

AllCare Coordinated Care Organization

Transformation Plan Summary

Transformation Initiative Descriptions

◆ Domain 1: Physical health, mental health, addiction recovery, and dental health integration

Purpose: The purpose of developing and implementing an integration plan for physical health, mental health, addiction recovery services, and dental health is to:

- Improve communication and understanding across the fields of practice
- Increase Primary Care Provider (PCP) knowledge of mental health and addiction recovery services and resources
- Increase Physical Health and Mental Health consultation and support
- Use performance measures that promote collaboration
- Ensure education and continuing education of PCPs on treating addictions and clients with mental illness
- Develop service integration practice guidelines
- Integrate electronic health record systems
- Complete regular cost analyses and quality/outcome assessments to enhance program effectiveness and identify areas for performance improvement

Approach: Our approach involves the following tasks:

- Inventory and evaluate current programs, services and community supports in each county
- Complete a gap analysis and identify existing strengths, weaknesses, opportunities, and threats
- Identify and evaluate alternative integration and collaboration models of care, building upon existing resources
- Develop the preferred program description(s)
- Define roles and responsibilities across care settings
- Implement
 - Provider and staff training on the new model of care
 - Patient/Client engagement
 - Program roll-out
- Ongoing program evaluation

Benchmarks for July 1, 2015 include: Increase the number of AllCare members in our three county service area who have a diagnosis of severe and persistent mental health conditions and a diagnosis of diabetes who had HgbA1C and LDL laboratory tests. Utilizing our community mental health agency's data, identify the number of AllCare members diagnosed with severe, persistent mental illness and the

AllCare CCO claims database to identify those members with SPMI and diabetes who have claims/encounters processed (appropriate CPT codes) for a HgbA1C and LDL laboratory tests in 2012.

First milestone to be achieved July 1, 2014: 10% improvement over baseline measurement. Primary benchmark to be achieved July 1, 2015: 20% improvement over baseline measurement.

◆ Domain 2: Patient centered primary care home implementation

Purpose: AllCare CCO will facilitate adoption of the Patient Centered Primary Care Home (PCPCH) model of care across our three county service area. This will achieve the following objectives:

- Ensure that over 75% of Medicaid beneficiaries enrolled in AllCare have a Patient Centered Primary Care Home that is recognized by the State of Oregon as Tier 1, 2, or 3
- Improve the health of all Medicaid beneficiaries enrolled in AllCare, including the dually eligible
- Become the health plan of choice among Medicaid beneficiaries across the service area through excellent customer experience, quality, and outcomes
- Support our contracted providers through training, collaboration, and incentives that promote the triple aim and goals of a patient centered primary care home
- Address the health literacy and health disparities among sub-populations
- Support primary care providers' adherence to AllCare policies and procedures for Patient Centered Primary Care Home, including data reporting requirements, EMR Adoption, and meaningful use, and health information exchange.
- Create a PCPCH department/designated program within AllCare to oversee and coordinate the clinical and technical components of this new model of care
- Fully support local and regional Health Information Exchange efforts that support data sharing between the PCPCHs and their partners in care coordination and care management
- Operationalize the health information exchange functionality for Greenway users as soon as possible

Approach: AllCare is in the process of developing a two-tiered approach to achieve PCPCH adoption across the service area. The first approach involves development and deployment of four training modules on the basic concepts of the new model of care and the associated state measures for PCPCH recognition that measure application of those concepts. The training modules are supported by personal coaching within the practice sites.

Our second approach is to redesign AllCare's services and workflow processes for care coordination and case management that support our PCPCHs, particularly small and solo practices that do not have the staff or capacity to fully implement the new model of care. This will ensure that all Medicaid beneficiaries have access to the full range of health services including wellness and prevention, community support services, chronic care management, complex care management, and

integrated/multidisciplinary team case management. Upon completion, AllCare CCO will have the capacity and trained personnel to provide the following services:

- Individual case planning for transitions of care across care settings for hospitals, skilled nursing facilities, residential care facilities, and the state mental health hospital.
- Care coordination for preventable and avoidable ambulatory care and emergency department visits, targeting Members who need assistance navigating the health system effectively and efficiently.
- Case management for chronic conditions
- Multidisciplinary team management for patients with chronic conditions who also need care coordination to effectively navigate the health system
- Collaboration and support for our contracted PCPs and PCPCHs that need assistance with care coordination, behavioral health integration, management of complex conditions, prevention and wellness.
- Collaboration with Long term Care providers, public health, hospital systems, law enforcement agencies, and educational systems that impact the health and wellbeing of our beneficiary population.

Planning, development, and implementation of the new model of care and AllCare internal functional plan is underway and will continue through 2013. The PCPCH training modules are currently available for all contracted providers use. The functional planning process redesign effort launched on February 25, 2013 and will be ready for deployment in Mid-2013.

Benchmarks for July 1, 2015 include: Increase the number of AllCare members enrolled in recognized PCPCH. Number of AllCare CCO members assigned and engaged with a PCPCH (in our three county service area) as measured by one visit (CPT 99201-99205, 99211-99215 or 99381-99387, 99391-99397) during 2012 with a corresponding reduction in ED utilization (ED codes 99281-99285) during 2012.

First milestone to be achieved by July, 2014: Increase from current three county level of 56% to 75% of AllCare members are assigned to a PCPCH with at least one PCPCH visit and a 5% reduction in ED utilization over baseline.

Benchmark to be achieved as of July 1, 2015: Incent capitated PCPs to provide necessary primary care services in office to reduce avoidable ED visit thereby improving health outcomes at reduced costs.

◆ **Domain 3: Payment methodologies and alignment with health outcomes**

Purpose: AllCare CCO plans to establish fair and equitable provider payment methodologies that promote high quality, efficient, and cost effective health care for AllCare CCO beneficiaries while at the same time, encourage creative and flexible solutions to meet the needs of our Members. This will:

- Ensure that all sectors of the health system over which we have control are financially sound within the confines of the state global budget.

- Ensure that the payment methodologies reward value (measured by quality and outcome) and incentivize providers to “do the right thing.”
- Establish payment schemes that reward efficiencies, promote use of creative/flexible solutions to patient problems, and compensate for non-traditional activities such as individual care planning, prevention, team-based care, and population health.
- Migrate to “part” or “full” risk payment schemes over the next three years.
- Ensure that payment schemes include methods to incentivize compliance with terms and conditions of participation in the Medicaid program.
- Use non-traditional supports to promote better individual health, better population health, and improved patient experience.
- Clearly communicate with stakeholders that new payment methodologies may result in reallocation of funds across care settings.
- Educate our contracted providers on the alternative payment schemes that are currently being tested across the nation and involve them in developing and testing innovative models.
- Test new payment schemes in local, small demonstration projects prior to full implementation.
- Address the Oregon Health Authority’s (OHA) main principals of equity, accountability, simplicity, transparency, and affordability as much as is practical within the small rural communities that we serve.

Approach: AllCare CCO plans to stabilize our current payment methodologies that were recently put in place and monitor their effectiveness to meet the triple aim of better health, better care, at reduced costs. We will apply the OHA measures, examine the state primary care home recognition measures, and evaluate our internal quality and outcome measures per the Consumer Assessment of Healthcare Providers and Systems (CAHPS), the Healthcare Effectiveness Data and Information Set (HEDIS), and the Health Outcome Survey (HOS) to test our current payment models.

Reward successful PCPs via a shared savings program, as measured by each providers’ 2012 PCP visits/1000 and ED costs for their assigned enrollees in our three county service area recognizing care delivered in a PCP setting leads to better health outcomes and avoidable transitions of care. Utilize AllCare CCO Provider Profile (claims data) to measure patient engagement in terms of PCP visits/1000 and ED costs for the two time periods to measure savings.

First milestone to be achieved by July 1, 2014: 8% increase in the rate of PCP visits/1000 with resulting ED cost savings to be shared with PCP/PCPCH.

Benchmark to be achieved by July 1, 2015: 12% increase in the rate of PCP visits/1000 with resulting ED cost saving to be shared with PCP/PCPCH.

◆ Domain 4: Community needs assessment and improvement plan

Purpose: The purpose of our Community Health Needs Assessment (CHNA) is to develop and implement an on-going process in partnership with local CCOs and other stakeholders to regularly identify gaps in health services and programs across care settings. AllCare will use the CHNA to develop a Community Health Improvement Plan (CHIP) that focuses on improving access, quality, outcomes, service integration and delivery, health equity, community supports, and customer/provider experience. In addition, we will undertake three health improvement initiatives each year designed to provide better health, better care, at reduced cost. Our CHIP will:

- Ensure that appropriate access to needed services and community supports are available to all AllCare beneficiaries.
- Address population based health improvement opportunities to meet Healthy People 2020 goals, objectives, benchmarks and targets as well as Oregon Health Authority (OHA) quality measures.
- Mitigate health disparities among subpopulations.
- Identify and promote creative, cost effective, and flexible solutions to address known gaps in the health system.
- Elevate the definition of “healthy communities” to emphasize healthy lifestyles through non-traditional means such as urban design that promotes outdoor activities and school health programs.
- Utilize non-traditional community workers within the natural support system.
- Establish a list of priority improvement initiatives each year.

Approach: Our approach for completing the Community Health Needs Assessments in each county and preparing the AllCare Community Health Improvement Plan involves six phases that mirror the MAPP process (Mobilizing for Action through Planning and Partnerships) typically used in Public Health planning and recommended by the Oregon Health Authority.

Milestone to be achieved on July 1, 2014: Submission of completed Community Health Improvement Plan for Josephine, Jackson and Curry counties.

Benchmark to be completed by July 1, 2015: Define strategies to implement CHIP and update as appropriate.

◆ Domain 5: Electronic health records, information exchange, and meaningful use

Purpose: AllCare's goal is to encourage adoption of electronic medical records across all care settings that are interoperable, support confidential and secure data sharing, and achieve CMS meaningful use requirements in support of Patient Centered Primary Care Home recognition among our contracted primary care providers and their staff. This will:

- Support our contracted providers in their ability to qualify for CMS meaningful use incentive bonuses.
- Reduce unnecessary duplication of diagnostic and treatment services through data sharing and care coordination via electronic transmission of personal health information.
- Ensure that appropriate consumer consents are in place and that provider systems comply with AllCare CCO's confidentiality and security policies and procedures for health information exchange.
- Utilize EMR report capabilities to evaluate CCO effectiveness based on de-identified encounter data.
- Support community based initiatives to establish health information exchanges that are secure and financially sustainable.
- Promote use and application of common evidenced based clinical protocols that are embedded into EMR system design for consistent clinical decision support.
- Facilitate physical health, dental health, mental health, and addiction recovery service integration through electronic data sharing and development of a single patient record.
- Establish a PCPCH department/designated program to coordinate clinical transformation and technology transformation processes and procedures. (Refer to Domain #2 for a complete description of our Care Coordination Resource and QI Data Management Center.)

Approach: Over the next three years, AllCare CCO plans to:

1. Strengthen current efforts around EMR adoption, health information exchange, and meaningful use with specific emphasis on increasing the availability of and access to advanced directives / POLST forms embedded in Members' electronic medical records.
2. Spread the use of HIT in support of CCO initiatives around service integration, Patient Centered Primary Care Home, community health needs assessment, and general business analytics in support of quality improvement initiatives, care coordination, early identification and intervention, and cultural competencies.
3. Expand data sharing capabilities to our contracted skilled nursing facilities and mental health entities in support of care coordination, transitions of care planning, and patient care integration.
4. Encourage adoption of mobile devices and applications that support patient engagement in their health and care planning efforts.

5. Explore how tele-medicine devices and technologies can be used to strengthen Member access to timely and high quality health services.

Benchmarks include: % of AllCare contracted providers in Josephine and Curry counties that use the Greenway Electronic Medical Records software and access Greenway's PrimeDataCloud technology for information sharing across care settings. We feel this approach will result in faster adoption of electronic data sharing as technology evolves and is accessible in the Southwest Oregon.

Utilizing reports generated by the Greenway EHR systems track data exchange transactions for 2013.

First milestone to be achieved by July 1, 2014: 10% increase of eligible Greenway EHR users sharing data across care settings as measured by the number of data exchange transactions per provider compared to baseline.

Benchmark to be achieved by July 1, 2015: 20% increase of eligible Greenway EHR users sharing data across care settings as measured by the number of data exchange transactions per provider.

◆ Domain 6: Communication planning to promote cultural competency and respect between AllCare and the members we serve

Purpose: AllCare will encourage the adoption of policies and procedures that ensure communication, outreach, Member engagement and services are tailored to the cultural and linguistic needs of people with diverse backgrounds and do so in a manner that affirms and values the dignity of all individuals.

Approach: Among our current OHP Members, approximately 4,800 are minorities and the overwhelming majority (97%) are Latino. Latinos comprise 15% of AllCare CCO Members compared to only 9.6% of the service area population. Given current demographics, AllCare will initially focus on our Latino Members to ensure they have the community supports they need to be successful in managing their health. Our objectives are to:

- Create a system where there is no wrong door by encouraging all stakeholders to embrace the dynamics of personal differences through acquisition of cultural knowledge, skills, and practices that reflect the needs of our Latino members and other culturally diverse Members as appropriate.
- Provide culturally and linguistically competent training among AllCare staff.
- Encourage everyone to embrace these core values for all members:
 - Integrity to always do the right thing
 - Stewardship of the public trust
 - Responsibility for our actions
 - Respect the dignity and diversity of colleagues, communities, and the people we serve

- Professionalism by embracing the highest standards, methods, behaviors, and personal characteristics exhibited by the best people in their respective fields.
- Promote provider use of information sharing technology across care settings to ensure timely access to needed information in support of patient care.
- Build upon and provide additional support services to existing clinics that serve a large number of AllCare Members.
- Work with our Latino members, Latino community-based programs and public health departments to generate quality standards that include cultural competence and incentives for providers to meet those standards.
- Create an AllCare care coordination team that focuses on Latino members.
- Encourage providers to refer their eligible patients to our Latino care coordination team.
- Recruit community health workers with Spanish language expertise and incorporate them into team based care within our Primary Care Homes and AllCare's care coordination team.
- Follow the Office of Equity and Inclusion's policy on collecting race, ethnicity and language data.

Benchmarks include: Through targeted member materials and outreach utilizing the community health worker skilled and focused on the AllCare Medicaid membership increase the number of children aged 6-18 in our three county service area who receive a well-child check up from a PCPCH or PCP. This group is at risk for unhealthy behaviors and substance experimentation. In addition there are needed immunization boosters and HPV vaccinations for females. Based on analysis of this age group data there was a significant decrease in well child care in the age group 6-18 with no race/ethnicity differentiation. Identify children on the 834 file who have had a well-child checkup (utilizing appropriate CPT codes) in 2012.

First milestone to be achieved by July 1, 2014: Improve 20% over baseline # of children 6-18 years of age who have received an annual well child checkup from PCPCH or PCP.

Benchmark to be achieved by July 1, 2015: Improve 30% over baseline # of children 6-18 years of age who have received an annual well child checkup from PCPCH or PCP.

◆ Domain 7: Alignment of workforce configuration with the cultural diversity of the communities we serve

Purpose: AllCare CCO's goal is to transition over time to a more diverse workforce that equitably reflects the racial, ethnic, cultural, and lifestyle diversity within the communities we serve. Our objectives for workforce transformation build upon the realities of our current workforce with full recognition that provider recruitment and retention is very difficult in rural areas. As such, the following objectives offer a practical foundation and framework upon which to address health disparities and cultural competencies within our workforce and across the continuum of care:

- Communicate the need for greater workforce diversity by building the business case for change. Elevate the discussion among our contracted providers around the importance of diversity and its impact on health outcomes, quality of care, quality of life, and Member satisfaction.
- Create innovative incentive programs that will attract culturally sensitive job seekers across our service area and across care settings.
- Offer providers tools, guidance, and criteria they can apply in their practices to embed cultural sensitivity into all Member interactions, assist in educating current staff on diversity issues, and provide guidance for recruiting a more culturally diverse staff.
- As resources allow, fund training and education to increase the number of state certified bilingual providers.
- Ensure comprehensive implementation and adherence to non-discrimination policies and procedures.

Approach: Based on the demographic profile of our service area and the inventory of providers available to meet the needs of special populations, AllCare will focus on the following targeted initiatives:

1. For our Hispanic enrollees with Low English Proficiency (LEP), AllCare will develop programs designed to increase Spanish speaking and culturally sensitive peer supports, community health workers, and health navigators to ensure that Members understand the resources available to them through their physical, mental, and dental health providers as well as through other community supports;
2. For non-Hispanic minority enrollees, AllCare will create a contact tree to increase access to local bilingual and culturally sensitive community programs;
3. AllCare will begin the process of collecting information on the health care needs, sensitivities, and preferences among our LGBT Members.
4. AllCare will increase health literacy and improve health outcomes across all OHP members by encouraging contracted providers and their staff to engage in on-line health literacy training programs.
5. AllCare will develop in-house resources that can assist our small and rural providers with culturally and linguistically competent care coordination, particularly for Hispanic Members.
6. AllCare will infuse discussion of cultural competencies into our regular interaction with providers, their staff, our CCO committees, and the CCO Board.
7. AllCare will continue its collaboration with local colleges to provide input on curriculum choices that embrace cultural and linguistic competencies as part of their health care training programs.

Our initiatives address OHP enrollees from all racial and ethnic cultures, those with disabilities, and those with diverse sexual orientations. The plan also applies to the recruitment and training of AllCare staff, our entire provider network and their staff, as well as community supports that interact with our Medicaid beneficiaries through their association with AllCare CCO.

Benchmarks include: Increase the number of PCP/PCPCH or OB practice sites completing cultural diversity training programs. Perform a baseline survey (by 7.1.2013) and subsequent surveys in 2014 and 2015 to measure training program participation.

First milestone to be achieved by July 1, 2014: Improve 15% over baseline the rate of cultural diversity program completion by contracted providers.

Benchmark to be achieved by July 1, 2015: Improve 30% over baseline the rate of cultural diversity program completion by contracted providers.

◆ **Domain 8: Quality improvement planning and measurement of underserved and diverse populations**

Purpose: AllCare's plans to establish a framework within which it can collaboratively develop with its CCO stakeholders and partners a set of realistic quality and accountability measures specific to cultural competencies across the continuum of care. The plan will include measurable incentives that ensure racial, ethnic, and linguistic disparities in access, quality, and experience of care are mitigated over time.

Approach:

1. Establish standards of clinical care, customer experience, and value that a) reflect current medical literature and national benchmarks; b) lead to improved performance; and c) support ongoing evaluation of patient outcomes and per capita expenditures among our diverse patient populations.
2. Establish standards for access, availability, and integration across care settings that provide objective criteria and processes to monitor diverse patient populations' quality.
3. Promote evidence based protocols that are specific to diverse patient populations, particularly expectant mothers' prenatal care during the first trimester.
4. Assess continuity of care, service integration, and care coordination across all care settings and population groups.
5. Monitor over and under-utilization across all care settings and population groups.
6. Investigate trends in patterns of care among physical health, mental health, dental health, and community programs for diverse population groups.
7. Collaborate, where feasible, with other CCOs to develop consistent quality and accountability measures to reduce administrative burdens for our providers and to minimize conflicts.

Benchmark measurements include: Identification of AllCare CCO pregnant members who use any substance that can have an adverse impact on fetus and /or newborn baby and enhance referral process to appropriate community treatment program(s) for their substance abuse issues. Utilize the 834 file to identify pregnant members and develop a process/tool to assess substance abuse in AllCare pregnant

members. Implement this tool in OB and Family Practice offices who provide prenatal care to pregnant members and obtain appropriate referrals to treatment programs.

Milestone to be achieved by July 1, 2014: Identification process is in place and a baseline developed identifying those members who are pregnant and need substance abuse program intervention

Benchmark to be achieved by July 1, 2015: Achieve success in attending to pregnant moms with substance abuse by obtaining appropriate referrals for 15% of those identified.