	Additional Info
HB 4013	E-prescribe fix	Technical fix to ensure that Schedule II drugs are eligible for e-prescribe.	Passed House & Senate	Included watered-down step therapy amendment.
HB 4050	Self-Insurance	Prohibits insurers from issuing policies against risk of economic loss assumed under less than fully insured employee health plans to employer group with 50 or fewer covered lives	Passed House & Senate	
HB 4073	E-cigarettes	Amends laws related to consumption of tobacco products by minors to include references to consumption of vapor products by minors.	Died	Rep. Tomei will form a work group to discuss e-cigarette impacts, regulation, etc.
HB 4074	Medical imaging	Authorizes Board of Medical Imaging to waive licensing fee for rural imaging professionals	Passed House & Senate	
HB 4085	Colorectal cancer screening	Modifies requirements for insurance coverage of colorectal cancer screenings and laboratory tests.	Passed House & Senate	
HB 4108	Durable Medical Equipment	Requires OHA to establish a system for repurposing DME that is no longer medically appropriate	Passed out of Committee	
HB 4109	Basic Health Plan (BHP)	Requires OHA to commission independent analysis of a BHP in Oregon	Passed out of Committee	
HB 4110	Requires insurers to pay for incarcerated members	Requires insurers to pay for the health care of their members even if they are incarcerated by county jails.	Referred to W&M Capitol Construction subcommittee	
HB 4115	E-cigarettes	This bill would amend laws related to consumption of tobacco products by minors to include references to e-cigarettes.	Died	Rep. Tomei will form a work group to discuss e-cigarette impacts, regulation, etc.
HB 4122	Statewide contracting and quality assurance	Requires that state procure quality management services if project is more than $5 million, is an IT project	Passed House, headed to Senate floor	This was labeled the "Cover Oregon" bill
HB 4124	Youth suicide intervention	Establishes Youth Suicide Intervention and Prevention Coordinator in AMH. Requires update of Youth Suicide Intervention and Prevention Plan once every five years	Passed out of Committee	
HB 4154-B	Tax credits through Cover OR	Requires Oregon Health Insurance Exchange Corporation to request federal agency to allow individuals and businesses to qualify for premium tax credits, cost -sharing reductions and business tax relief if individuals and businesses enrolled in qualified health plans directly with insurers	Headed to full W&M	

Bill #	Name	Description	Status as of 2/28	Additional Info
SB 1523	Austism coverage	Requires coverage of ABA and treatment of children with pervasive developmental disorder by self-insured plans offered by PEBB, OEBB, and OHSU.	Died	Explained that PEBB/OEBB are integrating this already (bill passed last year with a Jan. 2015 effective date)
SB 1526-A	CHIP subsidy	Requires OHA to look into seeking federal approval of using CHIP $ to subsidize costs of commercial insurance for kids between 200-300 FPL	Passed House & Senate	We'll report back in September 2014
SB 1539	Step therapy drugs	Limits the ability of ALL health plans, including the CCOs, in the state to use “step therapy” as a means to control utilization of prescription drugs	Died	
SB 1560	Telecare	Modifies requirements for health plan coverage of telemedicine services	Died	Work group will be formed
SB 1562-B	Pregnant diabetics	Modifies requirements for health insurance coverage of services, medications and supplies necessary for management of diabetes during pregnancy.	Passed House & Senate	Amendments were added requiring state agencies to provide to Cover Oregon any reports or findings resulting from an independent review, if review is contracted for or paid for, in whole or in part, by a state agency.
SB 1565	HERC "nondiscrimination"	Prohibits discrimination based on age, expected length of life, present or predicted disability, degree of medical dependency or quality of life in issuance of health benefit plans and in determination of medical services covered by state medical assistance program.	Died	
SB 1569	Toxic chemicals disclosure	Requires OHA to establish and maintain list of designated high priority chemicals of concern for children's health used in children's products.	Died	Final version was watered-down; likely to come back next year
SB 1577	Silver Alert System	Requires police to adopt policies, including alerting medica, for missing vulnerable adults	Passed House & Senate	
SB 1579	Prescription refill frequency	Requires certain health plans with prescription drug benefits to cover refills of prescription drugs in accordance with plan for synchronizing refill dates of patient's prescription drugs.	Passed House & Senate	

Bill #	Name	Description	Status as of 2/28	Additional Info
SB 1582-B	TMIP/reinsurance	Adjusts attachment points for reinsurance program; defines funding source for Temporary Medical Insurance Program (TMIP);	Headed to full W&M	The amended version allows insurers to continue a transitional health benefit plan until December 31, 2015 or a later date if specified by DCBS