AllCare

A Southwest Oregon Care Coordination Organization

AllCare CCO

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Preface

AllCare CCO's Transformation Plan provides a blueprint to guide development of an integrated health system that embodies the triple aim of better population health, better individual health, and lower costs. Although the Plan is comprehensive, it remains fluid and allows for exploration of alternative approaches and models to meet our overarching goals. Modifications and derivations will certainly occur and our journey will likely lead us to new paths yet to be envisioned or defined.

As the health system changes, so will our Plan. Many unknowns remain and our future success requires flexibility, practicality, and resilience to know when to embrace new ideas and when to abandon unworkable or outdated ones. To paraphrase what John Sculley of Apple once said, planning is part of our organization's mind set. Our people must think about change all the time. It's part of who we are. It's our values and our vision which must be embraced at all levels of the organization.

With that in mind, please remember as you read our plan that it is more than a map of our transformation journey: it is a tool to guide the way.

Douglas L. Flow, Ph.D
Chief Executive Officer
AllCare CCO

INTRODUCTION AND OVERVIEW OF PLANNING PROCESS

Transformation Plan Framework

AllCare CCO's service area encompasses Josephine, Jackson, and Curry County plus two contiguous zip codes in Douglas County. This reflects the natural transportation and commercial network that supports our health system in Southwest Oregon. The following transformation plan addresses the needs specific to this service area, and is reflective of the underlying demographics of the population and the cultural intricacies of the communities we serve.

AllCare CCO's transformation planning process strives to embrace the triple aim while mitigating traditional health sector silos, creatively managing a global budget, and developing and implementing innovative service delivery models that expand access, improve quality, and promote health equity and cultural competencies across the continuum of care. Our plan utilizes a consistent planning approach that is founded upon measurable goals and objectives for each of the eight transformation domains:

- Physical health, mental health, addiction recovery, and dental health integration
- Patient centered primary care home implementation
- Payment methodologies and alignment with health outcomes
- Community needs assessment and improvement plan
- Electronic health records, information exchange, and meaningful use
- Communication planning to promote cultural competency and respect between AllCare and the members we serve
- Alignment of workforce configuration with the cultural diversity of the communities we serve
- Quality improvement planning and measurement of underserved and diverse populations

Oversight of the planning and implementation process will be guided by AllCare's Executive Leadership Team which will serve as the Transformation Team. This Team and the AllCare CEO will collaborate with the AllCare CCO Board of Directors and it will ensure that the transformation plan serves as a continuous quality improvement program that is iterative, builds upon its successes, and strives to achieve better health, better care, and lower costs.

The work plan for each domain follows a similar framework and technical approach that allows customization for each domain. This framework includes documentation of underlying regulations and health policies, planning assumptions, resource requirements, and predetermined timelines and milestones. Planning activities are guided by five major process flows: planning, development, implementation, program evaluation and specific measurement milestones.

We recognize that our transformation process is a journey rather than an end unto itself. We further recognize that assumptions will change over time to reflect new realities; that the regulatory landscape will shift and that health policy will continue to evolve thereby generating new strategies and renewed fiscal pressures to do more for less. To this end, our transformation plan is a living document that will change as current Member, clinical, community, financial, and political needs change.

Our planning process addresses the data it needs to support each transformation domain and strives to minimize redundancies in data compilation, surveys and administrative burdens on our providers and consumers while assuring that accurate and reliable information is available to inform our decisions. The plan encourages creative pilot demonstration projects to test and evaluate innovative solutions to ensure that CCO goals and objectives are being met before expanding new programs, processes, or procedures across our network of contracted providers, community based programs, and other business associates.

In keeping with Oregon Health Authority principles, our plan strives to embrace partnerships and, where appropriate, emphasizes transparency to support those partnerships as we collaborate on improved quality, expanded access, and lower costs. However, we are also mindful of the uniqueness of the people and communities we serve. A one-size fits all approach will not meet the needs of all individuals, their families and caregivers, and their providers. Therefore, we emphasize flexibility to support long range viability through alternative competitive pathways to meet our goals.

Overarching Goals

AllCare CCO strives to achieve the following overarching goals as part of its transformation process. These goals apply to all domains.

- The transformation process must bend the total cost curve.
- Capacity will be expanded through budget neutral initiatives that prepare AllCare for increased enrollment through the Affordable Care Act and/or other state and national health reform efforts.
- Provider contracts will move toward part or full risk financial arrangements as soon as practical and incorporate new policies and procedures emanating from this transformation plan.
- Stakeholders will do their fair share to achieve the transformation goals and objectives and will receive equitable reward for their efforts.
- Stakeholders will be accountable for quality outcomes, health equity, cultural diversity, and cost effectiveness.
- Transformation programs, policies, and procedures will be practical, flexible, and sustainable over time.

Resources

The transformation plan will be implemented by AllCare CCO staff, led by a core transformation team comprised of our chief executives. The transformation team will report to the Chief Executive Officer who will, in turn, collaborate with the AllCare CCO Board for oversight and guidance. Where practical, the transformation team will be financed through external funding sources, such as grants and in-kind support.

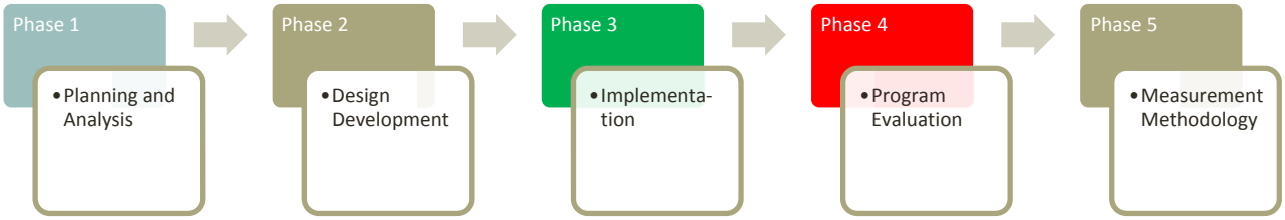
Data sources will include provider and consumer surveys, claims data, encounter data, demographic data, financial data, and literature searches on best practices, benchmarks, and lessons learned. A major output of the transformation process will be an overall data management plan and process in support of quality management, performance improvement, and daily operations of the CCO. In an effort to minimize provider administrative burdens, AllCare CCO may seek out other stakeholder organizations to collaborate on specific parts of the transformation process such as the community health needs assessment, cultural diversity initiatives, quality improvement across small and diverse populations, workforce transformation, and health information exchange.

Stakeholders will be engaged in the planning and implementation process through representation on the CCO Board of Directors, the Community Advisory Councils, Clinical Advisory Panel, and the County Commissioners Council. Other stakeholders will be involved as needed by each domain. Application of Oregon Health Authority guidance will ensure consistency with state and CMS health policy directives.

Transformation Plan Design

The AllCare Executive Team is responsible for Transformation Plan implementation. This core team consists of the Chief Executive Officer, Chief Financial Officer, Chief Medical Officer, Chief Quality Officer, Director of CCO Development, and Director of Communications. For specific domains, the core team will be augmented by subject matter experts in mental health, addictions, public health, dental health, community supports, health information technology, and legal counsel.

For the most part, the Plan embraces a five-phased transformation process that is applied to each domain.



Phase 1, Planning and Analysis, involves research, data collection and analysis, preliminary planning assessments, identification of transformation options and innovative solutions, and high level feasibility studies. The CCO Board and other stakeholders will provide input and feedback as part of the planning and analysis process.

Phase 2, Design Development, involves detailed preparation of new policies and procedures, innovative designs and solutions that will be tested and piloted by stakeholder volunteers, their staff and consumers where indicated. AllCare staff will ensure programs, policies, and procedures are cohesive, consistent, and non-duplicative across the continuum of care.

Phase 3, Implementation, involves roll-out of new programs, policies, and procedures across the health system. Implementation will be incremental to ensure that stakeholders are able to accommodate changes in a practical and flexible manner. AllCare transformation staff will train, educate, coach and communicate with stakeholders (including Members, providers, and community supports) across the continuum of care and periodically evaluate adherence to new initiatives over time. Staff will report to the CCO Board regularly to ensure program effectiveness and successful progress against goals and objectives. The Executive Team, in collaboration with the AllCare CCO Board, will troubleshoot and resolve emerging issues identified by staff and stakeholders throughout the implementation process and will hold stakeholders accountable for meeting quality, cost, and outcome goals and targets.

Phase 4, Program Evaluation, is embedded throughout the Transformation Plan, providing annual progress evaluations against goals and objectives. The AllCare CCO Board will be responsible for reviewing annual progress reports prepared by the Transformation Team. The evaluation and assessment process will include data generated by AllCare staff, independent audit information from external evaluators for the CCO, as well as mandatory mental health and addiction recovery audit information prepared annually for the state.

Phase 5, Measure Methodology, identifies the Milestones and Benchmarks embedded into the CCO Contract, Exhibit K. These benchmarks will be used by the Oregon Health Authority to measure progress toward goals, including one or more milestones. A Benchmark and at least one milestone is required for each transformation domain.

Guiding Principles

The following guiding principles emphasize our renewed commitment to the experience of care and our collective goal as a Care Coordination Organization to be the CCO of choice through superior customer service and high quality outcomes.

AllCare CCO Guiding Principles

Guiding Principles	Transformation Implications	Performance Measurement
There is no wrong door into the health system.	No matter how a Member in need of service is identified or what intake portal they use, it is staff responsibility to ensure their needs are met in a timely and professional manner.	Timeliness of services. Member experience of care.
All Members are treated equally.	All Members will receive the same level of timely care and service regardless of their age, disability, health literacy, racial, ethnic, or cultural background, or sexual orientation. Staff will serve AllCare, CareSource and Special Needs Members as equal in priority, within the limits of their specific insurance coverage and benefit plan. New Members (state workers, teachers, and/or insurance exchange enrollees) will be similarly served.	Member surveys on their experience of care. Declines in health disparities and inequities. Timeliness of services. Improvement in health status indicators
Staff is expected to do the right thing to meet Member needs in creative and innovative ways.	Staff will offer flexible services, coordinate with PCPs, community health workers, peer supports, and health system navigators to ensure Member needs are met cost effectively, efficiently, and in a timely manner. Staff will ensure that Members receive the care and service they need in the most appropriate care setting and by the right care team. Staff will promote high quality care and excellent experience of care for all Members, similar to that which they expect for themselves and their families.	Number of flexible services cost-effectively deployed to meet Member needs. Member surveys on their experience of care.
Staff is empowered to proactively identify and prevent illness; promote wellness, and intervene early as Members' needs change.	It is staff responsibility to reach out to Members, their providers, and their care givers for early intervention. Staff is expected to allocate time for early identification of at-risk Members based on defined criteria and evidence based protocols. Staff is encouraged to promote health, wellness, and early intervention through on-site collaboration with PCPCH providers, other PCPs, Members, and their care-givers.	Number of Member referrals for care coordination, chronic disease management, complex case management, and prevention and wellness.

Domain 1:#

Develop and implement a health care delivery model that integrates mental health, physical health, addictions, and dental health. This plan must specifically address the needs of individuals with severe and persistent mental illness.

Regulatory Requirements

OAR: 410-141-3015

Certification Criteria for Coordinated Care Organizations

(3) Applicants must describe their demonstrated experience and capacity for:

(e) Coordinating the delivery of physical health care, mental health and chemical dependency services, oral health care, and covered long-term care services;

OAR: 410-141-3160

Integration and Care Coordination

(1) In order to achieve the objectives of providing CCO members' integrated person centered care and services, CCOs must assure that physical, behavioral and oral health services are consistently provided to members in all age groups and all covered populations when medically appropriate and consistent with the needs identified in the community health assessment and community health improvement plan (Plan). CCOs must develop, implement and participate in activities supporting a continuum of care that integrates physical, behavioral, and oral health interventions in ways that are whole to the member and serve members in the most integrated setting appropriate to their needs:

(a) CCOs shall ensure the provision of care coordination, treatment engagement, preventive services, community based services, behavioral health services and follow up services for all members with behavioral health conditions;

(b) CCOs must enter into contracts with providers of residential chemical dependency treatment services not later than July 1, 2013 and must notify the Authority within 30 calendar days of executing the contract;

(c) By July 1, 2014, each CCO must have a contractual relationship with any dental care organization that serves members in the area where they reside;

Program Goal##

AllCare plans to create a care delivery model, predicated on the Patient Centered Primary Care Home (PCPCH) model of care, that addresses the full continuum of physical health, mental health, addiction recovery services, dental health, and covered long term care services where beneficiaries, including those with severe and persistent mental illness and/or addictions, feel comfortable receiving evidence based diagnostic and treatment services, annual health assessments, screenings, preventive services, and care planning to improve their health status, enhance their quality and longevity of life, and promote self-management of their complex conditions.

Objectives

Our objectives for service integration seek a comprehensive approach that is practical and flexible. For example, we envision a delivery model that will involve a range of integration options that:

- Address diverse beneficiary needs
- Build upon local resources and varying levels of capacity and capabilities across the service area
- Promote the use of cost effective and non-traditional models of care, and
- Integrate “recovery oriented” services and “trauma informed” treatment plans

All integration options will need to embody the following objectives:

- The integration model will create an efficient and productive collaboration across the continuum of care.
- The model will assign service delivery activities so that employees function at the top of their license or certification.
- The model will also develop and utilize new skill sets such as a peer wellness specialist and community health worker.
- The integration model will improve cost effectiveness through reduced duplication of services, efficient use of all care settings, information sharing, care coordination across the continuum of care, and early intervention.
- The model will eliminate current budget and service silos over time.
- The model will be funded through a flexible combination of CCO budgeted funds and other funding opportunities.
- Program services and treatment quality will be measured regularly to ensure integration goals and objectives are being met.

Purpose

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

- Improve communication and understanding across the fields of practice
- Encourage Members’ consent to share information within the care coordination team

- Increase 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
- Increase PCP exam time for at-risk patients to discuss physical health, mental health, and addiction needs
- Ensure education and continuing education of PCPs on treating addictions and clients with severe and persistent mental health issues
- Organize a series of collaborative meetings to identify barriers and resolve challenges that impede service integration
- 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
- Collect basic data for program evaluation, including
    - Health status indicators (basic lab data)
    - ER utilization pre- and post-integration, including dental visits
    - Psychiatric admissions and lengths of stay
    - Chart reviews to monitor consent forms, evidence of collaboration, prescriber history
    - Satisfaction surveys for providers and patients/clients
    - Long term care utilization statistics

Approach

Phase I: Planning

Task 1.1: Inventory and evaluate current programs, services, and community supports in each county

The inventory will consist of interviews with key personnel in each county together with a readiness assessment to determine if resources are in place and whether there is a willingness among physical health providers, mental health providers, addiction recovery counselors, and dental organizations to embrace integration and at what level. The inventory will document current capacity to meet future needs, identify current personnel resources, describe current processes and procedures for Member referrals, document current treatment processes and workflows, document current outcomes compared to Healthy People 2020 and other benchmarks, identify and describe known disparities across subpopulations, and inventory existing IT infrastructure. (The inventory will also address other domains, such as workforce diversity, quality improvement data needs, the community health needs assessment, and health information exchange.)

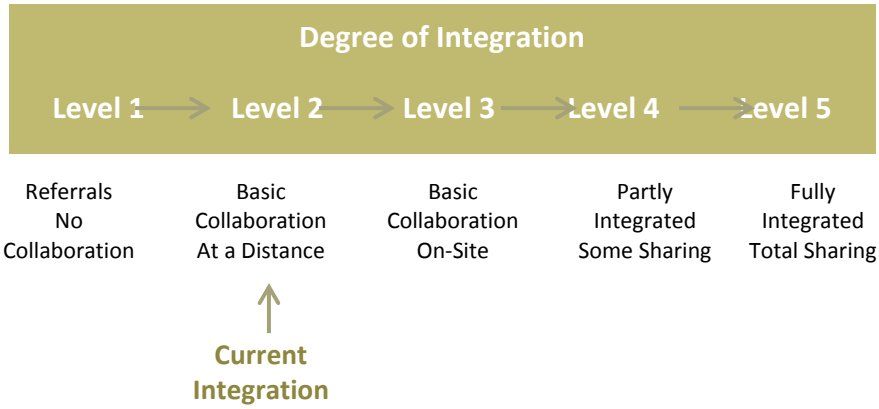
Task 1.2: Gap Analysis/SWOT Analysis (Strengths, Weaknesses, Opportunities, Threats)

This information will be collated and analyzed to identify gaps in programs, services, and community supports that may impact effective integration. It will also identify existing infrastructure upon which to successfully establish an integrated delivery system. This will be summarized into a SWOT-type of

analysis, allowing decision-makers to better understand the current landscape and the challenges that will need to be addressed.

Task 1.3: Identify Alternative Integration and Collaboration Models:

Our three-county service area is characterized as mostly rural and is largely designated as a manpower shortage area as well as an economically disadvantaged area. It is poorer than most of Oregon where 16% of the population qualifies for Medicaid, sicker based on the Behavioral Risk Factor Surveillance Survey (BRFSS) benchmark comparisons, and older with 21% of the population aged 65 and over. These characteristics inhibit development and implementation of a single service integration plan. Instead, AllCare plans to develop a range of integration models that build upon the resources available within each community we serve. Those models will follow one of five basic service integration frameworks, each with a more intense degree of integration.



While many of our providers are currently at either Level 1 or Level 2, it is our desire to transition as many of our patient centered primary care homes to Level 4 or Level 5, particularly for our severe and persistently mentally ill (SPMI).

1. Level One - Minimal Collaboration: This model envisions mental health, addiction recovery and other health care professionals working in separate facilities with separate systems, with limited communication or co-management of Members with complex physical, mental, and/or addiction needs. Such cases will likely be referred to AllCare's Care Coordination Resource Center which is described under Domain #2 on the Patient Centered Primary Care Home. The Resource Center is designed to serve small rural providers who have limited resources to fully integrate services across care settings and/or do not plan to implement the Patient Centered Primary Care Home model of care. In such instances, providers will be encouraged to refer their patients to the Care Coordination Resource and QI Data Management Center (described in detail under Domain #2 – Patient Centered Primary Care Home) where there will be integrated care teams available to meet their complex needs.

2. Level Two - Basic Collaboration at a Distance: This model also envisions providers functioning in separate facilities but engaging in regular communication and collaboration about shared

patients within a team-based treatment model. Communication occurs primarily via telephone, secure messaging for health information exchange, and eventually tele-health. All communication is driven by each patient's specific care plan that integrates physical health, mental health, and addiction recovery treatment through an AllCare case manager. While this is not preferred, the model is designed to ensure that the Member's full range of health care needs is addressed in a timely and professional manner and in ways that promote self-management of their complex conditions. The down side is that there is less opportunity for merging siloed cultures, minimal sharing of patient care treatment responsibilities across care settings, and limited ability to hold professional personnel accountable for quality, prevention, and early intervention. This model is attractive in areas that have few resources and where geographic distances make full collaboration and integration impractical if not impossible.

3. Level 3 - Basic Collaboration On-Site: This model envisions mental health, addiction recovery and other health care professionals sharing the same facility but using separate systems to manage care. They engage in regular communication about shared patients through telephone, secure messaging, and some face-to-face encounters. This model typically results in greater cultural integration and increased understanding of one another's professional role and responsibilities. There is also a stronger sense of being part of a larger, multidisciplinary team even though they do not share in a common language or an in-depth understanding of each other's worlds. This type of treatment integration model is adequate for serving Members with moderate biopsychosocial interplay that require occasional face-to-face interactions of the care team to coordinate complex treatment plans. However, those with much more challenging problems, such as people with severe and persistent mental health issues together with co-morbid conditions will need access to AllCare's integrated care team for case management of complex conditions. This model is now under development on a pilot basis. The project involves co-location of a Patient Centered Primary Care Home provider within a Mental Health Center that serves Members with severe and persistent mental health issues plus chronic physical conditions.

4. Level 4- Close Collaboration in a Partly Integrated System: Mental health and other health care professionals share the same sites and have the same systems in common, such as scheduling and charting. There are regularly scheduled team meetings about patients, mutual consultation, and coordinated treatment plans. There is a shared allegiance to a biopsychosocial systems paradigm that benefits patient care and minimizes care management complications. This model is appropriate for larger group practices that have the resources to provide care coordination, prevention, and early intervention services within the context of a primary care home, team-based model of care. Typically, however, there remains a lack of shared vision; cultural silos persist; and the potential for ongoing tension around roles and responsibilities continue with medical physician dominance over clinical decisions.

5. Level 5 - Close Collaboration in a Fully Integrated System: Professionals share the same vision with equal access to a seamless web of biopsychosocial services. Both providers and Members have the same expectations of a team offering prevention and treatment. All professionals are committed to a biopsychosocial systems paradigm and embrace an in-depth understanding of each other's roles and cultures. Regular collaborative team meetings are held to discuss patient issues and team collaboration issues. There is a conscious effort to balance power and influence among professionals according to their roles and areas of expertise. This model offers the best setting for treating the most difficult and complex biopsychosocial cases with challenging management problems.

Task 1.4: Present Preliminary Findings and Conclusions

Based on the information gathered in Task 1.3 and the inventory of resources developed in Task 1.1, planning staff will align specific clinics and providers with the various integration models described above. The Transformation Team will present staff to the AllCare CEO, and the CCO Board for review and discussion around next steps to achieve the appropriate level of integration within each practice site.

Phase II: Development

Upon approval to proceed, the Allcare Transformation Team will undertake development of a detailed implementation plan that will address program definition, roles and responsibilities, policies and procedures, cultural barriers, costs and other implementation parameters associated with the integration models to be deployed in each type of practice setting.

Task 2.1: Define Basic Roles and Responsibilities

Dr. Jurgen Unutzer, a leader in the IMPACT depression treatment model and research, posed several fundamental questions that need to be answered in preparation for implementation of an integration model. These questions apply equally to all types of integrated models and programs. *(Integrated Behavioral Health Project Tool Kit, pg 42)*

1. How will Members be identified?
2. Who will prescribe psychotropic medication?
3. Who will provide counseling/psychotherapy?
4. Who will provide mental health back-up?
5. How will chronic disease management and preventive care be addressed?
6. Who will track clinical outcomes and how?
7. How will treatment changes be identified?
8. How will team members communicate?
9. What is the overall implementation strategy?
10. Who will lead/coordinate the implementation effort?
11. What are the anticipated barriers and challenges?
12. How will we measure success?

13. How can the model be sustained?

The transformation team will work with key stakeholders throughout the integration planning and development process to address these questions and develop solutions for mental health and addiction recovery integration. The solutions will likely be different for each model and for each community to be served.

Dental integration is also important, particularly around health information access. Currently, AllCare offers local dentists access to pharmacy data via a patient portal sponsored by our pharmacy benefits manager. In the future, our local dental providers will be able to access additional patient data through the health information exchange. AllCare is also working with Members to promote better health system navigation skills for accessing preventive dental care from their dentist rather than rely on emergency room services for urgent and more costly interventions.

Discussions are also underway between the Transformation Team and local long term care facilities and DHS case workers as part of our ongoing care transitions program to reduce avoidable hospital readmissions and to ensure that patient information, care plans, and medications are appropriately transferred to the receiving entity, whether that is an assisted living facility, residential care facilities, skilled nursing facility, or other care setting. DHS has been very successful in transitioning our Members to independent care settings through their care coordination and case management program supports.

Task 2.2: Program Description

Each of the recommended integration models will be clarified by developing plans around the following implementation requirements. These implementation requirements are based primarily upon the Center for Healthcare Strategies Integration Tool Kit.

Sites: Which clinical sites (both physical health and behavioral health) will undertake integration?

Program Definition: What are we trying to achieve at each site?

Model: Which model meets the program definition to be implemented at each site?

Services: What services will be implemented at each site, such as individual or group therapy (with or without peer counseling)

Work Flows: How will Members be served within each clinic, including scheduling, waiting, data sharing, care planning, family involvement, assessment and treatment, labs, prevention, education, referral, follow-up, etc.

Staff: Which staff will be out-stationed or otherwise assigned to each site, for how long and on which days?

Policies and Procedures: What policies and procedures need to be developed and communicated within each site, across multiple sites, and with AllCare CCO? And who will develop those policies?

Space: What type of space will be needed to implement the integration model and how will that be accommodated in specific sites.

Compensation: How will providers be compensated for the integration services they deliver or arrange to be delivered?

Training: What types of training and/or cross-training needs to be developed, who will develop the training materials, who will undergo the training process, and who will do the training?

Communication Structure: What will be the communication structure for sharing information across the continuum of care, care planning, care coordination, data management, and data reporting for program evaluation and quality management?

Timing: What is the timeline for implementing the defined training and program changes?

Task 2.3: Financial Projections

There are two financial projections to be developed. The first is the implementation budget for launching full integration of physical health, mental health, and addiction services. The second is the operating budget for delivering the services sustainably over time.

The AllCare Transformation Team, in collaboration with the AllCare CEO and CFO, will create a financial model for projecting future operating costs for an integrated system. Those costs will be based on assumptions about the projected target population, program description, staffing plan, staffing costs, program workflows, policies and procedures, and other cost drivers.

The projected operating budget will serve as the yardstick against which we can measure and evaluate program effectiveness and sustainability over time. It will also allow quantitative evaluation of new programs and services. The projected implementation budget will identify the level of capital investment needed throughout the transition phase.

Task 2.4: Program Documentation

With stakeholder input, the Transformation Team and staff will prepare a detailed implementation plan that includes, at a minimum, the information identified above. The implementation plan will be comprehensive to meet the needs of AllCare's total service area and will be phased in over time. The plan will allow flexibility and time to test new policies and procedures to ensure they are effective and efficient.

In addition, the plan will address known barriers such as the "cultural divide." This includes solutions on how to consistently address Members as either patients and/or clients; agreement upon the pace of treatment processes and scheduled appointments; clarity around specific wrap around services for foster children, evidence based protocols, and admission policies; collective understanding of what constitutes a timely referral, standardized documentation protocols, and clear definition of what constitutes a "stable" individual (e.g.: no medical change in six months, no hospitalization in the past

year, no ED visits in the last six months, no need for ongoing case management.) The planning team will work with key stakeholders to facilitate agreement on these significant cultural challenges.

Task 2.5: Approval to Proceed

The detailed plan will be presented by the Transformation Team to the CCO Board for review and comment.

Phase III: Implementation

The implementation process will be rolled out through the following phased activities: communication, provider and staff training, Member engagement, and program rollout.

Task 3.1: Communication

The focus of the communication plan is to ensure continuity of care and to make sure Members have access to their PCP, mental health provider, and medications as needed. AllCare CCO will develop an implementation communication plan and structure for informing providers, their staff, and Members about the integration plan and what it means to them. The communication plan will include a clear message as to why integration is needed, how it will impact providers, staff, Members and stakeholders, what is to be expected and when. It will include an information hotline to answer questions and to help Members (as well as providers) navigate their way through the new program alignments across the service area.

The communication plan will be developed by enlisting the help of community stakeholders and launched through a multi-media messaging strategy. Multi-media messaging will include a variety of channels such as direct mailings to CCO enrollees, special information meetings or webinars targeting providers and their staff, posters and brochures in waiting rooms, web site advertisements/announcements, messaging via CCO Committees and Councils, and other methods as new opportunities arise.

The Transformation Team, in collaboration with the AllCare Communications Director, will be responsible for developing and implementing the communication plan.

Task 3.2: Provider and Staff Training

The planning team, in collaboration with the AllCare Provider Relations manager, will develop an action plan for retraining, and repurposing existing staff while training new staff on the integration model, its policies, procedures, and work flows, and its communication structure for assuring appropriate and timely referrals, continuity of care, care coordination, data management, and cultural competencies. The training programs will be conveniently available via webinars, face to face coaching within clinics, policy and procedure manuals, information hotline, and website instructions. (Where feasible, staff training will be integrated with other workforce transformation initiatives described elsewhere in this plan.)

The training action plan will include: 1) clear timelines and schedules for rolling out the training courses, 2) identification of target personnel for each training session, and 3) follow-up to ensure registration and participation. The training will be rolled out prior to program implementation in order to minimize unnecessary disruption to patient/client access to care once the integration goes live. Due to the number of training topics at each practice site, the trainers will devise methods to incentivize staff participation in the training effort.

Task 3.3: Patient/Client Engagement

Member engagement will occur on two levels. On a broad scale, Members will be informed of the newly integrated program via the communication plan which is described in Task 3.1 above. A more directed engagement process will focus on the target population. This will occur through ongoing care planning, case management, care coordination, and outreach activities.

Each targeted Member who is currently involved in care coordination will be identified prior to program implementation and scheduled for a counseling session. The session will serve as a face to face opportunity to develop and/or revise each person's individualized care plan to reflect the integrated program processes and procedures, including introduction of new members of the care team. This session will involve care givers, physical health staff, mental health counselors, dental health, community supports and AllCare case managers.

Implementation of Member engagement activities will jump start program rollout, allowing patients and staff to incrementally incorporate program changes into their daily routine. Staff will be able to absorb their new responsibilities with Members with whom they have served for many years and who they have an existing client-provider relationship. This phased approach is part of our strategy to incrementally roll-out the integration plan.

New patients/clients with severe and persistent mental health conditions or addiction recovery needs will be referred directly into the integrated treatment program based on their initial health needs assessment that is required of all newly enrolled OHP beneficiaries. The new patients will be absorbed into the new program immediately, thereby bypassing the old delivery model.

Task 3.4: Program Roll-Out

As staff and enrollees adjust to the new integrated care coordination functions, other new work flows and program elements can be rolled out, such as:

- New scheduling, data sharing, assessment, treatment, labs, prevention, education, referral, and follow-up
- Cultural transformation to ensure physical health, mental health, addiction recovery, and dental health providers use standardized documentation requirements, flexible patient scheduling procedures, and other integration supports

- Communication structure for sharing information across the continuum of care, care planning, care coordination, data management, and data reporting for program evaluation and quality management
- Other elements of integration that arise as part of the planning, development, and implementation process

The Transformation Team will provide routine updates to the AllCare CCO Board regarding its implementation activities throughout the roll-out process.

Phase IV: Program Evaluation

The final phase of our Integration Plan is to evaluate the program pre-implementation, during implementation, and post-implementation. The planning team will identify a set of key indicators that will be tracked over time. Those indicators will reflect the goals and objectives of the initiative, including:

- Health status indicators (basic lab data)
- Emergency Room utilization
- Psychiatric admissions and lengths of stay
- Chart reviews to monitor consent forms, evidence of collaboration, prescriber history
- Satisfaction surveys for providers and patients/clients
- Costs

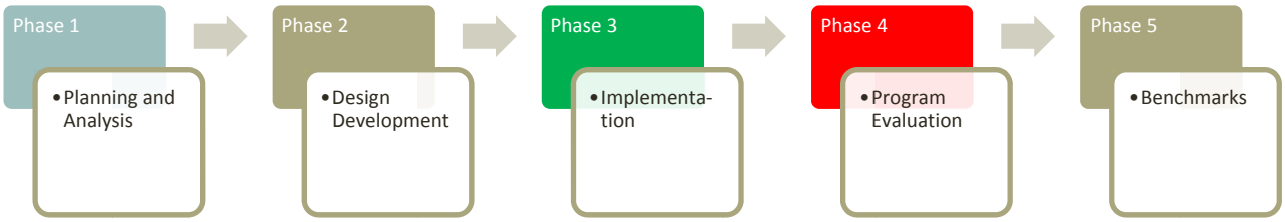
Baseline data will be collected as part of Phase I, Tasks 1.1 Inventory of Current Programs, Services, and Community Supports in each county and through Phase II Task 2.4 Financial Projections. The baseline data will serve as a yardstick to measure program performance and to identify areas for program improvement. The evaluation data will be collected, analyzed, compiled and presented by the planning team to the AllCare CCO for review and feedback.

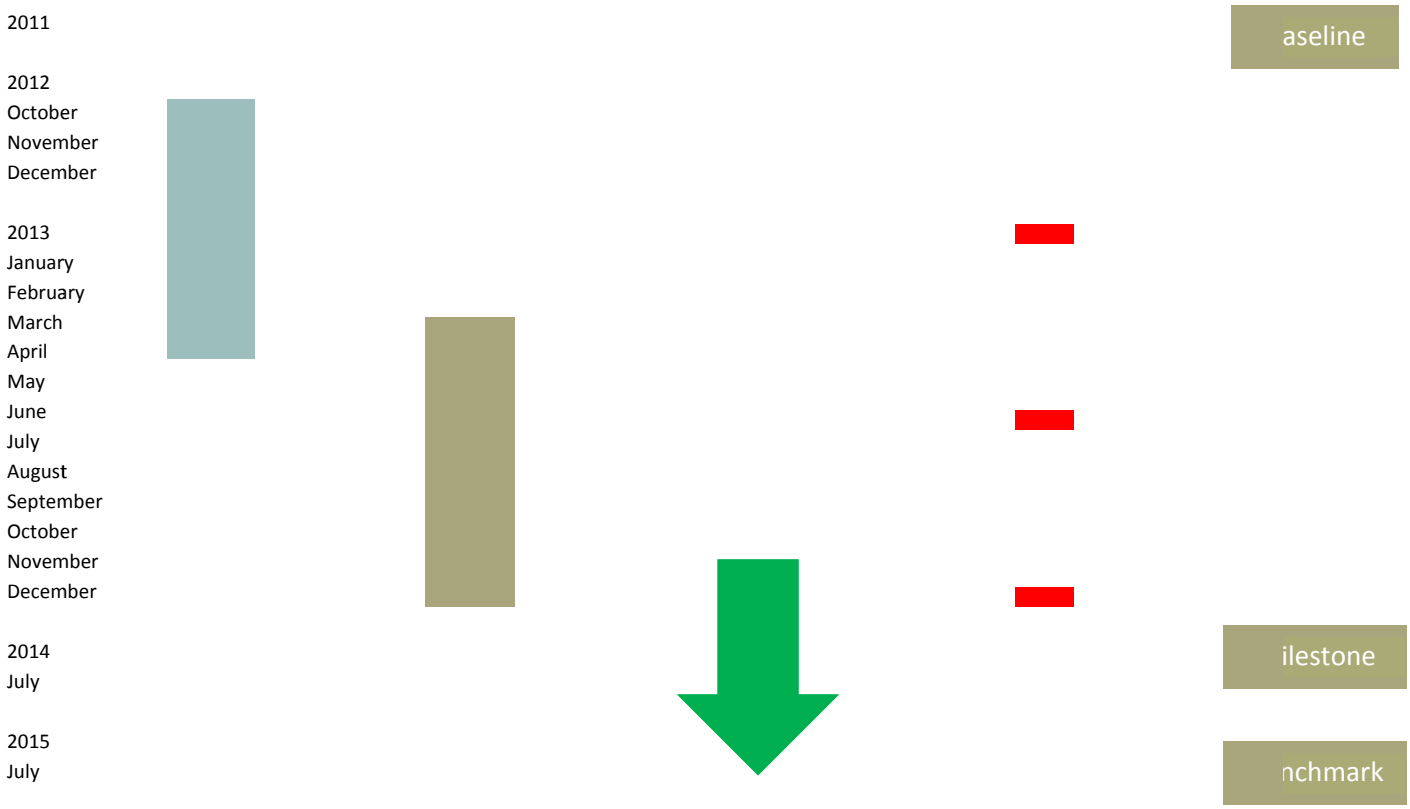
Phase V: Measurement Methodology

Benchmark 1	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.
How Benchmark will be measured (Baseline to July 1, 2015)	Utilizing our community mental health agency's data , identify the # 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.
Milestone(s) to be achieved as of July 1, 2014	10% improvement over baseline measurement.

Benchmark to be achieved as of July 1, 2015	20% improvement over baseline measurement.

Timelines





Domain 2:#

Continue implementation and development of Patient-Centered Primary Care Home (PCPCH)

Regulatory Requirements

OAR: 410-141-3160

Integration and Care Coordination

(3) CCOs must develop and use Patient Centered Primary Care Home (PCPCH) capacity by implementing a network of PCPCHs to the maximum extent feasible:

(a) PCPCHs should become the focal point of coordinated and integrated care, so that members have a consistent and stable relationship with a care team responsible for comprehensive care management;

(b) CCOs must develop mechanisms that encourage providers to communicate and coordinate care with the PCPCH in a timely manner, using electronic health information technology, where available;

(c) CCOs must engage other primary care provider (PCP) models to be the primary point of care and care management for members, where there is insufficient PCPCH capacity;

(d) CCOs must develop services and supports for primary care that are geographically located as close as possible to the member's residence and are, if available, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations. CCOs shall ensure that all other services and supports are provided as close to the member's residence as possible.

Program Goal##

Facilitate adoption of a Patient Centered Primary Care Home (PCPCH) model of care by all primary care providers and those across the continuum of care with whom they collaborate.

Objectives#

Our objectives for expanding adoption of the Patient Centered Primary Care Home model of care include the following:

- 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, and support each PCPCH in their efforts to adhere to state recognition measures.
- 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 across the service area.
- 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. (i.e.: Care Coordination Resources and Data Quality Improvement Center)
- 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 (including dental health, long term care, mental health, and addiction recovery services).
- Operationalize the health information exchange functionality for Greenway users as soon as possible. (Please refer to Domain #5 for a detailed description of our plan.)

Assumptions#

The Patient Centered Primary Care Home model of care is the core of AllCare CCO operations. It is assumed that the PCPCH implementation process will span 1-2 years and that over 75% (OHA goal) of all AllCare enrollees will be assigned a PCPCH to coordinate their care in our provider network.

In addition, AllCare continues to build upon its current strategy of on-line PCPCH transformation training, supported by hands-on coaching in a way that minimizes service disruption and ensures optimal access to needed primary care services. And finally, it is assumed that primary care practices that are recognized by the state as PCPCHs, will receive increased payments from the state on a continuous basis to compensate for their added care coordination and care management functions.

Resources

As of December 15, 2012, there were 27 practice sites in our three county service area recognized by the state as Patient Centered Primary Care Homes. Of these, 15 are located in Josephine County representing 63 primary care providers, 11 sites are located in Jackson County, representing 73 providers, and 1 practice in Curry County representing 3 providers. Approximately 82% of AllCare's Medicaid patients are assigned to a Patient Centered Primary Care Home in Josephine County and 56% are assigned across the three county service area.

AllCare is in the process of implementing a patient centered primary care home within one of our contracted mental health centers as a pilot project (described in Domain #1 to serve those with severe and persistent mental illness). In addition, we have an exhaustive plan under development to create a PCPCH care coordination and resource center that will assist our small practices with their care

coordination, care planning, and case management activities as well as provide support for health prevention and wellness programs.

AllCare also supports or sponsors numerous community programs in Josephine County that are typically staffed by what are now defined as community health workers. Many of these programs and sponsorships are in the process of expanding to Jackson and, where feasible, to Curry County, including:

- Living Well with Chronic Disease
- Babies in the Library
- Foster Child Outreach
- Goals of Care – Advanced Directive and POLST Project
- Happy Healthy Kids Day
- Immunization outreach
- Jog your Memory
- Josephine County Food Bank
- Josephine Community Library
- Maternity Outreach and Baby Bank
- Obesity Project (Pilot)
- Perinatal Task Force Project
- Recovery Fair
- Tobacco Cessation
- Walk-N-Rollers - weekly Walking Group

AllCare and its parent organization, Mid Rogue IPA, has long-established partnerships with community based programs, public health, mental health, addiction services, and dental services. We also maintain our own behavioral health network with 25 local mental health and addiction recovery specialists who participate on our care teams within the PCPCH model of care. Representatives from these organizations are members of our county-based Community Advisory Councils, Clinical Advisory Panel, and CCO Board of Directors.

Other resources available to support development and implementation of the patient centered primary care home model of care include our executive leadership team and staff as well as our Mid Rogue IPA Holding Company Board of Directors and its standing committees.

Approach

AllCare's approach to promote implementation of the Patient Centered Primary Care Home model of care is two-fold. The first approach is to assist our contracted providers to transition to this model of care. Targeted providers include primary care, women's health, mental health, and some medical specialties that sometimes function as primary care providers for those with chronic and/or complex conditions. We are achieving this through a combined effort of on-line training modules supported by hands-on practice coaches.

The second approach is to develop the AllCare "Care Coordination Resource and Quality Data Management Center" to support all our practice sites. The purpose of the Center is to collaborate with

our practice sites that do not have the resources or capacities to offer a full complement of patient centered primary care home and care coordination services, particularly as it relates to mental health and addiction recovery integration, lifestyle management, and multidisciplinary case management for Members with complex conditions including the dually eligible, frail, and vulnerable populations.

PCPCH Web-based Training: The Patient Centered Primary Care Home training is currently available to our contracted providers. It consists of four, one hour long modules with extensive supporting resources. Each module includes the Oregon State PCPCH measures along with training in the underlying functional concepts. The modules are:

1. Introduction to Patient Centered Primary Care Home
2. Improving Outcomes with Team Based Care & Population Management
3. Comprehensive Care Planning & Patient Experience Surveys
4. Care Coordination and Integration

This is a link to a video demonstration of the PCPCH training modules and resources:
www.CareSyncConsulting.com/MedicalHomeTrainingDemo.html

The modules and the training web site have extensive supporting documentation and tools that can be accessed through links within each training module. This includes:

- Waiting room surveys for patient self-screening
- Short Exacerbation Plans for patient teaching on five chronic diseases
- Preventive care patient teaching sheets
- Protocols and standing order sets
- Draft policies and procedures for the PCPCH Measures
- Self-management support toolkits
- Electronic flow sheets for clinical documentation and decision support

The training modules were predicated on two pilot test sites in late 2011 and early 2012. One involved a group practice with five physicians plus nurse practitioners and other patient supports. The other site was a sole provider. Both sites were the first to be recognized by the state of Oregon as Patient Centered Primary Care Homes and both achieved Tier 3 upon their initial application.

Care Coordination Resource and Quality Data Management Center: Our second approach to implement and expand the Patient Centered Primary Care Home model of care is to establish the Care Coordination Resource and Quality Data Management Center. The Center is currently under development and will be operationalized in early 2013. It consists of five care coordination teams, including:

- Utilization Management
- Care Coordination
- Clinical Integration
- Prevention and Wellness

- Quality Improvement and Data Management

Each team has responsibility for all or parts of AllCare's internal functions related to:

- Inpatient discharges and 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.
- Chronic conditions case management/disease management
- 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.

The clinical integration team focuses on coordination and integration between physical health, mental health, addiction recovery, and dental health on a pilot basis. This is a new program and continues to function in start-up mode. As full integration is achieved, this team will merge with the general care coordination team where all care coordination activities will be fully integrated. The clinical integration team is currently planning and developing the integration strategy outlined under Domain #1 on Physical Health, Mental Health, and Addiction Recovery service integration.

For purposes of creating the Care Coordination Resource and QI Data Management Center, AllCare has established the following functional definitions:

Care coordination involves arranging for transportation, meals, community supports, follow-up appointments for home health, Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST), and other transitions of care following an acute episodic event such as hospital stays as well as avoidable ER visits and improved access to primary care services. This team will include case managers, our Exceptional Needs Care Coordinators (ENCCs), and non-traditional staff, such as community health workers, patient navigators, long term care staff, and peer wellness specialists.

Case management involves development of comprehensive care plans for persons with chronic conditions. AllCare will focus on six major chronic diseases, including asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), depression, hypertension, and diabetes. Care teams will be established that, at a minimum, will include the Member, their care-giver, the PCPCH provider, and the nurse-case manager. Other supports will be added as needed, such as long term care staff, pharmacy and specialty providers. The nurse-case managers collaborate with the PCPCH team to develop an integrated care plan and are responsible for monitoring progress toward goals, medication adherence, and lifestyle changes to improve quality, independent living and longevity.

Multidisciplinary case management will address complex conditions that require a combination of case management functions and care coordination functions. Eligible Members are served by multi-disciplinary teams that focus on Members with specific chronic conditions and whose ability to manage their health is complicated by social determinants of health, health disparities, English as a second language or Low English Proficiencies, and trauma informed health. Criteria for determining the need for complex case management involve Members with high acuity health conditions, one or more chronic diseases, persistent and severe mental health or addiction issues, trauma, the dually eligible, and frail and vulnerable populations.

The following charts provide a high-level description and overview of our new functional plan for the Care Coordination Resources and QI Data Management Center. The functional activities of the new center include the following:

- Internal and external intake portals for care management
- Care management triage and case assignment criteria
- Inpatient transitions of care
- Intensive disease management for chronic conditions
- Multidisciplinary team case management for complex conditions
- Patient Centered Primary Care Homes support services
- Patient education and support services for appropriate health system access and navigation

Management of these new functions will be delegated to a new administrative position, tentatively titled the Chief Quality Officer (CQO) who will report to AllCare's Chief Executive Officer and participate as part of the AllCare CCO Executive Management Team. There will be manager/supervisory staff for each functional team who will report to the new CQO. The CQO will be responsible for external liaison communication with our contracted network of providers in support of multi-disciplinary team care and care coordination across care settings.

Functional Plan: Intake Portals for Care Management

Care Management Team	External Intake Portals	Internal Intake Portals
Utilization Management Team (UM)	Members will be referred to UM or identified by UM through regular reports from Hospitals, Skilled Nursing Facilities, and prior authorization requests from providers	
Care Coordination Team (CC)	Referrals will originate from Providers (PCPs, PCPCH), Emergency Room Utilization Reports, HotSpot Reports, Community Health Agencies, Public Health, Members, and Care Givers	Internal referrals will be identified by the QI Data Management Team through claims analysis and encounter data, Initial Health Risk Assessment surveys, Member Services, Enrollment, Executive

		Leadership, and UM referral
Clinical Integration Team (CCI)	Referrals will be generated by Mental Health and Addiction Recovery providers, PCPs, PCPCH, and specialists, hospitals, external agencies (such as police, schools, child welfare), DHS, residential housing, state mental health hospital, Members and Care Givers In addition, referrals will occur through the Maternal and Infant Care PIP that is currently under development at the Women's Health Center in Josephine County and in the future in Jackson and Curry Counties.	Same as the Care Coordination Team
Prevention and Wellness Team	Referrals will be made by Primary Care Homes, PCPs, PCPCHs, and specialists, community agencies, Members, Care Givers	QI Data Management Team, Clinical Integration Team, Care Coordination Team, Member Services (stable Members only), and the Initial Health Risk Assessment survey
QI Data Management Team	Hospital ER Reports, Hospital Discharge Reports, Pharmacy Benefits Manager Data, State and National Benchmarking data, state-generated enrollment/demographic data on race, ethnicity, and language, community health needs assessment data, clinic data on patient demographics	Claims data, encounter data, health risk assessment data

Functional Plan: Care Management Triage and Case Assignment Criteria

Care Management Team	Triage Criteria
Utilization Management Team	All Inpatient admissions will be reviewed by UM nurses prior to discharge Referral criteria for care coordination include: • Specific diagnoses (to be determined) • Disability (to be defined) • Older adults with complicating issues (to be defined) • Pharmaceutical management for high cost medications

	• Frailty • Cost (to be defined) • Care Giver Needs • Presence of Social Determinants of Health • Known Safety Issues are indicated at discharge site
Care Coordination Team	Basic • Members with 3 or more ER visits in last 12 months for any reason or acuity • Members with an ER visit for dental conditions = auto referral for care coordination with DCO • Members referred by UM nurses based on discharge criteria • Health Risk Assessment survey results with acuity score of 4 or 5 • Claims/encounter data indicate presence of chronic medical conditions • Claims/encounter data indicate risk for chronic medical conditions • Claims/encounter data indicate over or under-utilization of the PCP or PCPCH • Essette acuity scale indicates need • Patient self identifies his/her needs • Provider identifies Member needs • Care Giver identifies Member needs Complex Conditions • High acuity patients whose conditions are complicated by social determinants of health, health disparities, cultural needs, and/or Low English Proficiencies or ESL and who also have: • An acute event (stroke, heart attack, trauma) • Multiple chronic conditions
Clinical Integration Team	Basic • Any member with 3 or more ER visits in last 12 months for any reason or acuity due to mental health MH) and/or addiction (AD) conditions and/or co-morbidities • Members referred by UM nurses based on discharge criteria • Health Risk Assessment survey results with acuity score of 4 or 5 due to mental health and addiction with or without co-morbidities • Claims/encounter data indicating MH/AD risk • Expectant mother has MH/AD needs • Essette acuity scale indicates MH/AD need • Patient identifies MH/AD needs • Provider identified MH/AD needs • Care Giver refers due to MH/AD needs

	Complex Conditions • High acuity MH/AD patients whose conditions are complicated by social determinants of health, health disparities, cultural needs, and/or Low English Proficiencies or ESL and who also have: • Trauma informed diagnoses • Multiple chronic health conditions
Prevention and Wellness Team	• 100% of New Members with Health Risk Assessment scores of 1 or 2 for on-going screening and prevention services • 100% of patients who smoke • 100% of patients with obesity as measured by BMI • 100% of patients with memory loss issues • Internal CC or CI referrals of stable patients

Functional Plan: Inpatient Transitions of Care

Care Team	Functional Responsibilities
Utilization Management	Prior to Discharge, UM staff will initiate care planning processes that include: • Reconcile medications to the outpatient formulary • Order home services, PT, OT, and Durable Medical Equipment (DME) as needed • Follow-up with PCP on clinical care plan to be implemented upon discharge • Document in Essette (AllCare CCOs case management software) • Refer to Care Coordination or Clinical Integration Team for care management • Ensure data and care plan information is effectively transitioned to receiving case manager and/or the receiving facility when indicated (Please refer to the AllCare original CCO application for certification and the readiness review submittals for a detailed description of this process.)
Care Coordination Team	Implement care coordination process for physical health that includes the following functional activities: • Verify/confirm that medications, devices, and home health/therapies were obtained and scheduled as ordered • Develop care coordination plan and integrate with discharge treatment plan • Schedule PCP/PCPCH follow-up and arrange transportation • Schedule other provider follow-up as needed and arrange transportation • Ensure member and care giver understand discharge instructions and/or integrated treatment and care plan • Review Signs and Symptoms Report

	• Utilize long term care services to ensure meals are provided, safety issues are addressed, and in-home services (if eligible) are scheduled • Document in Essette • Monitor progress toward discharge goals or care plan goals • Revise care plan as needed • Once stable, refer to Prevention and Wellness team to address lifestyle management issues as indicated.
Clinical Integration Team	Implement care coordination process for mental health and/or addiction recovery: • Verify/confirm that medications, devices, and home health/therapies were obtained and scheduled as ordered • Develop care coordination plan and integrate with discharge treatment plan • Schedule PCP/PCPCH and/or MH/AD follow-up and arrange transportation • Schedule other provider follow-up as needed and arrange transportation • Ensure member and care giver understand discharge instructions and/or integrated treatment and care plan • Review Signs and Symptoms (s/s) report • Utilize long term care services to ensure meals are provided, safety issues are addressed, and in-home services (if eligible) are scheduled • Document in Essette • Monitor progress toward discharge goals • Revise care plan as needed • Once stable, refer to Prevention and Wellness team to address lifestyle management issues as indicated.
Prevention and Wellness Team	• Ensure that all Members who are stable post discharge receive information on prevention and wellness programs • Encourage enrollment in Prevention and Wellness programs • Arrange for transportation as needed • Monitor Member progress toward meeting lifestyle management goals • Document in Essette • Refer to CC or CI care team if health status declines
QI and Data Management Team	• Collect, compile, and analyze data from internal and external sources • Monitor staff compliance with roles and responsibility via Essette audit • Evaluate overall program effectiveness based on number of readmissions, preventable readmissions, avoidable ER visits • Report results monthly • Celebrate successes • Recommend program improvements to management as needed

Functional Plan: Intensive Disease Management for Chronic Conditions

Care Team	Functional Responsibilities
Utilization Management	• Ensure that the lowest cost and most effective levels of care are provided • Make appropriate referrals to care coordination and care integration teams
Care Coordination Team	Implement evidence based chronic care management plans for Members with: • Asthma • Congestive Heart Failure • COPD • Diabetes • Hypertension Case Workers: • Establish multidisciplinary care team, including the Member, care giver, PCP and specialty consults as needed • Develop disease management plan in collaboration with PCP/PCPCH and Member using evidence based clinical protocols • Identify health disparities and integrate remedies into care plan • Schedule regular follow-up appointments with PCP/PCPCH and/or specialty consults • Ensure Member gets to scheduled appointments • Monitor medication adherence • Coach Member on progress toward care planning goals • Monitor progress • Revise goals as needed • Document progress in Essette
Clinical Integration Team	Implement evidence based chronic care management plans for Members with: • Depression (including minor depressive episodes, suicidal ideations, suicide attempts) • Anxiety and somatic signs and symptoms • Severe and persistent mental health condition(s) • Opiate Addictions for expectant mothers • Narcotic Abstinence Syndrome for babies born to addicted mothers Case Workers: • Establish multidisciplinary care team, including the Member, care giver, PCP/PCPCH, MH/AD Counselor and specialty consults as needed • Identify health disparities and integrate solutions into the care plan

	• Develop disease management plan in collaboration with PCP, MH/AD Counselor, Member, care giver, and peer supports • Schedule regular follow-up appointments with PCP/PCPCH and/or specialty consults • Ensure Member gets to the appointments • Monitor medication adherence • Coach Member on progress toward care planning goals • Monitor progress • Revise goals as needed • Document progress in Essette
Prevention and Wellness Team	Implement evidence based chronic care management plans/programs for Members in need of : • Weight Loss/Management • Smoking cessation • Immunizations • Preventive Medicine
QI and Data Management Team	Develop and monitor population based registries that target: • Asthma • CHF • COPD • Diabetes • Depression • Anxiety • Hypertension • Severe and Persistent Mental Health Conditions • Addicted mothers and infants • Obesity • Smoking • Health Disparities Communicate registry data routinely with AllCare staff, PCPs/PCPCHs, Mental Health and Addiction Recovery for care management determinations

Functional Plan: Multidisciplinary Team Case Management for Complex Conditions

Care Team	Functional Responsibilities
Utilization Management	• Same as for Transitions of Care • End of life planning/advanced directives/POLST forms
Care Coordination Team	Same process as described under Chronic Conditions, and add: • End of life planning/advanced directives/POLST forms • Medication reconciliation • DME if needed • Arrange for home care or hospice as needed • Address home safety issues • Engage Long Term Care providers as needed • Arrange for community programs, including racial, ethnic, and language supports as needed • Monitor health status and progress • Document in Essette • Revise care plan and care team as indicated • Ensure basic and timely health screening
Clinical Integration Team	Same process as described under Chronic Conditions, and add: • End of life planning/advanced directives/POLST forms • Medication reconciliation • DME if needed • Arrange for home care or hospice as needed • Address home safety issues • Engage Long Term Care providers as needed • Arrange for community programs, including racial, ethnic, and language supports as needed • Monitor health status and progress • Document in Essette • Revise care plan and care team as indicated • Ensure basic and timely health screenings
Prevention and Wellness Team	• NA
QI and Data Management Team	• Collect, compile, and analyze Essette data • Monitor staff compliance with roles and responsibility • Evaluate overall program effectiveness based on number of readmissions, preventable readmissions, avoidable ER visits • Report results monthly • Celebrate successes • Recommend program improvements as needed

Functional Plan: Collaboration and Coordination with Primary Care Providers

Care Team	Functional Responsibilities
Utilization Management	• Auto-approve a limited number of behavioral health visits in response to PCP/PCPCH request to evaluate Member needs • Assist provider to determine if Member qualifies for referral to Care Coordination Team, Clinical Integration Team, or Prevention and Wellness Team
Care Coordination Team	Functional support for small and/or rural practices: • Provide intensive disease management services for specific medical conditions • Define chronic conditions based on Health Plan designated diagnostic codes for use by PCPCH to determine need for CC/CI • Provide special attention to frail elderly and dually eligible with a focus on medication adherence, home safety, community supports, and transportation • Communicate with PCP/PCPCH on their Members' ER utilization, hospital and skilled nursing facility (SNF) admissions, discharges, and transitions of care • Embed care management workers and/or non-traditional community workers into practice sites on a regular basis to ensure services are available close to Member's home
Clinical Integration Team	• Provide or arrange to provide access to mental health and addiction recovery supports in collaboration with the PCPCH and PCP • Customize the integration model based on local resources within the practice and surrounding community • Embed MH and/or AD workers into local practice sites on a regular basis
Prevention and Wellness Team	• Support Members' lifestyle change management through education, training, coaching, and peer supports • Focus on population management improvement programs to address identified health disparities. • Coordinate follow-up appointments for routine preventive screening
QI and Data Management Team	• Develop and maintain profiles on provider needs and preferences, specialty referral patterns, and common/basic Member needs that require AllCare collaboration and coordination.

	• Create and maintain centralized data bank that includes o Lists of local community programs and supports o Contact trees that identify local volunteers with special cultural, ethnic, racial, linguistic, or LGBT expertise • Develop and communicate Member registries that identify at risk patients within each provider's practice. • Assist with quality improvement efforts through Community Health Needs Assessment (CHNA), Community Health Improvement Plan (CHIP, Benchmarking, and Performance Improvement Plans (PIPs) at the local level.

Functional Plan: Member education and support services for appropriate health system access and navigation

These functional activities are designed to identify Members who are using the health system inappropriately and engage them in more optimal management of their health. This involves Members who use emergency room services for dental health (whether emergent or not), non-urgent medical conditions, drug seeking activities, preventable after-hours care, inappropriate use of specialists for primary care, chronic conditions poorly controlled, and other activities that are not contributing to the triple aim. Functional supports include:

- Member education on health system access and navigation
- Patient Centered Primary Care Home assignment and engagement
- Member engagement in end of life planning, advanced directives, and POLST forms
- Care coordination to address barriers to care, health disparities, and low English proficiency (LEP) and/or English as a second language (ESL)
- Referral to public health, Department of Health Services case workers/Long Term Care providers, or community programs
- Referral to care coordination for ongoing monitoring and redirection
- Referrals to dental health providers

Identified Members will be referred to the Prevention and Wellness services for assistance with maternal and infant care, obesity, smoking, immunizations, physical fitness, general health education and other lifestyle management needs. For unmet mental health needs and/or addiction recovery, Members will be referred to the Clinical Integration Team. And all other Members will be served by the Care Coordination team.

To assist Members at the point of service, case managers will float between emergency departments and primary care home practice sites to help with health system navigation and triage, similar to the

project currently underway with Providence Medical Group in Medford. Non-traditional health care workers will be engaged to assist with patient education and coaching on health system utilization and Long Term Care/DHS staff will be included as needed. Dental providers will have access to electronic medical records systems or provider portals to improve quality, patient safety, and health outcomes.

In general, care management staff will develop individualized care plans that address PCP access issues, transportation, and other barriers to care such as social determinants of health (e.g.: English as a second language, low English proficiency, low income, housing, meals, health education, health equities, and health disparities.) Staff will be empowered and encouraged to include flexible services within the care plans as well as innovative and creative solutions that address each Member's needs. Staff will monitor Member response to new healthcare and health system expectations, coach as needed, and communicate positive feedback as Members exhibit appropriate health system interactions.

Implementation Requirements#

Planning and development of the new functional plan is underway and will continue through 2013. This includes the following activities:

1. Establish criteria and definitions for determining who needs a care plan
    a. Inpatient transitions of care and preventable readmissions
    b. Avoidable ER visits at all acuity levels
    c. Frail and vulnerable populations
    d. Complex conditions by diagnoses
    e. Social determinants of health
    f. Health disparities and benchmarks
    g. Access barriers
2. Define staff roles and responsibilities based on licensure and certification
    a. Match current staff skills to defined staff roles and responsibilities as described in the new functional plan
    b. Identify gaps in staff expertise
    c. Assess need for retraining and/or recruitment
    d. Work with human resources to recruit new staff and retrain/repurpose current staff
    e. Utilize when feasible existing stakeholder staff such as public health, gospel mission, and similar symbiotic relationships across care settings
3. Assess need to revise and refine documentation structure within the Essette software to support new purposes and eliminate old and inefficient functionality
4. Create decision trees that assist staff in determining when to refer Members to the Prevention and Wellness Team, close case management files, and transition case management to maintenance mode
    a. Define maintenance mode and closure criteria
    b. Train staff on use of the decision trees
    c. Create on-line capability that can be monitored
5. Define flexible benefits criteria

   a. Empower staff to be creative
   b. Set reasonable cost limits for activities that do not require prior authorization
   c. Set up a mechanism to easily fund flexible benefits and to monitor staff activities (e.g.: Pay-Pal)
6. Ensure that ER and admission data are documented in Essette on a daily basis.
7. Define:
   a. High acuity
   b. Normal health
   c. Conditions for chronic disease management and complex patient care
8. Create staff training curriculum and support manuals
   a. Require all staff to complete the PCPCH and Care Coordination on-line training program
   b. Develop descriptions of each core teams' roles and responsibilities
      i. Hold all staff accountable for understanding each teams' roles and responsibilities
      ii. Regularly revisit team descriptions and revise as programs and services change
   c. Develop basic description of each health plans' benefits, coverage limitations, and exclusions for staff reference and hold staff accountable for knowing this information and/or how to easily access it.
   d. Develop list of acronyms and their meanings
   e. Require staff to undergo cultural diversity training via the Centers for Medicare and Medicaid Services (CMS) and the Oregon Health Authority (OHA) web based training (Refer to Domain #7 for greater detail)
      i. Use existing registration mechanism within the PCPCH web-based training modules to measure and monitor compliance
      ii. Incorporate pre and post-test assessment to measure degree of understanding
      iii. Routinely revisit training to maintain skills
   f. Resurrect the acuity criteria and train staff on their meaning and functionality in case triage
9. Engage Human Resources to revise job descriptions to reflect new functional plan.

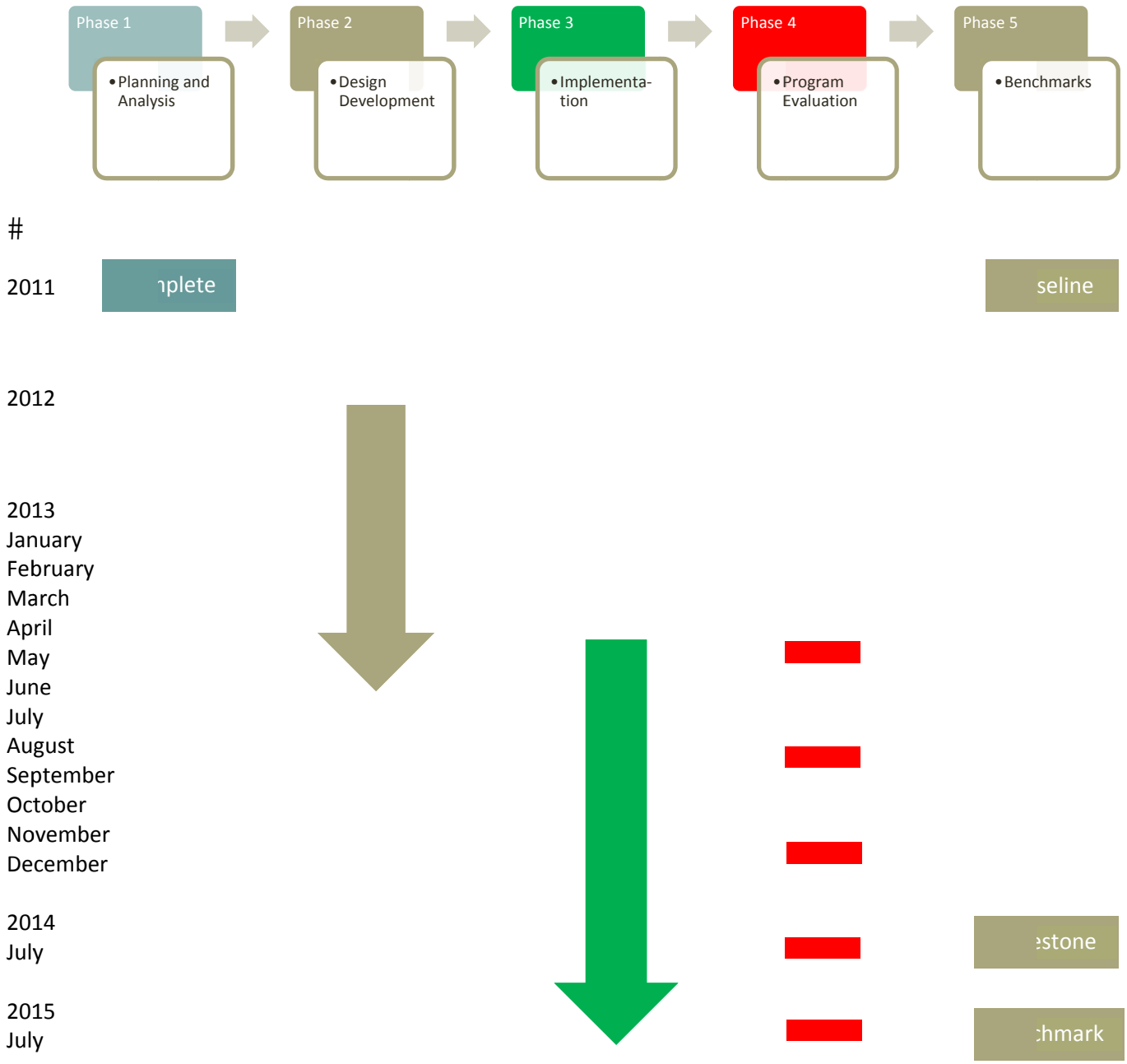
Implementation will occur as planning and development activities are completed and staff is ready for training. This will likely begin in late February or early March, 2013 and is scheduled to be completed and fully operational by July 1, 2013. Staff training will expand to other AllCare internal departments to ensure that all staff who have Member contact and care coordination referral functions understands the new functional plan and operating model in a way that emphasizes our guiding principle of "no wrong door" in accessing needed services and supports.

As the new functional plan is operationalized within AllCare CCO, additional provider training modules will be developed supplemented by hands on coaching at practice sites. This will ensure that our contracted providers understand how best to refer their patients for care coordination and it will define expectations, roles, and responsibilities for all members of the care management team. The provider training modules will be available for use during 2013.

Measurement Methodology

Benchmark 2	Increase the # of AllCare members enrolled in recognized PCPCH's.
How Benchmark will be measured (Baseline to July 1, 2015)	# 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.
Milestone to be achieved as of July 1, 2014	60% of AllCare Members in our three-county service area 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	70% of AllCare Members in our three-county service area are assigned to a PCPCH with at least one PCPCH visit and an 8% reduction in ED utilization over baseline.

Timelines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Domain 3:#

Implement consistent alternative payment methodologies that align payment with health outcomes.

Regulatory Requirements

OAR: 410-141-3015

Certification Criteria for Coordinated Care Organizations

(3) Applicants must describe their demonstrated experience and capacity for:

(d) Developing and implementing alternative payment methodologies that are based on health care quality and improved health outcomes;

(25) CCOs are encouraged to use alternative payment methodologies, consistent with ORS 414.653. The applicant must describe its plan to move toward and begin to implement alternative payment methods alone or in combination with delivery system changes to achieve better care, controlled costs and better health for members.

Program Goal##

It is AllCare's goal 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.

Objectives#

AllCare's objectives for provider payment methodologies build upon current efforts that compensate providers for minimizing unnecessary or avoidable emergency room visits, preventing avoidable hospital inpatient stays, preventing avoidable readmissions through care coordination, and ensuring that medications are reconciled post discharge per our formulary. In addition, our goals going forward 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.

Assumptions#

AllCare assumes that Medicaid funding will continue to decline in Oregon and that everyone will need to do more with less. It is also assumed that many providers within the CCO network will experience significant changes in how they deliver care and how they are remunerated in the future. It is also assumed that this is an evolving process and that payment methodologies will shift as new care delivery models are implemented, care becomes more integrated, and data sharing becomes the norm.

We recognize, however, that the demographics of the communities we serve do not allow substantial experimentation of alternative payment schemes. Much of our service area population is low income. A significantly high percentage of the population is eligible for Medicare and Medicaid. Both federal and state health care programs are highly regulated and limit our ability to test new ideas without adversely impacting long term financial sustainability of the organization. A small mistake could seriously affect solvency and/or erode capital reserve requirements set by the state. Our approach, therefore, is very conservative, measured, and practical.

Resources

Resources available to complete this plan include guidance provided through 1) the Oregon Health Authority, 2) research available through the Center for Healthcare Quality and Payment Reform, the Health Care Incentives Improvement Institute, and the Patient-Centered Primary Care Collaborative, and 3) lessons learned through demonstration projects funded by the Centers for Medicare and Medicaid Services (CMS).

The AllCare Executive Leadership team will be responsible for developing alternative payment methodologies that align with health outcomes. Those methodologies will be guided by input from the

AllCare Board of Directors (and its Provider Payment Task Force), the Clinical Advisory Panel on clinical issues, and legal counsel for contracting issues.

Approach

There are six basic types of payment reform and each has multiple permutations as to how the payments are actually configured and tied to various health outcomes and quality measures:

1. Fee for Service is the traditional reimbursement scheme that pays providers for delivering medically necessary health care. Most payers are moving away from this type of payment due to its inherent incentive to provide care that is not needed, is duplicative, or where lower cost and equally effective options are ignored.
2. Pay for Performance is a fee-for-service payment model that withholds a portion of claims paid and redistributes the withhold based on quality indicators;
3. Shared Savings is based on the fee-for-service payment model that evaluates payments made over the prior 2-3 years and sets cost-saving targets for the ensuing year. If providers meet or exceed those targets, they then share in a portion of the savings. Typically, distribution of savings across multiple medical groups or individual providers is tied to quality measures and outcomes.
4. Bundling involves paying the "care team" (hospital, providers, ancillaries) a single payment for each type of episode of care (e.g.: cardiac arrest, stroke, hip replacement) and it is up to the members of that care team to distribute the bundled payment fairly and equitably;
5. Medical home is a model of care that focuses on keeping patients healthy through prevention, early intervention, and care coordination across care settings. Typically, providers are paid extra for the additional activities and functions related to care management, data/utilization management, and population health.
6. Capitation is a payment scheme that focuses on managing the health of a population of patients assigned to each provider or medical group practice. The provider receives a monthly payment for each enrollee and is tasked with, or at risk for, maintaining the health of that population within the payment limits.

Our Current Model: Our approach builds upon what is already in place or in the process of being implemented. Recent payment changes for our contracted hospitals include transition from discount fee-for-service payment methodologies to a case rate using Diagnostic Related Groupings (DRG) bundled payments for inpatient services and a case rate using Ambulatory Payment Classifications (APCs) for hospital-based outpatient services.

AllCare pays its shareholders in Josephine County on a full risk basis as well as our Alcohol and Drug Rehabilitation providers in Josephine and Jackson Counties. It recently moved all mental health providers to a capitated global budget payment model.

AllCare currently pays fee for service for some primary care and many medical and specialty care services and monitors appropriateness of services delivered through vigorous prior authorization

processes and utilization management. However, AllCare recently implemented specific targets for reducing utilization of healthcare services that are provided outside of clinical practice sites. This includes targets designed to reduce non-urgent emergency room visits, ambulatory care sensitive hospitalizations, and use of high-tech diagnostic imaging when less costly procedures are equally effective.

Quarterly reports indicate substantial reduction in unnecessary ER visits and the associated costs. For example, AllCare has experienced a 21% decrease in the number of emergency room claims paid between Q3 2011 and Q3 2012. In 2010, the rate was 48.5 claims per 1000 Members and by the third quarter of 2012 it was 38.1 claims per 1000 Members. In the future, higher acuity ER visits will be reduced through better care coordination within the primary care home model of care.

There has also been a significant decline in readmissions. In the first quarter of 2010, 7% of all payments for hospital services were due to readmissions. By the third quarter 2012, the rate was only 4%.

AllCare recently began gathering and sharing data through use of a 14 point dashboard to monitor physician performance. Those measures may eventually be tied to payment incentives as trend data is developed over time and opportunities for personal performance improvement are verified.

In addition, AllCare has been an early promoter of the patient centered primary care home model (PCPCH) of care and, at this time, 82% of all Medicaid patients enrolled in AllCare have a patient centered primary care home assigned to manage their care in Josephine County. AllCare has also been an early promoter of electronic health records (EHR) and currently 84% of all primary care providers in Josephine County use EHRs and 56% of providers across the three county service area use EHRs. This is the highest EHR adoption percentage in the state.

Our future plan is to do the following:

1. 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.
2. Monitor the effectiveness of payment schemes used by other CCOs. If such schemes demonstrate high quality outcomes at reduced costs and continue to meet the OHA main principles of equity, accountability, simplicity, transparency, and affordability, then AllCare will evaluate the potential impact within our service area. We will also explore the feasibility of new payment models through pilot demonstration projects prior to full implementation.
3. Educate our contracted providers on new payment models that are currently used in the state and across the nation in similarly configured geographic and demographic areas. Our purpose is to ensure that our provider community thoroughly understands payment reform and accepts that new payment models are designed to create a more equitable and accountable health system for all provider types as well as payers and patients.

Specific payment schemes under consideration include but are not limited to:

- AllCare is exploring the use of provider withholds that will be dispersed based on health outcomes
- AllCare may apply bundled payments to hospitals and hospitalists rather than make separate payments. This may also apply to small providers/hospitals in geographies where there is insufficient capacity to meet the needs of the population or, conversely, in areas where there are manpower shortages.
- AllCare may explore inclusion of contractual warranties that eliminate hospital and/or provider payment for preventable or avoidable post-discharge complications and readmissions.
- AllCare may pay primary care practices a care management fee that is tied to utilization, performance incentives and quality measures. In lieu of referring Members to AllCare's Care Coordination Resources and Quality Data Management Center for case management, AllCare may pay its providers to perform these additional functions within their own clinics.

Any transitional payment reform needs to manage risk while ensuring quality, accountability and equity across the provider network. AllCare is considering payment methodologies that limit provider financial risk associated with unusually expensive patients or to adjust for costs that the provider cannot control. There are four methods that are under consideration at this time:

- Condition/Severity Adjustments that would pay a provider different amounts depending on the type and severity of the Member's health condition;
- Outlier Payments and Adjustments that would pay a provider more when the cost of caring for the Member exceeds a defined threshold, or will participate with the provider to determine appropriate levels of accountability and outcomes measurement related to the total cost or quality of care when certain conditions are met;
- Risk Corridors that limit the extent to which the cost of actual service delivery for a group of patients far exceeds the payment typically allocated for defined conditions, services, and procedures; and
- Exclusions and Risk-Sharing arrangements that exclude the costs of services provided by certain outside providers from payments or having two providers accept accountability (and the associated payment) for different portions of the total costs of caring for a group of patients.

Implementation Metrics: As incentives to control cost are introduced into payment methodologies, AllCare will ensure that quality of patient care continues to improve, particularly reduction in health disparities and increase in prevention/wellness services. This will require that quality measures and quality incentives be integrated into the payment model(s). Our plan is to collaborate with our providers to build upon current provider profile report to develop incentives designed to improve quality, eliminate disparities, and reduce practice variation in the delivery of similar services. Individual provider measures currently profiled include:

- PCPCH Status by Tier

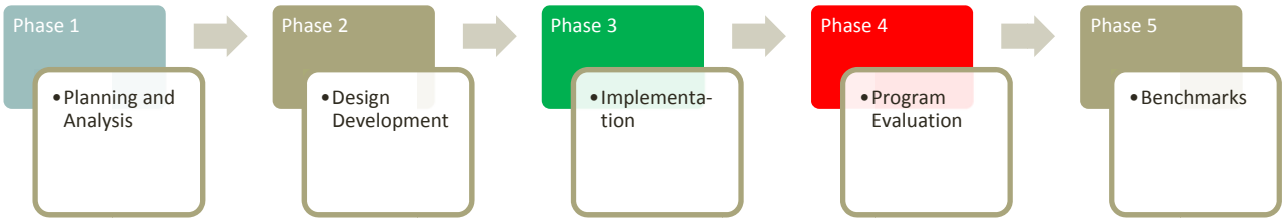
- OHP Member months
- Average Member Risk Factor
- ER Claims Paid on Members
- Inpatient Claims Paid
- Outpatient Claims Paid
- Pharmacy Claims Paid
- Capitated Member Months
- Capitation Per Member Per Month
- Claims Paid to Provider
- RVU Performed outside Capitation
- Utilization: Evaluation and Maintenance Encounters
- Utilization: CT, Lab, MRI, PT, Prevention
- Utilization: ER Visits
- Number of Denials
- Number of Complaints

Measurement Methodology:

Benchmark 3	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 recogonizing care delivered in a PCP setting leads to better health outcomes and avoidable transitions of care.
How Benchmark will be measured (Baseline to July 1, 2015)	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.
Milestone to be achieved as of 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 as of July 1, 2015	12% increase in the rate of PCP visits/1000 with resulting ED cost saving to be shared with PCP/PCPCH.

Our measurement methodology for Domain #3 reflects our overarching principle of the triple aim: better health for the population, better care for each individual, at lower costs. As we focus on cost reduction through appropriate utilization of emergency services, we are ensuring that our Members receive the right care, in the right location, by the right provider which, in turn, allows our providers to better coordinate patient care and improve outcomes over time. It is our intention to reward providers' efforts through a shared savings program.

Timelines



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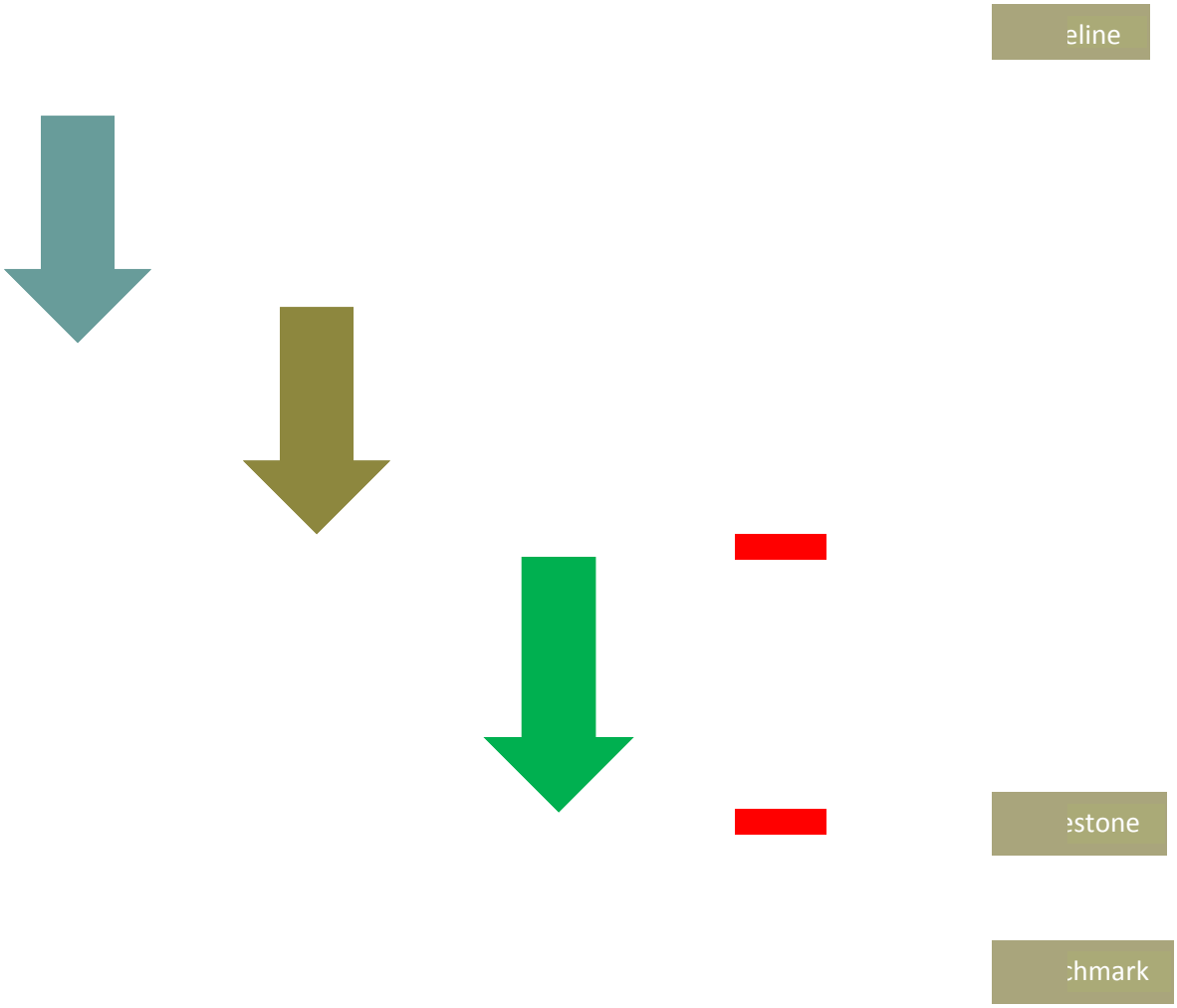

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Domain 4:#

Complete a Community Health Assessment and Community Health Improvement Plan

Regulatory Requirements

OAR: 410-141-3145

Community Health Assessment and Community Health Improvement Plans

(1) CCOs must partner with their local public health authority, local mental health authority and hospital systems to develop a shared community health assessment process, including conducting the assessment and development of the resulting community health improvement plan (plan).

(2) CCOs must work with the Authority, to identify the components of the community health assessment. CCOs are encouraged to partner with their local public health authority, hospital system, type B Area Agency on Aging, APD field office and local mental health authority, using existing resources when available and avoiding duplication where practicable.

(3) In developing and maintaining a health assessment, CCOs must meaningfully and systematically engage representatives of critical populations and community stakeholders to create a plan for addressing community health needs that build on community resources and skills and emphasizes innovation including but not limited to the following:

(a) Emphasis on disproportionate, unmet, health-related need;

(b) Emphasis on primary prevention;

(c) Building a seamless continuum of care;

(d) Building community capacity;

(e) Emphasis on collaborative governance of community benefit.

(4) The CCO requirements for conducting a community health assessment and community health improvement plan will be met for purposes of this law if they substantially meet the community health needs assessment requirement of the federal Patient Protection and Affordable Care Act, 2010 Section 9007 and the community health assessment and community health improvement plan requirements for local health departments of the Public Health Accreditation Board, and worked with AAA and local mental health authority.

(5) The CCO's Community Advisory Council shall oversee the community health assessment and adopt a plan to serve as a strategic population health and health care system service plan for the community served by the CCO. The Council shall annually publish a report on the progress of the Plan.

(6) The plan adopted by the Council must describe the scope of the activities, services and responsibilities that the CCO shall consider upon implementation. The activities, services and responsibilities defined in the plan may include, but are not limited to:

(a) Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;

(b) Health policy;

(c) System design;

(d) Outcome and quality improvement;

(e) Integration of service delivery; and

(f) Workforce development.

Program Goal##

The goal 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 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.

Objectives#

Our objectives are to:

- 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.

Purpose#

The purpose of a community health needs assessment is to involve the community in examining local data and gaining local perspectives about health needs. It includes information and lessons learned from past assessments, identifies current and emerging health problems or issues, and makes recommendations for future health planning and investment. The expected outcome is development of a comprehensive document that illustrates health needs and service gaps across our service area and elevates our most pressing health needs to be addressed each year. The Community Health Improvement Plan will document the rationale for choosing those health needs and specifying a plan of action to address those needs.

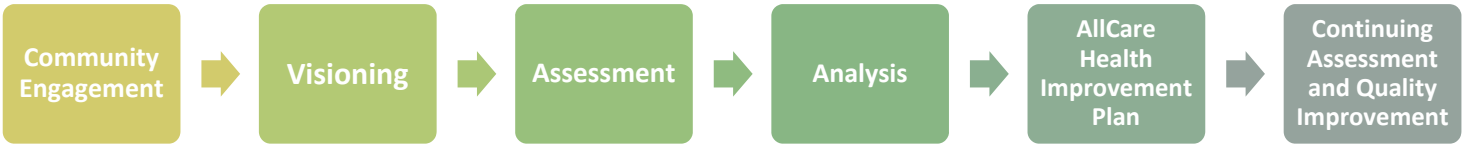
Resources#

The Community Health Needs Assessment builds upon existing data prepared by hospitals, mental health agencies, public health agencies, and national publications such as Healthy People 2020 and census data. We also rely on state reports such as

- County Health Rankings prepared by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute
- Health Indicators Warehouse by the National Center for Health Statistics
- Community Health Status Indicators report prepared by the Oregon's Department of Human Services (DHS), providing information for improving Community Health
- DHS and Oregon Health Authority (OHA) county fact sheets
- Oregon County Demographic Base Statistics, including insurance rates by region and federal poverty data
- County level information on chronic disease and related risk factors from the Behavior Risk Factor Surveillance System (BRFFS)
- Developmental disabilities report for Oregon
- Fact Sheet on the dually eligible in Oregon
- Reports on Long Term Care supports and services for the aged and disabled

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:



Phase I: Community Engagement

According to HB3650 and HB 1580, AllCare CCO is responsible for improving the health of the communities we serve. AllCare has activated three Community Advisory Councils (CAC), one in each county in our service area. Their main responsibility is to provide guidance and input on the Community Health Needs Assessment (CHNA) and the AllCare Community Health Improvement Plan (CHIP). Members of each CAC include representation of public health, mental health, addiction recovery services, providers, community supports, and Members.

In Jackson and Josephine Counties, AllCare is collaborating with other CCOs, local public health departments, and Community Mental Health Programs to develop a Community Health Needs Assessment. In December, 2012, the collaborative collectively engaged a consultant to launch the community health needs assessment process. In early 2013, the consultant will:

- Complete a meta-analysis of existing health needs assessment documents to compile current quality metrics now collected and used by health care organizations
- Analyze current health status trends based on known quality data and metrics
- Determine gaps in data and quality metrics needed to meet the Oregon Health Authority baseline quality metrics and individual entities' community health improvement plans
- Develop a recommended process to collect additional data required for the health needs assessment.

Nine entities are involved in this collaboration, including Asante Health System, Providence Medford Medical Center, Jackson County Public Health, Josephine County Public Health, Options for Southern Oregon (Community Mental Health agency for Josephine County), Jackson County Mental Health, Jackson Care Connect CCO, Primary Health of Josephine County CCO, and AllCare CCO. Our planning process will be transparent to the public and the results will be available for public review. It is anticipated that the meta-analysis will be complete in March, 2013.

Curry County has embarked on an alternative approach that reflects the local public health department's decision to seek state designation/recognition which has an accelerated timeline. This process requires implementation of the MAPP process (Mobilizing for Action Through Planning and

Partnership.) The Curry County Public Health Department, in collaboration with the AllCare Community Advisory Committee, is being assisted with this process by Oregon Health Sciences University faculty.

Phase II: Visioning

The AllCare Transformation Team will create a broad definition and description of what constitutes healthy communities for Southwest Oregon. This will serve as the vision to be used by the Community Advisory Committees as they evaluate the assessment data, identify community health needs in their respective county, and make recommendations on AllCare CCO's community health improvement initiatives. The vision will likely address prevention and wellness, healthy lifestyles, public health needs, mental health and addiction recovery/prevention, dental health, health literacy, environmental health, health policy and social determinants of health.

Phase III: Assessment

There are three components to the needs assessment. One involves a robust quantitative evaluation of current health status within the communities we serve. This will provide baseline data that will assist in identifying areas for performance improvement across care settings for specific population groups, and chronic conditions. AllCare Health Plan has created an initial draft needs assessment based on current community assessment reports prepared by Asante Health System, local public health authorities and state reports. This assessment is provided as an appendix to this plan and is titled: "Initial Review, Documentation, and Summary of Existing Hospital and Public Health Plans." Development of new quantitative information will be completed in collaboration with other local CCOs.

The second component is a qualitative evaluation of people's perceptions about their health system, their own health, and the social determinants of health within each of our counties. This information will be collected through surveys and focus groups with our Members, community support program representatives, and local health policy stakeholders. This is currently in progress in collaboration with other local CCOs.

The third component involves an environmental scan. The environmental scan is a systematic way to explore and interpret external social and economic intelligence and emerging trends that impact our health system. This provides a better understanding of the nature of what is driving change within our health care system and the context for assessing the potential impact that change may have on AllCare CCO Members. The environmental scan will address the social determinants of health and will be completed in collaboration with other local CCOs, health departments, mental health programs, and will embrace other stakeholders such as schools, government, employers, and welfare agencies.

Taken together, the three components provide detailed data, evaluation, and assessment for creating an informed Health Improvement Plan that outlines a roadmap to improve the health of our Members

and the communities they live in. It also lays the foundation and offers a framework to continuously assess our health system and identify future quality improvement needs.

Upon completion, the data assessment will establish a comprehensive and descriptive profile of public and private resources, capacities, and metrics needed to support ongoing community health assessment activities and population health improvement priorities. This information will serve as the yardstick against which we will measure progress toward goals over time.

There are three key areas of focus for the data assessment. Some of these datasets have been collated or are partially collated within the Initial Review submitted as part of our Readiness Assessment in summer, 2012. Some have not been addressed at all. The following provides a status update of the current data collection and assessment process.

Status Update of Current Data Assessment

Key Area of Focus	Topics	Data Requirements	Status
1. Quantitative Review	A. Health Statistics and Demographics	1. Demographics 2. Health Status 3. Quality of Life 4. Behavior Risk Indicators 5. Chronic Diseases	Complete Complete Complete Complete Complete
	B. Subpopulations Health Status	C. Racial and Ethnic Communities D. Tribal Members E. Older Adults F. People with Disabilities G. LGBT Populations H. Uninsured/Underinsured	Partially Complete Partially Complete Partially Complete Incomplete Incomplete Partially Complete
2. Qualitative Review	C. Community Perceptions	1. Community Perceptions of Health and Quality of Life 2. Knowledge of Community Resources and Assets 3. Social Determinants of Health	Incomplete Incomplete Incomplete
	D. Public Health Collaborations	1. Current Collaborations 2. Use of Nationally Recognized Performance Standards	Partial Incomplete
2. Environmental Scan	E. Emerging Trends	1. Process for conducting an environmental scan 2. Documentation	Incomplete Incomplete

The current data assessment is “in-process” and requires additional time and resources to complete as described below:

1. Quantitative Review: Our Initial Review focused on Health Statistics and Demographics which is complete and documented in Appendix A. The Initial Review needs to be expanded to address the needs of our subpopulations, including people with disabilities, LGBT groups (lesbian, gay, bisexual, and transsexual), racial and ethnic communities, tribal members, and the uninsured. Very little information is currently known about their health status, requiring that foundational datasets be established that will allow us to measure and monitor the health of these subpopulations over time.

Due to the small numbers within the subpopulations, AllCare CCO plans to collaborate with other CCOs to collectively address these needs. AllCare recommends the following process:

- Establish a CCO collaborative to address the health status of subpopulations
- Have the collaborative prepare a baseline data collection instrument or a set of questions that can be part of each CCO's initial health needs assessment required of all new OHP enrollees.
- Develop a set of common measures to be collected by PCPs that will tag encounter data to identify and monitor the health status of subpopulations over time.
- Routinely collect data from PCPs on those measures
- Report on each CCO for their internal health improvement plan
- Identify any disparities compared to the general populations
- Identify variations in acuity across CCOs, indicating adverse selection
- Report on all CCOs in the service area to monitor overall health status for each subpopulation

(This information will also be used to address Domains 6, 7, and 8 of AllCare CCO's aggregate Transformation Plan.)

The local CCO collaborative work group will identify recommended solutions to collectively improve health status for subpopulations and report those recommendations to each CCO Community Advisory Committee (CAC). It will be the responsibility of the AllCare CACs, the CAP, and the Transformation Team to evaluate those recommendations and create a specific set recommendations for the AllCare CCO Board. The AllCare Board will be responsible for endorsing the final content of the AllCare Community Improvement Plan.

2. Qualitative Review:

AllCare's Initial Review included citations from a report prepared by Asante Health Services that addressed community perceptions of Health and Quality of Life. That report was based on focus groups and surveys among residents of Josephine and Jackson Counties and will serve as a significant resource for our qualitative review. In addition, Curry County statistics were also collected but aggregated into a larger secondary service area for the Asante Community Health Needs Assessment. Asante has offered the disaggregated data on Curry County as part of our qualitative data collection and analysis for the CHNA.

A second part of the Qualitative Review is to prepare an inventory of community resources and assets. The inventory will cover physical health, mental health, dental health, addiction recovery, and community based services. The inventory will be completed by AllCare staff in collaboration with other CCOs in all three counties.

Data collection on the "Social Determinants of Health" is also incomplete. This encompasses the health policy and social initiatives that a community might collectively embrace to improve the health of the entire population. The Community Advisory Council in each county will provide input and feedback regarding:

1) Health policy and social initiatives that could make a difference in local communities
2) Health improvement priorities
3) Resources necessary to meet the top priorities
4) Action plans and timelines to pursue the initiatives
5) Public/private partnerships to achieve those goals

We will likely rely on partnerships with local business, local government, religious affiliates, and other community-based organizations to accomplish these objectives. Please refer to the Initial Review (attached as an Appendix to this document) for an expanded explanation of potential health policy and social initiatives that could be undertaken by the CACs.

3. Environmental Scan: The environmental scan is a systematic way to explore and interpret external social and economic intelligence and emerging trends to better understand the nature of what is driving change within our health care system. It also provides a descriptive context for assessing the potential impact that change may have on AllCare CCO. There are essentially three phases for completing the environmental scan:

- Develop an environmental scan approach. This will define the breadth and depth of the analysis and will determine how broad the scope will be, how deep the analysis will go, and how far ahead in the future we want to look. This includes identification of who should participate in the scan.
- Scan the environment. This may involve a variety of methods and approaches including literature searches on emerging trends, focus groups to gather local customer perspectives, interviews with stakeholders, and surveys.
- Analyze the data. This involves an assessment of "what does it all mean" for AllCare CCO and its stakeholders.

The healthcare environmental scan for AllCare CCO will address the following areas of focus. This will likely reflect an accumulation of data from research, surveys, and interviews.

Environmental Scan Areas of Focus:

1: Describe the political and health policy environment for the state of Oregon and Southwest Oregon for 2013 – 2015

2: Quantify the projected demographics for the service area (including generational differences and subpopulation disparities) and describe how those trends will likely impact the need for health care programs and services over the next three years

3: Describe the future economic environment and the implications that this will have for future demand for health services and the provision of funding to meet that demand.

4: Describe how we might do business differently over the next five years, such as increased use of technology (e.g.: tele-health for 24/7 diagnostics and treatment, peer group consults, non-traditional workers) to meet patient needs.

5: Describe the future health care delivery system in Southwest Oregon as it relates to:

- Global budgets and the ability to fully integrate clinically, financially, and administratively
- Hospital systems, particularly ongoing market pressures to reduce costs, reduce unnecessary ER visits and readmissions, and decrease costs overall
- Health care workforce issues that will be impacted by increased demand due to aging, potential manpower shortages, and pressure to increase labor costs
- Technology, particularly the impact of accelerating Electronic Health Record adoption, the State Health Insurance Exchange and regional/local Health Information Exchange.
- Physician shortages in primary care and surpluses in other specialties
- Health coverage and the emergence of new delivery models and benefit packages that may complement or contradict the CCO model of care
- Access to coverage via health insurance exchanges and the health care mandate for currently uninsured people – who will play and who will opt out and how should AllCare respond
- Market consolidations among 1) health plans, 2) hospital systems, and 3)provider groups
- Risk sharing and incentivizing providers to do the right thing
- Competitive landscape among CCOs in Southwest Oregon

6: Patient engagement in their health and quality of life goals through care coordination and the patient centered primary care home

7: Wild cards – identify emerging trends that might impact AllCare CCO both positively and negatively; what solutions are there to minimize the negatives and exploit the positives

8: Power of community cooperation to address local health care needs versus respect for individual preferences

9: Description of what all this means for AllCare CCO and the communities we serve

Phase IV: Data Analysis

While data collection and compilation is an important activity when performing a Community Health Needs Assessment, it only goes so far. Equally important is accurately interpreting what the data mean for decision-makers who are charged with improving the health system. Data interpretation is imperative to answer strategic questions such as the following:

- Are there disparities or inequities in receiving health services among distinct population groups based on where people live, income, age, sex, sexual orientation, culture, or race? If so, why?
- What is the root cause of the disparities or inequities? Is it due to manpower shortages, transportation, health literacy, English as a second language, cultural barriers, financial barriers, homelessness, religion, mental health, addictions, discrimination, or other barriers to care? What can we do to reduce or mitigate the root causes?
- Are there specific physical or mental health conditions and chronic diseases where local incidence rates are materially higher or lower than statewide and national norms? If so, what are those conditions and why are the rates not meeting expectations? What can we do to improve incidence rates over time?
- Is the local economic, social, educational, and political environment contributing to health care disparities and inequalities, longevity, and quality of life for specific population groups? If so, how can we engage in a community-wide discussion on solutions?
- Are there manpower shortages within the health system and across care settings? If so, where are the shortages? What types of health professionals are needed most? What is the root cause of the shortages? What patients/clients are most severely impacted by the shortages? How can we work together to reduce the shortages over time and where should we focus our efforts in the near term?
- What behavioral risk factors are prevalent across the service area (e.g.: tobacco use, obesity, alcohol use, diet and exercise, teen births, suicide, etc.) and what are the implications for our health system and the health status of our beneficiaries?
- What are we doing in the area of wellness and prevention to keep people healthy? Do our efforts appear to be having a positive impact on quality outcomes, reduced morbidity and mortality, and reduced cost? If so, how can we expand on our successes? If not, what more can we do?
- Do we have any control over the social determinants of health, such as health policy, jobs, quality schools, and public safety? If so, what can we do to minimize the social impacts that contribute to poor health outcomes and maximize the ones that have a positive impact on health status of our enrollees?
- Is the configuration of our health services and community supports meeting the needs of our enrollees? Are there sufficient resources to enhance longevity and quality of life? What more can we as a health plan do to strengthen local resources and supports?

These are the types of strategic questions that AllCare CCO and the CACs need to answer before we can establish its Community Health Improvement Plan priorities. To accomplish this, the Transformation Team will analyze data collected during the Assessment Phase, summarize the findings and conclusions in a way that informs AllCare's executive team and its three CACs of the strategic, operational, and clinical imperatives currently facing providers and beneficiaries in each county. We will perform additional evaluation to identify root causes for serious gaps and lapses in the local health system. And we will complete a literature search to identify lessons learned in other health systems and describe the options available to address local needs.

AllCare executive management will establish criteria for setting priorities and evaluating options as a means to achieve the overriding vision of the local health system. The criteria will address financial measures such as capital requirements, return of investment, and cost reduction potential. The criteria will also address benefits such as potential impact on population health, elimination of health disparities, increase in health manpower, and/or improvement in individual health for targeted subpopulations.

Based on the criteria, the Transformation Team, in collaboration with the CACs, will evaluate and compare options and set their priorities. The priorities will be presented to the Community Advisory Council in each county for review, feedback, and recommendation to proceed. The priorities for each county may differ year to year depending on local needs.

The assessment, analysis, findings, conclusions, and recommended strategic initiatives for each county will be documented and communicated to key stakeholders, including the CACs, Clinical Advisory Panel, CCO Board of Directors, and the Holding Company's Board of Directors.

Phase V: Completion of the Community Health Improvement Plan

The AllCare Community Health Improvement Plan (CHIP) will guide internal decisions around improving population health and the health care system for the communities served in Southwest Oregon. The purpose of the Plan is to realize the overarching goals of health system transformation, including better health, better care and lower cost. The CHIP will include the following information and supporting documentation in its initial plan:

1. Executive Summary and Vision
2. Identification of Stakeholders Involved in the Planning Process
3. Description of the Planning Process and Analytic Approach
4. Description of the Service Area
    a. Demographics
    b. Public and Private Resources, Capacities, and Infrastructure
    c. Network Adequacy and Workforce Development
    d. System Design and Service Integration
    e. Quality and Outcome Health Status Indicators
    f. Health Disparities
5. Environmental Scan and Emerging Health Care Trends

   a. Health Policy
   b. Social Determinants of Health
   c. Emerging Trends
6. Identification and Evaluation of Health System Needs
7. Recommended Health Improvement Priorities, Health Indicators, and Benchmarks
   a. Near Term 1-3 Years
   b. Longer Term 4-6 Years
8. Business Justification of Community Health Improvement Priorities
   a. Goals, Objectives, and Strategic Initiatives
   b. Methods to Achieve Goals, Objectives, and Strategic Initiatives
   c. Budget and Other Resource Requirements
   d. Cost/Benefit Analysis and ROI
   e. Clinical Implications for Community Health Improvements on:
      i. Data and Utilization
      ii. Stakeholder Budgets
      iii. Access and Service Location
      iv. Provider Network and Contracting
      v. Community Partnerships
      vi. Cultural Competency and Health Equity
9. Implementation Requirements and Timelines
   a. Project Leadership
   b. Timelines
   c. Milestones

Phase VI: Ongoing Evaluation and Assessment Process, Milestones, and Timelines

The AllCare Community Health Needs Assessment and Improvement Plan will be completed no less than every three years with annual progress updates. The progress updates will describe the scope of activities undertaken that year, progress made toward achieving identified goals, objectives, and performance measures, and a description of the progress made on health indicators as defined in the community health improvement plan. Where needed, the annual progress updates will include revised action plans to keep focused on successful achievement of desired results.

The future planning process will continually monitor local health care trends, including:

- Annual county public health plans
- Annual county mental health plans and independent auditors reports
- Hospital community needs assessments required every three years
- Statewide health improvement initiatives
- Health policy trends
- Local OHA quality measures and surveys
- AllCare specific quality measures and surveys

This will also include continuous monitoring of AllCare external reporting requirements, including National Institute for Mental Health, Substance Abuse and Mental Health Services Administration (SAMHSA), Agency on Healthcare Research and Quality (AHRQ), HEDIS, CAHPS, and CHIPRA, state program and policy initiatives, as well as national trade associations such as the American Medical Association, the American Hospital Association, the Primary Care Medical Home Collaborative and others. Over time, AllCare will work towards developing more granular data on our local health system, including greater emphasis on community perceptions of their health status and the local health system, evaluation of how well public health, mental health, and physical health partners are collaborating to achieve AllCare goals and objectives as defined in AllCare's Community Health Improvement Plan, and provider surveys that collect perspectives on how our services and programs can better meet their needs and those of the Members they serve on our behalf.

This information will be compiled and summarized annually and presented to our standing stakeholder committees, including the AllCare CCO Board of Directors, the Community Advisory Committees, the Clinical Advisory Panel, and the Mid Rogue Holding Company Board of Directors. Summary information will be available to the public and our enrollees via web based communication portals as well as annual brochures that describe our ongoing efforts to improve individual health outcomes, promote population health, and reduce costs.

Measurement Methodology

Benchmark 4	Completion of a Community Health Improvement Plan(CHIP) for Josephine, Jackson and Curry counties.
How Benchmark will be measured (Baseline to July 1, 2015)	Through collabration with community partners, stakeholders and other CCOs serving the region developing the Community Health Needs Aassessment and Community Health Improvement Plan.
Milestone to be achieved as of July 1, 2014	Submission of completed Community Health Improvement Plan for Josephine, Jackson and Curry counties.
Benchmark to be achieved as of July 1, 2015	Define strategies to implement CHIP and update as appropriate.

Timelines

Major Milestones	2013				2014				2015	
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
1. Complete the Meta-Analysis for Baseline Measures										
2. Complete Qualitative and Quantitative Assessments										
3. Complete Environmental Scan Assessment										
4. Analyze Data and Root Causes										
5. Complete Community Health Needs Assessment										
6. Establish AllCare CCO Health Improvement Priorities										
7. Document/ShareHealth Improvement Plan										
8. Prepare Status Updates										
9. Analyze Milestone and Benchmark Metrics										

Domain 5:
Develop electronic health records; health information exchange; and meaningful use.

Regulatory Requirements

OAR: 410-141-3180

Record Keeping and Use of Health Information Technology

(6) CCOs shall facilitate the adoption and use of electronic health records (EHRs) by its provider network. To achieve advanced EHR adoption, CCOs shall:

(a) Identify EHR adoption rates; rates may be divided by provider type and geographic region;

(b) Develop and implement strategies to increase adoption rates of certified EHRs;

(c) Encourage EHR adoption.

(7) CCOs shall facilitate the adoption and use of electronic health information exchange (HIE) in a way that allows all participating providers to exchange a member's health, behavioral health, and dental health information with any other provider in that CCO.

(8) CCOs shall establish minimum requirements for HIE, including rates of e-prescribing and electronic lab orders, over time.

Program Goal

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.

Objectives

Our objectives are to:

- 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.)

Assumptions

AllCare CCO will build upon current regional and state efforts to establish health information exchanges. We will also avail ourselves to external grant funding and/or other donations to achieve our objectives. And we recognize that some practices and programs will not adopt electronic health records or other supporting technologies and that alternative processes and procedures will need to be in place to adequately achieve our Health Information Technology (HIT) goals and objectives.

Resources

At this time, 69% of Jackson County's 71 providers involved in O-HITEC have electronic health record systems. Similarly, 84% of Josephine County providers and 50% of Curry County providers use electronic medical records. Asante Health System, Providence Medford Medical Center, and Sutter Coast Hospital have, or are in the process of implementing, EPIC as their electronic health record system. Designed primarily for hospitals and large group practices, EPIC will interface with AllCare's preferred vendor, Greenway Medical Technologies EHR software (PrimeSuite) for sharing continuity of care documentation between the hospitals and provider practices. Greenway is one of two EMR software vendors that target small and medium sized provider practices that have been selected by EPIC for system-wide interfaces between practice sites and hospitals.

While a high percentage of provider practices have electronic health record systems, there is little or no commonality among large medical groups in vendor software selection, except in Josephine county where 90% of those using an EMR, use Greenway Medical Technologies which is supported by AllCare's business associate, Mid Rogue eHealth Services as an application service provider. In Jackson County, fourteen different vender systems are in use and four different venders are used in Curry County.

AllCare is currently collaborating with Asante Health System, Providence Medford Medical Center, PrimeCare IPA, and Sky Lakes (Klamath Falls) to develop a regional health information exchange and a financially sustainable funding model for local HIE. Secure email messaging is scheduled for deployment in summer 2013 and the full HIE system (using Medicity software) will be rolled out over the ensuing two years.

As an interim solution for health information exchange, AllCare is in the process of upgrading Greenway EMR users by implementing PrimeDataCloud. This is an advanced care coordination and business analytics software upgrade for PrimeSuite. The upgrade will improve delivery of quality, cost-effective care within PrimeSuite practices as well as across the entire healthcare community. It supports secure information sharing needed for care coordination and provides real-time access to patient clinical data across provider sites. The upgrade promotes quality care through improved access to patient data as well as clinical support and convenient messaging capabilities that communicate between Greenway sites and it has the capability of data sharing with other EMR software users if they elect to connect to PrimeDataCloud.

PrimeDataCloud supports many of the Oregon Health Authority's goals and objectives for CCO health information technology. For example:

1) Spread of interoperability: The Care Coordination function allows for real time access to a single aggregated patient data view from all visits across participating practices. This supports development of a longitudinal Continuity of Care Document. This is a living document that expands as additional services, procedures, medications, and/or devices are ordered and delivered. Potential users include providers and their clinical staff, hospital clinical staff and discharge planners, care coordinators, and community health workers.

2) Early Intervention and Follow-up: The care coordination function also supports labor and delivery services where hospital staff can securely access a patient's maternity records, including prenatal patient flow sheets, lab work, and ante-partum summaries. Targeted users are Labor and Delivery Nurses and care planning staff for postpartum follow-up with the obstetrician and other members of the mother and baby's care team. This software upgrade will greatly improve our ability for early identification and intervention for these potentially high cost and extremely compromised mothers and infants.

3) Patient Engagement: There is also a "community document viewing" capability that supports full coordination of care across the local healthcare community by enabling access to a patient's

signed, saved, and registered documents from every provider, community supports, and AllCare Members and their care givers. This will support patient education and help Members participate in their care planning and management of their health.

4) Data Analytics: The Healthcare Analytics function is a business intelligence utility that provides a complete platform for clinical reporting and shared services, including metadata and content repository, report management, security integration, interactivity, and scheduling. It provides mission-critical insight and supports various reporting needs at a practice or community level. Targeted users include clinic staff, Mid Rogue eHealth staff, and independent auditors.

5) The Quality of Care functions include:

    a. Meaningful Use (MU) through a dashboard that arrays data from multiple practices and creates a composite report for tracking MU standards and measures. This allows monitoring of MU data capture and measurement of quality improvement outcomes across care settings.
    b. Physician Quality and Reporting System (PQRS) and e-Prescribing offers a simple opt-in process for measure selection and reporting. The measures are aggregated and sent by Greenway's qualified CMS Registry. This meets national standards for ePrescribing, ordering and results reporting.
    c. Clinical Decision Support provides an interactive and rules-based clinical alert function that supports improved patient analysis, diagnosis, and care planning. This functionality expands our ability to promote standardized evidence based clinical protocols across our network of contracted providers.
    d. Direct secure messaging services will be available for sending messages to a single practice site or to the entire PrimeSuite community from a central access point in the PrimeDataCloud. Targeted users are practitioners and their clinical staff, care coordinators, community health workers, and Mid Rogue eHealth Staff.

Approach

AllCare CCO's predecessor organization has been a leader in health information technology through its promotion of electronic health record systems and health information exchange since 2007. As demonstrated above, we continue to lead in this effort. However, there remain a number of HIT initiatives that will strengthen health system transformation. Over the next three years, we plan 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.
6. Find the means by which to financially sustain development, expansion, and maintenance of HIT infrastructure necessary to achieve CCO goals and objectives.

Phase 1: Planning

Task 1.1 Continuation of Current Efforts: Mid Rogue eHealth Services and AllCare will continue working with the CCO Board of Directors and the Clinical Advisory Panel to promote adoption of EMRs, Meaningful Use, and HIE among all health care providers as well as mental health, addiction recovery, dental health, public health and community programs. This includes directing eligible organizations to the Compass Project where they can access free EMRs as well as the associated training and interoperability. (The Compass Project is supported by the State of Oregon and is free to eligible EMR users.)

We will continue our ongoing efforts to monitor EMR adoption rates and current provider compliance with CMS meaningful use standards for Stage 1 and in the future Stages 2 and 3.

We will also continue to collaborate with the Jefferson Health Information Exchange to build infrastructure, develop a sustainable financial model, and work towards integration of the healthcare enterprise through harmonization of HIE standards. This includes communication of our PrimeDataCloud capabilities as an interim solution for all of our contracted practices regardless of EMR vendor.

Phase 2: Development

2.1 Exploration of New HIT Initiatives: New HIT initiatives emerge on a regular basis. As a leader in local health information technology, AllCare plans to explore how new technologies or new applications of existing technologies might improve access, enhance quality outcomes, and reduce costs. Specifically, AllCare will focus on Member engagement through technology and tele-health, including:

Patient Portals: AllCare will explore the feasibility of system-wide endorsement of patient portals within existing electronic health record systems. We will evaluate the extent of 1) provider support, 2) member support, and 3) operations and maintenance costs to assess the feasibility of broader application across our service area.

Smart Phone Applications: Mobile devices now support many health related applications that allow people to monitor their vital signs, blood sugar levels, blood pressure, and other important health risk indicators. Applications also support ePrescribing, results reporting, and other forms of secure communication. AllCare will evaluate current applications, test the most promising on a pilot basis, and if effective, endorse/encourage Members to include such applications within their care plans and to share their personal information with their primary care home provider and their care manager. This could serve as an educational tool and as a means for Members to identify changes in health status for early intervention and follow-up.

Task 2.2 Telehealth: Four new developments have elevated tele-health as an effective mode of care and as a means to expand access within our medically underserved communities:

1) Hand-held mobile devices support a wide range of communication technologies that make it easier for Members and their providers to communicate, whether that involves tele-health technologies, web-based meetings, emailing or texting anytime and anywhere;
2) The cost of deploying telemedicine has substantially decreased;
3) New payment models have eliminated artificial barriers to care that once required face-to-face appointments to receive payments; and
4) The proliferation of evidence-based clinical protocols has reduced the risk once associated with alternative modes of care.

Over the next three years, AllCare will explore the feasibility of tele-health options to evaluate its impact on access, quality, and cost. If feasible, we will move forward with development and implementation of infrastructure, policies, and procedures for proliferation of telemedicine opportunities across care settings.

Phase 3: Implementation

Task 3.1 Education: Member and provider education will be important for implementing any of our current HIT initiatives as well as any future endeavors. AllCare will develop and deploy an education program that encourages adoption of health information technology among Members and our network of contracted providers and community supports. The education will be supported by training on best practices and incorporated into other patient education, care planning, and care coordination efforts.

Task 3.2 Security: AllCare's information technology staff and our business associate (Mid Rogue eHealth Services) will ensure that all HIT deployments meet all security and confidentiality policies and procedures promulgated by AllCare as well as state and federal law.

Phase 4: Program Evaluation

AllCare will continue to monitor its network of contracted providers and its Members to ensure that technology is meeting the overarching goals of better health, better quality, and lower costs. We will also monitor the impact technology has on timely access to quality health care.

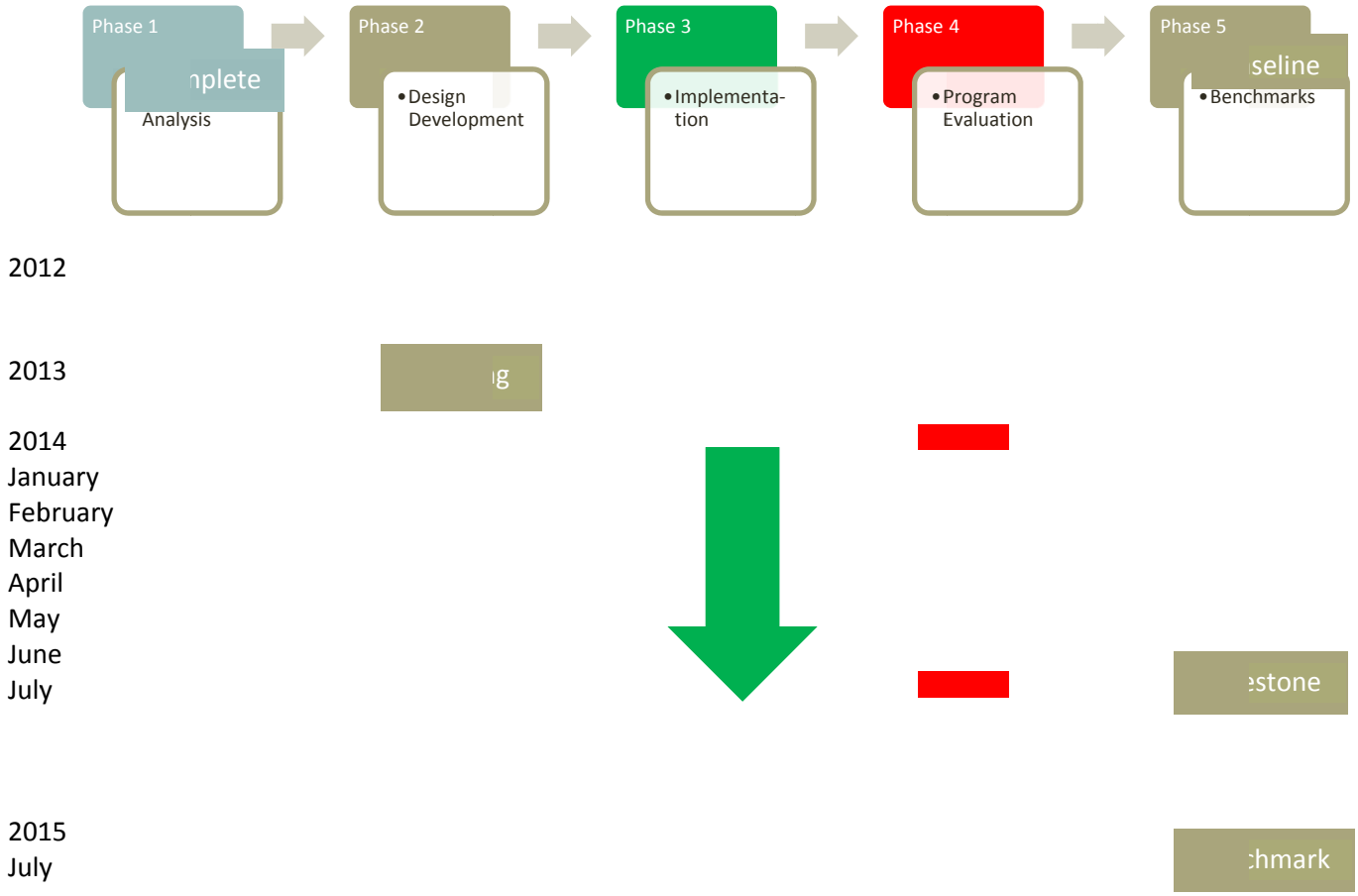
Phase 5: Measurement Methodology

Benchmark 5	% 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.
How Benchmark will be measured (Baseline to July 1, 2015)	Utilizing reports generated by the Greenway EHR systems track data exchange transactions for 2013.
Milestone to be achieved as of July 1, 2014	10% increase of eligible Greenway EHR users sharing data across care settings as measurecd by the number of data exchange transactions per provider compared to baseline.
Benchmark to be achieved as of 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.

Our measurement methodology for Domain #5 targets health information exchange to reduce costly duplication of diagnostic and treatment services while improving access to patient information across care settings which has been shown to improve quality outcomes. Over 80% of our contracted providers in Josephine County use the Greenway software for their electronic medical record system. This software functionally supports health information exchange for Greenway users and we are encouraging users to take advantage of this functionality until such time as regional or statewide HIE systems are in place.

AllCare CCO is willing 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. Our administrative staff is available for interviews with OHA's consultant and will participate as needed in stakeholder workgroups if requested by the OHA. Should the outcome of the statewide effort change the focus and intent of our transformation plan for Domain #5, AllCare CCO will update the plan to better align with statewide HIE initiatives.

Timelines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Domain 6:
Assure communications, outreach, Member engagement, and services are tailored to cultural, health literacy, and linguistic needs

Regulatory Requirements

OAR: 410-141-3220: Accessibility

(9) CCOs shall develop policies and procedures for communicating with, and providing care to members who have difficulty communicating due to a medical condition or who are living in a household where there is no adult available to communicate in English or where there is no telephone:

(a) The policies and procedures shall provide certified or qualified interpreter services by phone, in person, in CCO administrative offices, especially those of member services and complaint and grievance representatives and in emergency rooms of contracted hospitals;

(b) CCOs shall ensure the provision of certified or qualified interpreter services for covered coordinated care services including medical, behavioral health or dental care (when the CCO is responsible for dental care) visits, and home health visits, to interpret for members with hearing impairment or in the primary language of non-English speaking members. All interpreters shall be linguistically appropriate and be capable of communicating in English and the members' primary language and able to translate clinical information effectively. Interpreter services shall be sufficient for the provider to understand the member's complaint; to make a diagnosis; respond to member's questions and concerns; and to communicate instructions to the member;

(c) CCOs shall ensure the provision of coordinated care services which are culturally appropriate, i.e., demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the members' care;

(d) CCOs shall have written policies and procedures that ensure compliance with requirements of the Americans with Disabilities Act of 1990 in providing access to covered coordinated care services for all members and shall arrange for services to be provided by non- participating referral providers when necessary;

(e) CCOs shall have a plan for ensuring compliance with these requirements and shall monitor for compliance.

Definitions

The Oregon Department of Human Services (DHS) defines cultural competency as the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, abilities, religions, genders, sexual orientations, and other diverse backgrounds in a manner that recognizes, affirms, and values the worth of individuals, families, and communities, while protecting and preserving the dignity of each. Operationally defined, it is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes that create cultural settings in which quality of services produce better outcomes.

Cultural diversity has been defined by DHS as "the mosaic of people who bring a variety of backgrounds, styles, perspectives, values, and beliefs as assets to the groups and organizations with which they interact."

Source: "Cultural Competency & Diversity at DHS" 2008

Program Goal

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.

Magnitude of the Problem

According to 2010 US Census data, approximately 22,650 residents in our service area have English as a second language (ESL) and 15,500 are foreign born. Non-white Hispanics comprise the largest minority group at 9.6% of the total population while all other minorities combined equals 5.3% of the service area.

Demographics	Jackson	Josephine	Curry	Service Area	Oregon
Population	204,822	83,987	22,426	310,235	3,871,859
White Non-Hispanic	83.2%	88.4%	88.0%	85.1%	78.1%
Latino	11.2%	6.5%	5.9%	9.6%	12.0%
All Other Races	5.6%	5.1%	6.1%	5.3%	9.9%
% Foreign Born	5.7%	3.6%	3.8%	5.0%	9.7%
% English as Second Lang	8.7%	4.5%	4.4%	7.3%	14.3%

Source: 2010 US Census
Note: Data exclude Douglas County

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.

Once the Affordable Care Act is fully implemented in 2014, access to insurance coverage will improve through Medicaid expansion and the establishment of health insurance exchanges. This will likely benefit larger proportions of minority groups compare to today. This is particularly true for Latinos who currently experience the highest rate of un-insured of any racial or ethnic group. AllCare anticipates that the number of our Latino members will increase substantially in the next 18-24 months.

According to a recent article in Health Affairs, primary care providers report that they are less confident in the quality of care they provide to their Latino patients compared to the care they provide to white patients. They cited problems of inadequate time with Latino patients (36%), patients' non-adherence to recommended treatment (43%), relative lack of specialist availability (19%), and timely transmission of reports among physicians (15%). Only 4% cited difficulty communicating with Latino patients as a contributor to lower quality of care.

The Health Affairs article signifies areas where we as a health plan can greatly improve the quality of care received by our Latino enrollees. This includes development of strategies that promote timely transmission of patient records among physicians, use of community health workers and health advocates to coach our Latino members on their care plan to increase adherence to recommended treatments, flexible scheduling to allow longer patient visits for increased patient education, and application of culturally sensitive tools and models of care. Additional investigation is needed to determine if communication is a barrier to quality care and quality outcomes.

Objectives

Given our program goal, current demographics, emerging health system trends, and limited funding, AllCare's objectives will initially focus on our Latino Members to ensure they have the community supports they need to be successful in managing their health. Over time, we will address the bi-lingual and bi-cultural needs of other sub-populations, including the disabled, LGBT, and other racial and ethnic groups.

At the same time, we will encourage AllCare staff and our network of contracted providers to participate in on-line cultural competency training that will apply to all cultures, races, ethnic backgrounds disabilities, genders sexual orientation and others.

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.

Scope of our Latino Member Communication Initiatives

- 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.

Resources

The AllCare Transformation Team and selected staff will be responsible for developing the programs, policies, and procedures to implement our near term member communication initiatives that focus on the Latino population as well as those objectives that impact all members with diverse backgrounds. The executive team will collaborate with our Latino members and local community-based Latino programs and services to plan, develop, and implement our programs. And the executive team will solicit input from each County's Community Advisory Council, the Clinical Advisory Panel, and the CCO Board. Staff will research lessons learned from other diversity programs, specific to the Latino population.

This plan impacts AllCare staff, contracted network providers and their staff, community mental health agencies, community programs and services, and other organizations and their personnel that interact with our Medicaid beneficiaries, particularly Latinos, through their association with AllCare.

Approach

Phase I: Planning - Build Internal Infrastructure

Task 1.1: Train AllCare Staff in Cultural Competency

The AllCare staff in Member Services, Claims, Health Services, and Reception will be required to participate in on-line cultural diversity training offered by CMS's Office of Minority Health and programs offered by the OHA Office of Equity and Inclusion. The purpose of the training is to introduce staff to the basics of cultural competency, open a dialogue about the importance of showing respect for Members who have Low English Proficiency or English as a Second Language, and provide tools and supports for staff to better serve those Members.

Task 1.2: Create Latino-focused Care Coordination Team

The Director of Health Services (or designee) will work with the Human Resources Manager to recruit a Latino Community Health Worker(s) whose role is to participate in care planning and patient coaching for OHP Latinos. This new recruit will also support our primary care practices on site to assist with translation services, bridge cultural understandings, and ensure patient education of their doctor's treatment plan. This person will also assist with Latino health literacy and parenting.

For example, the community health worker will facilitate use of a new program initiative that targets Latino mothers by promoting their use of the "Learn the Signs, Act Early" program available on the CDC website under rural heath. This national campaign focuses on Spanish-speaking Hispanic parents living in rural and frontier areas. It is an easy-to-use training module that helps parents identify whether or not their child is exhibiting the age-appropriate behaviors that they should be. It also helps parents understand the need to encourage their children to learn age specific tasks including bed time reading, eating, walking, mimicking, pretending, and other behaviors.

Phase 2: Development

Task 2.1: Develop Communication Plan for Latino Members

The Director of Health Services (or designee) will collaborate with local community organizations and public health departments that serve the Latino population to develop messaging that will inform potential patients of AllCare's special care coordination programs to improve Latino health literacy and increase adherence to treatment plans.

Task 2.2: Develop Communication Plan for Providers

Communication plans will also be developed to transmit information to our network of contracted providers about our Latino care coordination team that will be available to assist with their treatment planning, coaching, and education for their patients. The communication plan will also encourage practices and their staff to participate in on-line cultural competency training provided by CMS and OHA that addresses the needs of all minority patient groups.

Task2. 3: Coordinate with CACs and CAP

The AllCare Transformation Team will provide information and solicit feedback from the CACs and the CAP on its Latino care coordination and cultural competency training program. The CACs, CAP, and CCO Board members will also be encouraged to take the on-line cultural competency training in order to make more informed decisions.

The AllCare Transformation Team will work directly with the CAP to ensure that their recommendations regarding evidence based clinical protocols, clinical policies and procedures, and recommended integration models address the implications of cultural competency as part of their clinical decision making processes.

Phase 3: Implementation

AllCare executive team and staff will be responsible for implementing the cultural competency communication plan. This includes implementation of the communication plan for both Members and Providers as well as engagement of community input from our CACs, public health departments, and community programs.

Task 3.1: Train AllCare Staff

AllCare staff will participate in on-line cultural competency training over the next six months and new staff will be required to take the training as part of their on-boarding process through the AllCare Human Resources Department.

Task3. 2: Recruit Latino Community Health Worker(s)

The HR department plans to recruit a Latino Community Health Worker who will assist with the care planning process and team based care within our primary care practices.

Task3. 3: Monitor Provider Training Compliance

The Manager of Provider Relations will periodically survey our network of contracted providers and their staff to determine who has successfully completed on-line cultural competency training. An alternative is to direct the training through our patient centered primary care home training site where providers can be monitored through the registration process. Periodic reminders will be communicated as needed.

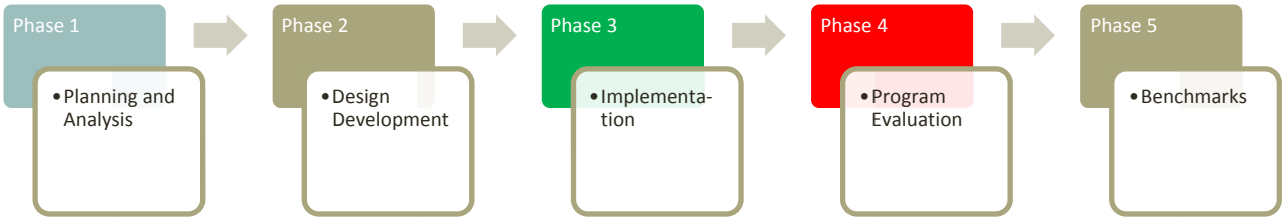
Phase IV: Program Evaluation

Through the regular Member satisfaction survey process, Latino Members will be asked to evaluate their experience with AllCare's care coordination staff and with their providers to assess overall program effectiveness.

Phase V: Measure Methodology

Benchmark 6	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.
How Benchmark will be measured (Baseline to July 1, 2015)	Identify children on the 834 file who have had a well child check up (utilizing appropriate CPT codes) in 2012.
Milestone to be achieved as of July 1, 2014	Improve 20% over baseline # of children 6-18 years of age who have received an annual well child check up from PCPCH or PCP.
Benchmark to be achieved as of July 1, 2015	Improve 30% over baseline # of children 6-18 years of age who have received an annual well child check up from PCPCH or PCP.

Timelines#



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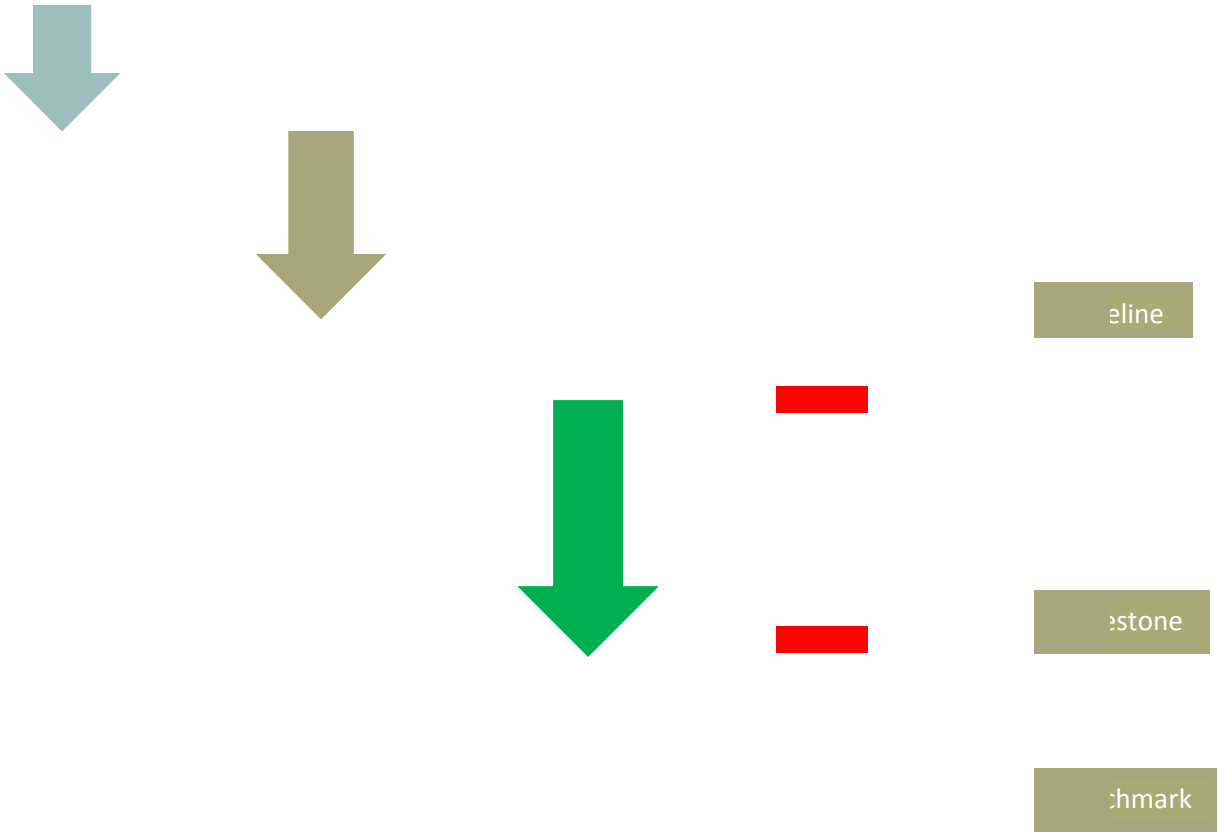


Domain 7:

Assure provider network and staff ability to meet cultural diverse needs of community (cultural competence training, provider composition reflects Member diversity, non-traditional health workers composition reflect Member diversity)

Regulatory Requirements

OAR: **410-141-3160 Integration and Care Coordination**

(2) CCOs shall develop evidence-based or innovative strategies for use within their delivery system networks to ensure access to integrated and coordinated care, especially for members with intensive care coordination needs. CCOs must:

(e) Demonstrate that participating providers have the tools and skills necessary to communicate in a linguistically and culturally appropriate fashion with members and their families or caregivers and to facilitate information exchange between other providers and facilities (e.g., addressing issues of health literacy, language interpretation, having electronic health record capabilities);

(5) The CCO must document its methods and findings to ensure across the organization and the network of providers there is documentation of the following coordinated care services and supports:

(e) Members have access to advocates, for example, qualified peer wellness specialists where appropriate, personal health navigators, and qualified community health workers who are part of the member's care team to provide assistance that is culturally and linguistically appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services;

Program Goal

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.

Objectives

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.

Workforce Demographics

All of Josephine and Curry Counties and parts of Jackson County are currently designated health manpower shortage areas and economically disadvantaged areas. As our population grows and ages, the need for additional manpower will increase. This transformation planning process offers an opportunity to guide our recruitment efforts to enhance our workforce demographics to more closely match that of the population being served.

The following table highlights current resources available to meet the special needs of some, but not all, subpopulations. This inventory double counts as many providers are able to meet the needs of more than one category of special needs. Information on LGBT communities is not available.

Special Need	Curry	Jackson	Josephine	Total
Blind	3	44	34	81
Aged	5	56	41	102
Disabled Children	2	40	28	70
Disabled Adults	3	49	38	90
High Health Care Needs	1	27	27	55
Multiple Chronic Disease	3	42	34	79
Mental Illness	1	34	36	71
Chemical Dependency	1	22	17	40
Spanish	1	33	11	45
German	0	3	3	6
French	0	3	2	5
Other languages (Swedish, Hindi, Portuguese, Chinese)	0	7	5	10
Total	20	360	276	656
Rate per 1000 population	0.9	1.76	3.33	2.11

Source: AllCare survey of physical health contracted providers

Scope of Our Workforce Transformation Initiatives

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.

Resources

The CCO Transformation Team will be responsible for ensuring that the workforce transformation plan moves forward. They will collaborate with the Community Advisory Councils (CAC) as those groups prepare the Community Heath Needs Assessment which will address health disparities across the service area. The Team will also collaborate with the Clinical Advisory Panel on best practices and evidence based clinical protocols that apply to Members with English as a Second Language (ESL) and Low English Proficiency (LEP) as well as specific ethnic and culturally sensitive groups.

Local representatives among diverse communities, including interpreters, will be engaged to assist with this effort through their involvement on the CACs as well as through informal meetings, interviews, and small work group settings. Local colleges that offer health care training will be engaged to address diversity curriculum needs as well as to address admission policies in order to build a health care work force that mirrors the local population demographics.

AllCare staff will research existing and emerging literature and research on best clinical practices as well as policies, processes, and procedures for treating and engaging specific subpopulations. This will include a focus on specific cultural preferences of diverse ethnic groups related to health and traditional

interactions with health care workers. AllCare will also rely on OHA staff and the state Office of Equity and Inclusion for guidance.

Approach

Phase I: Planning

Task 1.1: Inventory Current Community Resources and Create Contact Tree

AllCare CCO staff will complete an inventory of community resources available to serve racial, ethnic, disabled, and LGBT communities across the service area. This will include a survey of community based programs, services, and staff who could serve as peer supports, community health workers, and health navigators for our Members. We will assess the capability of each community based program and its staff to fill currently known gaps in cultural competencies across care settings and serve as members of our contact tree. We will also update our inventory of our existing network of contracted providers and gather additional information related to providers with specialized expertise serving LGBT communities. The contact tree will be available on our website for easy access by providers and community supports.

Task 1.2: Literature Search and Research

AllCare CCO staff will collect data on best practices and model programs to improve workforce diversity and cultural competencies. This information will be used to build the business case for change regarding health disparities and cultural competencies in our workforce. AllCare staff will collaborate with OHA staff and the Office of Equity and Inclusion for guidance on workforce transformation for rural areas and other best practices.

Task 1.3: Revise and Refine AllCare's Policies and Procedures

Based on best practice research and other data, AllCare will revise and refine policies and procedures to ensure cultural and linguistic competency awareness is infused throughout the organization. AllCare will also work with contracted providers and their staff to increase awareness of the importance of cultural competency in meeting the needs of subpopulations, particularly Hispanics, disabled, and the LGBT communities.

Task 1.4: Train/Retrain Allcare Staff

AllCare staff will be required to participate in on-line cultural competency training offered by the Office of Minority Health at the US Department of Health and Human Services. In addition, the Health Services staff will be required to take additional courses for specific racial and ethnic groups, persons with disabilities, and the LGBT communities. AllCare will designate, as needed, specific care coordinators who will specialize in meeting the unique preferences of Hispanics, disabled, LGBT, and other members with English as a Second Language (ESL) and/or Low English Proficiency (LEP).

AllCare will recruit a community health worker and/or train existing staff to provide culturally and linguistically competent care coordination services on behalf of our small and rural providers. Initially, the specialized care coordinator will focus on our Hispanic population.

Phase 2: Development

Task 2.1: Establish Provider Guidance for Cultural Competency

Based on the results of Phase I, AllCare will prepare cultural competency training and educational materials to guide our contracted providers and their staff. The materials will include:

- The business case for change and a description of why cultural competency is so important
- Web based links to AllCare's new policies and procedures on cultural competencies
- Web based links to State and Federal online cultural competency training courses
- Web based links to our Contact Tree for matching Member needs to community resources
- Resource guide and evidence based clinical protocols for treating Members with ESL/LEP

Task 2.2: Identify Members and Assign Health Navigators

AllCare CCO will modify its initial Health Risk Assessment to include questions related to cultural and linguistic preferences, ESL and LEP, and health literacy in order to identify Members who need access to non-traditional health workers and providers who are culturally and linguistically competent. Our intent is to ensure, upon enrollment, eligible Members are immediately supported by a designated health worker who can navigate the health system with them and serve as a health coach.

Task 2.3: Create Template for Recruiting Culturally Competent Providers and Staff

AllCare CCO staff will develop standardized policy and procedure templates to be used by our network of contracted providers to guide their recruitment and retention efforts to attract qualified personnel to treat Members with diverse backgrounds, disabilities, different sexual orientations, and other cultural factors. Our goal is to evolve the configuration of our local workforce, over time, to match the diverse needs of the Members we serve.

AllCare will periodically survey our contracted providers to evaluate the level of workforce diversity and to update our inventory of available local resources for our Contact Tree.

Phase 3: Implementation

AllCare CCO staff will ensure that our strategies for workforce cultural competency are consistent with the Community Health Improvement Plans for each county and with the evidence based clinical protocols. It will also be important to integrate planning, development, and implementation with other parts of the Transformation Plan, including development of a Quality Improvement Plan for culturally diverse populations and for overall improvement in communication on health literacy and health disparities across the service area and across care settings.

Task 3.1: Data Deficiencies

A key data deficiency now exists regarding our lesbian, gay, bisexual and transgender (LGBT) communities. This adversely impacts our ability to develop a culturally competent workforce and to establish a comprehensive Community Health Needs Assessment and Improvement Plan.

To remedy this problem, AllCare plans to initiate data collection efforts in two ways. The first involves revision of the Initial Health Risk Assessment Survey now used at the time of initial enrollment into AllCare CCO. We will begin to collect self-reported data on sexual orientation and provider preferences that ensure the Member is guided to a PCP/PCPCH who is trained in meeting those preferences. The questions to be asked will reflect current literature and evidence based protocols on best practices for collecting personal data, ensuring that the questions are asked in a meaningful and respectful manner.

The second data collection effort will build upon current "waiting room" surveys and questionnaires. We will work with our primary care providers (both physical health and mental health) to collect information on sexual preferences among current CCO Members. This data will be collected and aggregated across each county to inform our community health needs assessment and to periodically evaluate how well AllCare and its providers are meeting the needs and preferences of the LGBT communities in a culturally competent way.

Task 3.2: Integration with Community Health Needs Assessment and Improvement Plan

AllCare will gather statistics on our LGBT members as well as other culturally diverse Members for inclusion in the CHNA document for each county. The data will also be used to develop AllCare's Community Health Improvement Plan where we will develop specific strategies to address specific needs, including:

- Improvement in health outcomes among non-white Hispanics with low English proficiency and multi-generational poverty
- Improved health literacy among culturally diverse Members
- Development of workforce initiatives and improvement plans to address the special needs of diverse Members

Task 3.3: Integration with the Clinical Advisory Panel

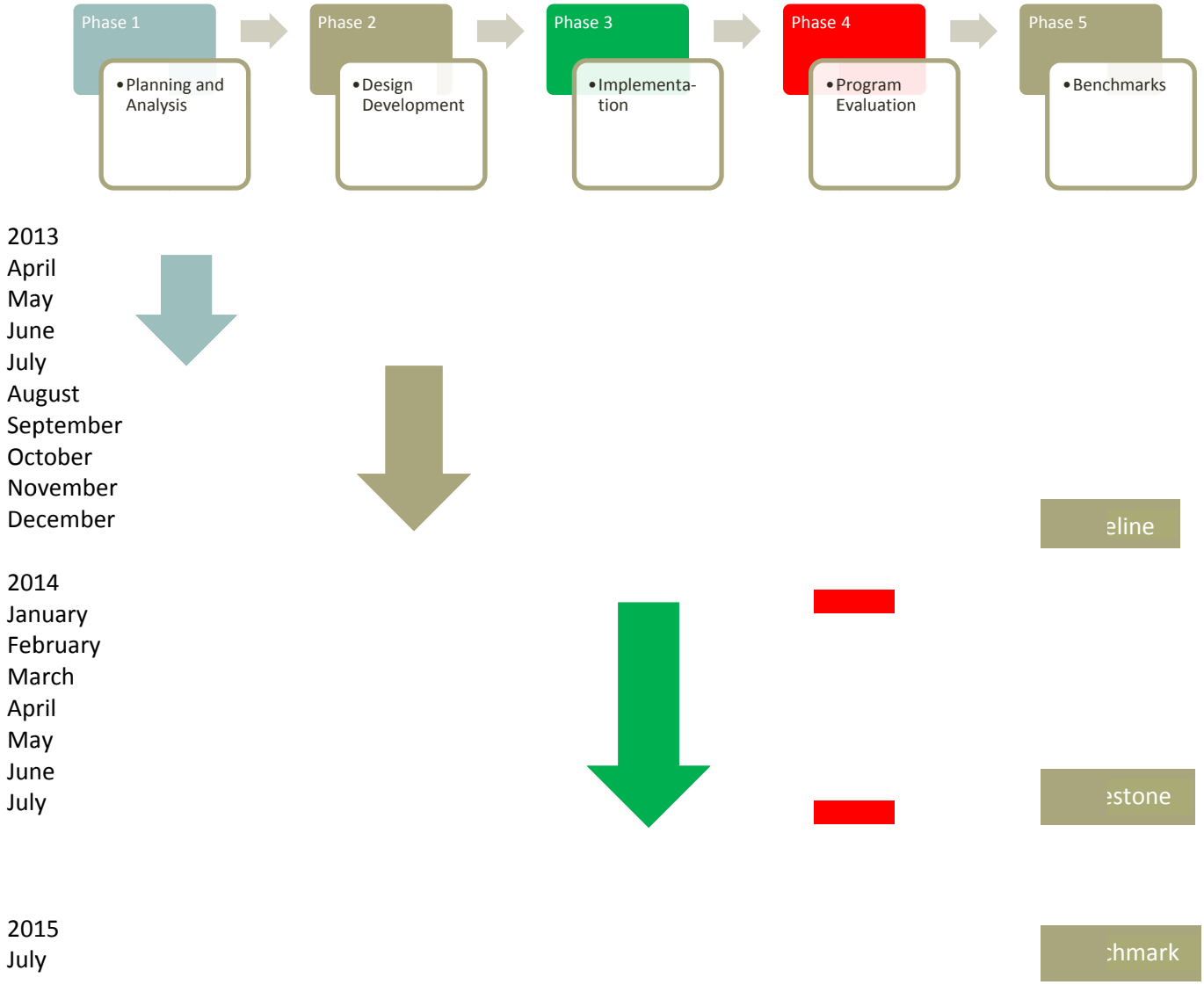
As new research on evidence based clinical protocols evolve around cultural competencies and health literacy, the Clinical Advisory Panel will be tasked with review of those protocols and development of recommendations regarding their deployment across the continuum of care. AllCare will coordinate with the CAP and deploy their recommendations to our providers as indicated.

Phase V: Measure Methodology

Benchmark 7	Increase the number of PCP/PCPCH or OB practice sites completing cultural diversity training programs.

How Benchmark will be measured (Baseline to July 1, 2015)	Perform a baseline survey(by 7.1.2013) and subsequent surveys in 2014 and 2015 to measure training program participation.
Milestone to be achieved as of July 1, 2014	Improve 15% over baseline the rate of cultural diversity program completion by contracted providers.
Benchmark to be achieved as of July 1, 2015	Improve 30% over baseline the rate of cultural diversity program completion by contracted providers.

Timelines



Domain 8:##

Develop a quality improvement plan focused on eliminating racial, ethnic, and linguistic disparities in access, quality of care, experience of care, and outcomes.

Regulatory Requirements

OAR: 410-141-3015: Certification Criteria for Coordinated Care Organizations

(24) CCOs' health care services must focus on achieving health equity and eliminating health disparities. Applicants must:

(a) Describe their strategy for ensuring health equity (including interpretation/cultural competence) and elimination of avoidable gaps in health care quality and outcomes, as measured by gender, race, ethnicity, language, disability, sexual orientation, age, mental health and addictions status, geography, and other cultural and socioeconomic factors;

(b) Engage in a process that identifies health disparities associated with race, ethnicity, language, health literacy, age, disability (including mental illness and substance use disorders), gender, sexual orientation, geography, or other factors through community health assessment;

(c) Collect and maintain race, ethnicity and primary language data for all members on an ongoing basis in accordance with standards jointly established by the Authority and the Department.

Program Goal

AllCare's goal is 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.

Objectives

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.

Resources

The Oregon Health Authority quality measures will serve as the initial standards for measuring, monitoring, and benchmarking quality of care, access to care, and care experience among diverse populations. Initial data on these measures will be reported to the CCO Board of Directors for review and comment on AllCare's quality improvement program for diverse populations. The data will be shared with the Community Advisory Councils in each county as part of the Community Improvement Plans and with the Clinical Advisory Panel as they review evidence based clinical protocols and their application to diverse populations.

Input will be solicited from stakeholders including diverse patient populations, agencies that serve diverse populations, behavioral health, dental health, and public health representatives, and other CCOs.

Assumptions

AllCare expects its network of contracted providers will be accountable to quality, access, and cost measures for all patient populations, including those from diverse communities.

The plan will address people of all cultures, languages, races, ethnic backgrounds, disabilities, genders, sexual orientation, and other diversity factors.

The plan impacts AllCare staff, contracted network providers and their staff, and other organizations and their personnel that interact with Medicaid beneficiaries through their association with AllCare.

This plan is predicated on our good faith effort to include all CCOs in the process in order to create a consistent set of community standards of care and service delivery for our diverse patient populations.

This plan relies on quality and health status data compiled by our partners and stakeholders, including Asante Health Services, public health, mental health agencies, and community supports.

Proposed Approach

Phase 1 & 2: Planning and Development

Task 1.1: Establish Baseline Data Requirements for OHA Measures

Currently, data are not available to assess the impact of quality, access, and experience of care among diverse populations. In addition, it is unclear if current databases are designed to extract information on specific sub-populations. And finally, it is also unclear as to whether there is concise and consistent agreement on the definition of specific sub-populations across the service area and across care settings. It is, therefore, necessary to do an inventory of what data are available on diverse populations, what data could be extracted from existing databases, and what gaps currently exist in our data collection efforts around the OHA measures. Once we have answers to these questions, we can develop a realistic subset of OHA measures that will serve as our baseline for developing our quality improvement plan for diverse populations and serve as our "yardstick" to measure performance improvement over time. (Where practical, data gathering for diverse populations will be integrated with the Community Health Needs Assessment as described in Domain #4.)

Task 1.2: Literature Search

AllCare planning staff will undertake a literature search of current evidence based clinical protocols and current performance statistics for OHA quality measures associated with diverse populations in Oregon and other US geographies. This will provide needed insight on quality expectations for each of our diverse population groups.

Task 1.3: Partner with Other CCOs and/or a Statewide Collaborative

AllCare may coordinate with other CCOs and/or a statewide collaborative to reach agreement on the set of measures and performance targets to be used by each organization and their network of contracted providers to evaluate quality of care for the diverse populations that we collectively serve. This information will be documented and AllCare will share the measures with our CCO Board, the Community Advisory Committees, and the Clinical Advisory Panel.

Task 1.4: Address Data Gaps

AllCare will identify methods and means to expand current datasets to include additional information on diverse populations where gaps in data now exist. We will work with our providers so that they can electronically identify specific sub-populations within their EMRs in a consistent manner and paper based systems as well; we will work with our internal staff to improve our ability to track diverse populations through our claims database; and we will work with the OHA on its ability to identify specific diverse populations at the time of enrollment for tracking and monitoring purposes.

Phase 3: Implementation

Task2.1: Collect Quality Data on Diverse Populations

AllCare will collect quality data, based initially on the OHA required quality measures, at least annually to assess health disparities, health inequities, and access to medically necessary and appropriate care among diverse populations. The Transformation Team and staff will review the data, identify areas for improvement, and initiate root cause analysis as to why the inequities and disparities exist.

Task 3.2: Action Plans

The Transformation Team will make recommendations on specific action plans designed to minimize and eventually eliminate root causes of health inequities and health disparities across sub populations. AllCare staff will develop remediation plans to address the recommendations and work with providers and their staff to implement new approaches and clinical processes that better meet the needs of diverse populations. This may include cultural competency training as well as increased understanding of specific cultures and their preferences around health and healthy lifestyles. It may involve better coordination across care settings to ensure that care takers understand each patient's unique needs and their unique treatment plan. It may involve enhanced efforts across the organization to improve access to the right care in the right setting by the right provider. Or it may involve intense peer support, coaching, and/or interpreters who are culturally sensitive to help patients with diverse backgrounds better understand how to best manage their health and to take responsibility for a healthy lifestyle.

Task 3.3: Quality Improvement Plan

Based on the data analysis, remedial initiatives, and OHA measures, the CCO Quality Improvement Committee will establish a set of performance targets and performance improvement initiatives every three years. The Quality Improvement Plan will be presented and approved by the CCO Board and rolled out to providers through the Community Advisory Committees, the Clinical Advisory Panel, and targeted education /training sessions for AllCare staff, contracted providers and their staff, and public health/community programs.

Phase 4: Program Evaluation

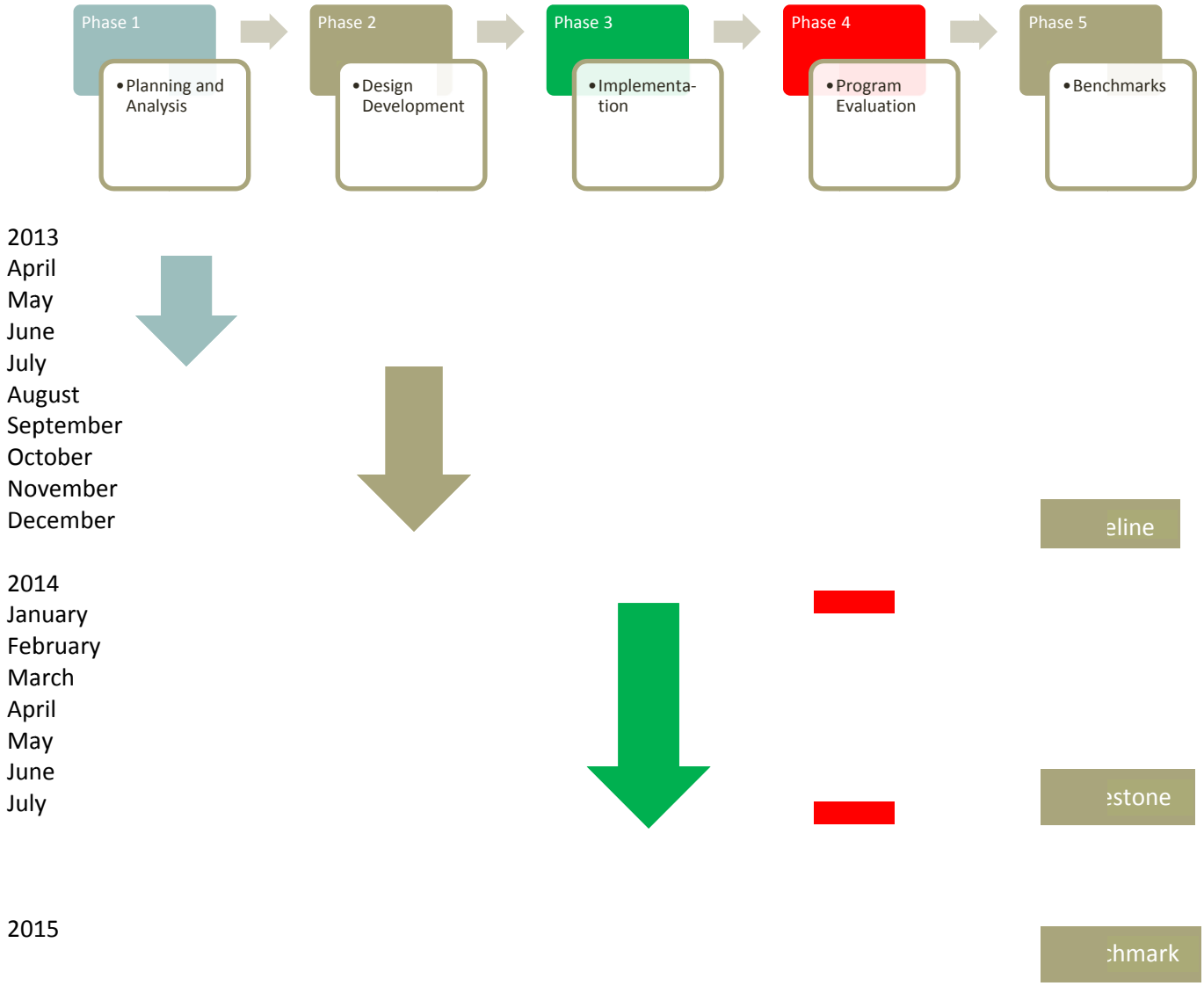
Periodically, AllCare with evaluate how well it is implementing its Quality Improvement initiatives for diverse populations and assess the positive and/or negative impact its initiatives are having based on the OHA measures and other measures that will evolve over time. We will examine how well our performance compares to our CCO partners and to state and national benchmarks on health equity among diverse populations. The program evaluation will be presented to the CCO Board for review and comment. This information will be used to update the Quality Improvement Plan for Diverse Populations every three years.

Phase V: Measure Methodology

Benchmark 8	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.
How Benchmark will be measured (Baseline to July	Utilize the 834 file to identify pregnant members and develop a process/tool to assess substance abuse in AllCare pregnant members.

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

Timelines



July

Appendix A: Initial Review

Community Health Needs Assessment Draft / Readiness Review

AllCare Health Plan Community Health Needs Assessment

Initial Review, Documentation, and Summary of Existing Hospital and Public Health Plans

Phase I: Community Engagement

AllCare Health Plan established a stakeholder group encompassing its three-county service area in fall, 2011. The group includes representatives from all three counties' public health departments and community mental health/addiction recovery programs, two dental health DCOs, all six hospitals that serve our Medicaid enrollees, community based social and health services programs, residential care facilities/skilled nursing facilities, and our provider network of physicians, mid-level practitioners, specialists, and ancillary providers.

The Stakeholder group has been responsible for developing AllCare Health Plan's Community Advisory Council (CAC) charter and membership, the Clinical Advisory Panel charter and membership, and the County Commissioner Council (CCC) charter and membership. It has overseen plans to integrate mental health and physical health with an eye toward the eventual integration of dental health. It has also collaborated in good faith on issues of contracting agreements within the context of the global budget framework and provided Memorandums of Understanding and/or Letters of Support for our CCO Application.

The Sb , takeholder group will sunset as we transition from an MCO to a CCO. Many of its members will continue as representatives on the CCO's governance committees and on various subcommittees of the board, such as the Quality Improvement and Accountability Committee, Finance Committee, Care Coordination Committee, and Provider Relations Committee.

The Community Advisory Council will be responsible for overseeing completion of the AllCare Health Plan Community Health Needs Assessment (CHNA) and will develop its work plan once the council convenes in late summer, early fall of 2012. A preliminary work plan for the community needs assessment will be incorporated into the AllCare Transition Plan, due to the Oregon Health Authority by September 15, 2012, with final approval to proceed by November 1, 2012. At that time, the AllCare CAC will commence work on updating this preliminary draft community needs assessment.

Phase II: Visioning

The visioning phase of the Community Health Needs Assessment will be complete as our Community Advisory Council work plan and schedule, beginning late summer, early fall of 2012.

Phase III: Current Data Assessment

A. Quantitative Review

1. Summary of CCO Service Area Demographics (citations)

The service area encompasses all of Jackson, Josephine, and Curry Counties plus two contiguous zip codes in Douglas Counties. According to census data, the total population is estimated to be 308,000. Approximately 50% of Josephine and Curry Counties are rural and more than 23% of their population is over 65 years of age. Jackson County population, while less rural, is also older with 17% over 65. This compares to a state average of 21% rural and 14% over 65. Experience for Douglas County zip codes is similar to that of Josephine County.

The service area is less diverse than other parts of the state. Only 10.8% of residents claim to be non-white, of which more than 70% are non-white Hispanic. Whereas the State averages 18% non-white of which 60% are non-white Hispanic. Of the current MCO OHP members that are non-white, 97% are non-white Hispanic. Less than 3% of the population is non-proficient in English with Spanish as the predominant second language.

Much of the service area is considered medically underserved. Parts of Josephine and all of Curry County are designated primary care manpower shortage areas. The national benchmark is one primary care provider for every 631 residents and, as shown in the following table, all of our counties exceed this benchmark, meaning that our local providers must serve more patients than their counterparts across the nation. In fact, Curry County would need to double the number of primary care providers to approach the national benchmark. Josephine County would need to add more than 40 providers to improve access to care. Jackson County would need to add 55 providers to meet the national benchmark for primary care. Currently mid-level practitioners fulfill a portion of the gap in primary care resources. However, as the population continues to age and as new federal health insurance subsidies take effect, the demand for providers will far exceed available resources.

The implications of mental health manpower shortages are far worse. All three counties are severely underserved and providers will need to collaborate on how best to meet these needs across the continuum of care as we integrate mental and physical health services. Dental services appear to be in adequate supply to meet current needs.

Ratio of Population per Provider Type (2005-2007): National Benchmark is 631:1

PROVIDER TYPE	Curry	Jackson	Josephine	Oregon
Primary Care Provider	1,321:1	762:1	933:1	739:1
Mental Health	3,539:1	3,179:1	7,379:1	2.211:1
Dental Health	2,041:1	2,213:1	2,555:1	2,360:1

Source: County Health Rankings and Roadmaps, Robert Wood Johnson Survey 2012

A significant indicator of access and availability problems is emergency room utilization. Recent data presented in Asante Health System's Community Health Needs Assessment (CHNA) for 2012 indicates that 8.2% of service area residents accessed hospital emergency room services more than once in the past year. Of these visits, 56.7% were self-reported by survey respondents as emergency situations and 30.3% occurred on weekends and after hours. However, 11.5% listed access problems as their main motivation of using costly emergency

department services for their primary care needs. Not surprisingly, low income adults were more likely to report multiple ER use compared to other population groups which may also be due to a lack of insurance coverage.

Focus groups addressed concerns about access to healthcare as part of the Asante CHNA process. Participants expressed concerns about the underinsured and the uninsured, emergency room utilization, physician office hours and location, public transportation (or the lack thereof) and language barriers. It was expressed that the underinsured typically involved the working poor who may have access to health insurance but the cost of deductibles, copays and premium shares were significant barriers to access needed services. It was also felt that many of the underinsured found it difficult to navigate the health system since many of the plans they can qualify for and afford do not cover many needed services. The respondents felt that the uninsured had no choice but to use emergency room services because they have no other options.

The focus group felt that many individuals were reluctant to take time from work to see their PCP for fear of losing one's job and the emergency room becomes their back-up alternative. Provider office hours and locations are barriers to access care. Many providers only work 3-4 days per week and do not offer after-hour alternatives or weekend clinics.

Transportation was also viewed as a barrier to access. In Jackson County, public transportation is limited and non-existent in Josephine and Curry Counties. That said, public transportation may not be a good option for individuals with small children, disabilities, or communicable illnesses.

Language was also identified as a potential barrier to access to care. Recent data indicate that there are 4,800 OHP members in the service area who list English as a second language and 97% listed Spanish as their first language. There are Spanish speaking federally qualified health plans available in Jackson and Josephine Counties but they are insufficient to meet the need. Additional certified interpreters are needed across the service area.

The percentage of uninsured adults is 25%, a bit higher than the state average of 23%. Income poses a significant barrier to health insurance where the average household income is 22% below the state average in Josephine County, 20.5% less in Curry County and 13% less in Jackson County. High un-insurance rates together with low average household income has adversely affected the ability of residents to access the care they need. Almost 55,000 residents or 18%, reported they did not seek medical care when needed due to the cost. This compares to 15% statewide. *(Source: County Health Rankings and Roadmaps, Robert Wood Johnson Foundation study)*

Contributing to low household income and the rates of uninsured is the high rate of unemployment. With the federal unemployment rate hovering between 8.1% and 8.2% and the state average at 10.8%, our service area is suffering with almost 36,000 or 11.7% of the population being unemployed. Consistent with state and national trends, this has affected young families the most. The result is that 25% of all children in the service area live in poverty.

This has led to some residents skipping or reducing medication doses in order to stretch prescriptions and save money. According to the Asante CHNA survey, 19% of respondents

indicated that they had skipped or reduced medications. This was highest among the low income, the uninsured, and non-white communities.

Access to health insurance coverage is also a major barrier to care. According to the Asante CHNA survey, 57% of adults, aged 18-64 received health insurance coverage through their employer or were self-insured. Government programs, including Medicare, Medicaid, and the military, covered 20% and 22% were uninsured. However, of insured adults, persons under 40, lower income residents, and non-white were most likely to have gone without coverage at some point in the past year. In addition, the rate of uninsured (22%) was higher than the national average (15%), higher than the state of Oregon (20%), and typically involved adult men (26.7%), low income (30%), and people of color (28%).

2. Service Area Health Status

Recent surveys prepared by the Robert Wood Johnson Foundation ranked 33 of Oregon's 36 counties based on a wide range of health indicators. The following table summarizes the results for our service area. Green indicates that the county ranked in the top one-third of all counties; yellow indicates the middle one-third and red indicates the lower third, or the worst performance.

Level of Performance on Key Health Indicators Compared to Other Oregon State Counties

High **Medium** **Low**

Key Health Indicators	Curry	Jackson	Josephine
Health Outcomes	28	15	29
Health Factors	19	13	26
Mortality	33	16	31
Morbidity	8	14	22
Health Behaviors	15	7	26
Clinical Care	26	10	13
Socioeconomic Factors	23	19	30
Physical Environment	1	27	6
Tobacco Use	10	19	30
Diet and Exercise	30	3	12
Alcohol Use	25	13	24
Access to Care	28	14	19
Quality of Care	21	11	12
Education	24	17	31
Employment	23	21	29
Income	19	11	30
Family and Social Support	33	21	30
Community Safety	14	24	20
Environmental Safety	12	26	12
Built Environment	1	26	7

High Performance	20%	25%	10%
Moderate Performance	30%	55%	30%
Low Performance	50%	20%	60%

The data identify many community needs across the service area and illustrate the diversity of need among the three counties. Of the twenty health indicators identified in this table, not one is ranked similarly for all three counties, creating a more difficult process for setting community health priorities and allocating resources for performance improvement.

Self-Reported Health Status (Asante 2012 CHNA): A survey completed by Professional Research Consultants, Inc. on behalf of Asante Health System indicates that 53% of the service area populations rate their overall health as excellent or very good. An additional 26.4% gave a "good" rating to their overall health.

However, 20.4% believe their overall health to be fair or poor. Those most likely to list their health status as fair or poor are low income (30.7%), non-white (29.6%), and residents aged 40 – 64 (24.7%). There were also differences across the service area. More than 25% of Josephine County residents rated their health as fair or poor compared to Jackson County at 13.3% and the state average at 16.8%.

The survey also investigated activity limitations and found that almost 39% of service area residents are limited in some activities due to a physical, mental, or emotional problem. This is comparable to statewide data but over two times higher than national prevalence rates of only 17%. Older adults (40+), low income, and non-whites were most likely to report reduced activity due to health problems. The type of health problems included back/neck problems, arthritis/rheumatism, or fractures and bone/joint injuries.

3. Quality of Life

Disabling Conditions: Potentially disabling conditions include arthritis, osteoporosis, and chronic pain. All have major effects on quality of life, the ability to work and exercise, and to participate in basic activities of daily living. There are more than 100 types of arthritis. It commonly occurs with other chronic conditions, such as diabetes, heart disease, and obesity. Arthritis affects one in five adults and continues to be the most common cause of disability. (Asante 2012 CHNA)

In the AllCare service area, approximately 25% of the adult population is diagnosed with arthritis which is equal to the state average and higher than the national average of 20%. One notable exception is Curry County where 34% have some type of arthritis. (Oregon BRFSS County

Combined Dataset 2006-2009) However, the survey prepared for the Asante CHNA reported that four in ten adults aged 50 and over suffered from arthritis and rheumatism. This is similar to the state total of 41% but higher than the national average of 35%.

Osteoporosis reduces bone strength leading to an increased risk of bone fracture. It is estimated that over 5.3 million people age 50 and over have osteoporosis, the majority of which are women. Half of all women and as many as one in four men aged 50 and older will have an osteoporosis-related bone fracture in their lifetime. According to the Asante survey 16% of respondents age 50 and over have osteoporosis which is similar to national averages but higher than the Health People 2020 goal of 5.3% or lower.

Chronic pain is common, costly, and potentially disabling. About 80% of all Americans experience low back pain in their lifetime and 20% experience protracted back pain. Low back pain is the second leading cause of lost work time (after the common cold) and the third most common reason to undergo surgery. In the AllCare service area approximately 28% of survey respondents living in Jackson and Josephine County suffer from chronic back pain or sciatica. This compares to a national total of 21.5%.

Injuries and Violence: According to Healthy People 2020, injuries are the leading cause of death for Americans ages 1 – 44 and the leading cause of disability for all ages regardless of sex, race/ethnicity, or socioeconomic status. Approximately one in ten people sustain a non-fatal injury serious enough for emergency department treatment each year.

In the service area, motor vehicle accidents, falls, and poisoning accounted for 80% of accidental deaths between 2005 and 2007. Altogether, unintentional deaths due to injury averaged 47.5 per 100,000 across the service area. However, the rate in Josephine County seriously skewed the average rate. Between 2005 and 2007, there were 60.3 due to unintentional injuries in Josephine County, a rate that is 27% higher than the service area average and 42% higher than Jackson County.

The same trends are apparent for motor vehicle accidents. The service area average was 17.4 crashes per 100,000 which is 36% higher than the state average of 12.8/100,000. By comparison, Josephine County experienced 27.4 car crashes per 100,000, more than double the state average for 2005 - 2007. Healthy People 2020 set a target of 12.4 crashes per 100,000 or lower, indicating a significant gap between current local conditions and the national benchmarks. (Asante 2012 CHNA)

Between 2005 and 2007, there was an average age-adjusted rate of 12.4 deaths per 100,000 population due to firearms in the service area. This is higher than state and national averages and fails to meet the Healthy People 2020 objective of 9.2 or lower. Again Josephine County was the outlier at 16.0 deaths per 100,000 population.

More than 53% of all adults report having a firearm in and around their home, including households with children, compared to a national average of 38%. Mid to high income households (65%) as well as men (60%) were most likely to keep firearms in the home.

Reports of violence are notably higher among young adults and low income populations. The subpopulation with the highest rate of violent crime is non-white at 10.5% followed by adults aged 18 -39 at 10.2%, and low income at 8.7%.

A total of 18.3% of service area adults report being threatened with physical violence by an intimate partner and almost 22% acknowledge that they have been slapped, pushed, kicked, or otherwise hurt by an intimate partner. Both statistics are significantly higher than the national average of 13.5%. The most dominant subpopulation involves non-whites at 38%, low income at 32%, and women at 28%.

(Source: Asante 2012 Community Health Needs Assessment)

4. Behavior Risk Indicators

Other indicators of community health status address health risk behaviors. As shown below, the majority of our service area is doing equal to or better than national benchmarks for adult obesity and physical activity and Curry County far exceeds expectations around sexually transmitted disease. However, the other benchmarks indicate there is much need for improved prevention and education on behaviors that lead to poor health and poor outcomes, including smoking, excessive drinking, motor vehicle accidents, teen births, and sexually transmitted disease.

Measure	Curry	Jackson	Josephine	Oregon State	National Benchmark
Adult Smoking	16%	20%	**25%**	18%	14%
Adult Obesity	30%	23%	25%	26%	25%
Physical Inactivity	24%	15%	22%	18%	21%
Excessive Drinking	**16%**	**15%**	**15%**	**16%**	8%
Motor Vehicle Crash Death Rate per 100,00	**23**	**16**	**26**	**14**	12
Sexually Transmitted Infections per 100,000	56	**245**	**202**	**303**	84
Teen Birth Rate per 1000 females aged 10-18	26	**37**	**38**	**35**	22

Source; County Health Rankings and Roadmaps, Robert Wood Johnson Foundation

Meets or Exceeds National Benchmarks
Indicates modest room for improvement
Falls somewhat short of National Benchmarks
Falls significantly short of National Benchmarks

Tobacco Use: According to the Oregon BRFSS County Combined Dataset (2006 – 2009) tobacco use in the service area is a significant contributor to the low health status of the population. As shown below, all three counties have higher rates of smoking compared to the state average.

Tobacco Use Statistics

Risk Behavior	Curry	Jackson	Josephine	Oregon
% of Adults who currently smoke age adjusted	18.4%%	21.9%	25%	17.1%
Smokeless Tobacco Use by Males age adjusted	--	5.3%	6.9%	6.3%
Quit Attempts During the Previous Year age adjusted	36%	47%	59%	48%
No Smoking Rules in Household	87%	88%	93%	90%
No Smoking Rules in Car	81%	80%	84%	83%

Source: Oregon BRFSS County Combined Dataset 2006-2009

Smoking is the single most preventable cause of death and disease in the United States. Tobacco use causes cancer, heart disease, lung disease (emphysema, bronchitis, and chronic airway obstruction), and premature birth, low birth weight, and infant death. Second hand smoke is equally risky. It can cause heart disease and lung cancer among adults and serious health problems for children, including asthma, respiratory infections, ear infections, and sudden infant death syndrome. Smokeless tobacco is also risky and can cause serious oral health problems, including cancer of the mouth, periodontitis, and tooth loss. Cigar smoking causes cancer of the larynx, mouth, esophagus, and lung. The US average percentage of smokers is 16.6% and the Healthy People 2020 target is 12% or lower. (Asante 2012 CHNA) To meet these benchmarks, Curry County would need to reduce smoking rates by 10% - 35%; Jackson County would need to reduce rates by 24% - 45%; and Josephine County would need to reduce its rates by 34% to meet the US average and 52% to meet the Health People 2020 target.

Population segments with the highest smoking rates include the low income (30%), people aged 40-64 (22.6%) and women of child bearing age (20.5%). There is virtually no disparity between white and non-white populations, at 18.7% and 18.0% respectively. However, of those who smoke at home, non-white populations far exceed that of white population at 20.4% versus 11.9% respectively. And low income households have the worst rate of smoking in the home at 22.1%. (Asante 2012 CHNA)

Obesity Trends:

Obesity is a national problem and Southwest Oregon is no different. According to Healthy People 2020, among adults, the prevalence is highest for middle-aged people and for non-Hispanic Black and Mexican American women. Among children, the prevalence of obesity is highest among Mexican American and non-Hispanic black girls.

The social and physical factors affecting diet and physical activity have an impact on weight and adversely result in higher mortality and morbidity rates. Epidemiological data show that a modest increase in mortality occurs for those with a Body Mass Index (BMI) above 25 and a significant increase for BMI above 30. This particularly impacts the incidence of cardiovascular disease. (Asante 2012 CHNA)

Service Area Obesity Rates
Benchmark for Obesity is 33.9% or higher for those with a normal BMI *(Healthy People 2020)*

Risk Behavior	Definition	Curry	Jackson	Josephine	Oregon
% Classified as Overweight age adjusted	BMI: 25.0 -29.9	30.4%%	38.2%	35.6%	36.1%
% Classified as Obese age adjusted	BMI: 30.0+	29.8%	21.0%	22.3%	24.5%
Total % of the Population with a BMI 25+		60.2%	59.2%	57.9%	60.6%
Percent of Population with Normal BMI	**HP 2020: 33.9% or higher**	**39.8%**	**30.8%**	**42.1%**	**39.4%**
% of adults who meet CDC recommended level of physical activity age adjusted		61.1%	57.5%	59.3%	55.8%
% of adults who eat their fruit & vegetables of 5 servings per day		37.4%	32.2%	22.4%	27.0%

Source: Oregon BRFSS County Combines Dataset 2006 - 2009

The service area population compares well to the Healthy People 2020 benchmark of 33.9% of the population or higher having a BMI at 25 or less. However, that leaves approximately 60% of the local population as overweight or obese, an alarmingly high percentage. High BMIs are highly co-related to other health issues. The Asante CHNA survey results indicate that the percentage of residents with Obesity, 52.7% reported high blood pressure compared to 23.4% of those with normal weights and 19.6% reported diabetes compared with 4.1% for those with normal weight.

Teen Obesity is a growing problem in Oregon. In 2001, 14.9% of youth were overweight and 7.3% were obese. By 2009, the statistics increased to 15.4% and 11.2% respectively. The good news is that the statistics for 8th graders improved by the time they reach 11th grade.

	Eighth Grade			Eleventh Grade		
	Male	Female	Total	Male	Female	Total
Overweight	15.4%	15.3%	15.4%	13.8%	12.6%	13.2%
Obese	14.0	8.5%	11.2%	13.0%	7.8%	10.4%

Source; 2009 Oregon Healthy Teens Survey reprinted in "Oregon Healthy Behaviors Statistics, 2012"

There are disparities in the prevalence of obesity among subpopulations of the service area. Low income populations reported an obesity rate of 34.3% and those aged 40 – 64 had an obesity rate of 31.9%. Those over 65 and non-white populations reported the most favorable results of 17.9% and 21.9% respectively. For all obese people in the service area, only 44% were counseled by their primary care provider on their weight and its impact on health status. (Asante 2012 CHNA)

Measures of healthy activities (eating fruits and vegetables and doing exercise) resulted in mixed reviews. While close to 60% of the population reported meeting the CDC requirements for physical activity, less than a third of the population ate their daily allowance of fruits and vegetables. Conversations with local focus groups indicate that many parts of Jackson County and all of Josephine County are "food deserts" meaning that there is an abundance of convenience marts that lack fresh produce and other healthy food choices. They also felt that there is a lack of education surrounding nutrition and obesity prevention, particularly among those with the Oregon Trail Card. Cooking classes may offer an avenue to teach basic skills about fresh foods and break the cycle of households growing up with only processed or microwavable food sources. (Asante 2012 CHNA)

Teen Births: Teen births as a percentage of all service area births was 11.8% in Jackson County and 11.2% in Josephine County from 2005- 2007. This compares to a state average of 6.1% and a national average of 10.4%. More disturbing over this same time period was the number of births to mothers who smoked during pregnancy. In Josephine County the percentage was 24% (almost double the state average of 13%) and in Jackson County the percentage was 16%.

(Asante 2012 CHNA) It is well understood that smoking during pregnancy seriously impacts babies and young children. According to the American Pregnancy Association, it can cause low birth weight, preterm delivery, and infant death. It can also cause more colds, lung problems, learning disabilities and physical growth problems in young children. Smoking after birth may cause an increase in infant colds, coughs, and middle ear infections which may lead to bronchitis and pneumonia. Recent studies have now linked babies and young children exposed to third hand smoke, caused by toxins left in carpet, furniture, drapes, hair, etc., to an increase in poor brain development and over time increased risk for asthma, learning disabilities, and cancer. (American Pregnancy Association)

Vaccinations: The Healthy People 2020 established targets for flu vaccines of 90% or higher and pneumonia vaccine of 60% or higher. Our service area population falls short on both prevention interventions. Flu vaccines among adults 65 and over was only 54% across Josephine and Jackson Counties compared to 65% in the state of Oregon and 72% nationally. Among adults aged 18-64 who were high-risk, only 44% received a flu shot and 42% received a pneumonia vaccine. High risk includes adults who report having been diagnosed with heart disease, diabetes, or respiratory disease. (Asante 2012 CHNA)

It is interesting to note that focus groups involved in the Asante Community Health Needs Assessment were particularly concerned about the low rate of immunizations in our communities, specifically in Ashland. They attributed the low rates to a general resistance to any external influence or control that might impact self-management of their health or their lifestyle.

5. Chronic Disease

According to "Keeping Oregon Healthy", heart disease, stroke, cancers, diabetes and chronic lower respiratory diseases account for more than three of five deaths in Oregon. In 2005, the statewide hospitalization costs of these diseases exceeded $1.4 billion. The report goes on to say that chronic diseases and their associated disabilities increase with age. That means as the baby boomer population ages, the number of Oregonians affected by these chronic diseases will escalate, significantly affecting the population's health status and resultant health care needs.

Cancer is the leading cause of death in Oregon. During 2004, 19,683 new cases were diagnosed in Oregonians and 7,320 people died from cancer. Cancer accounted for 24% of all deaths.

Lung cancer is the leading cause of cancer death in Oregon. In 2004, 2,074 Oregonians died from lung cancer, representing nearly 29% of all cancer deaths.

Breast cancer continues to be the most common cancer in Oregon, with 2,671 cases of invasive breast cancer diagnosed among women in 2004.

Heart disease is the second leading cause of death in Oregon for both men and women, accounting for 22% of all deaths.

Stroke is the third leading cause of death in Oregon. It is preventable; 65-80% of strokes are due to elevated blood pressure.

Asthma is the most common chronic disease among children, affecting 8.4% of Oregon youth.

Diabetes was the seventh leading cause of death among Oregonians in 2005. More than 179,000 Oregonians report having been diagnosed with diabetes, and perhaps as many as 62,000 adults in the state have diabetes but have not been diagnosed.

Arthritis is the most common chronic disease and affects 27% of adult Oregonians. It is a leading cause of disability.

High blood pressure is common among Oregonians; 70% of those who have had a heart attack also had high blood pressure.

Elevated blood cholesterol is a common condition; 36% of adult Oregonians have it. This condition increases the risk for both heart disease and stroke.

Obesity increased 57% among Oregonians between 1995 and 2005. Almost one in four adults in the state is obese, more than twice the rate seen just 15 years ago.

Depression is common among those with chronic diseases; one in ten Oregonians with a chronic condition had active symptoms consistent with major depression, and one in three had clinically relevant depression in the prior 12 months.

Early detection of disease through cholesterol screening, mammography and colorectal cancer screening can result in early treatment, reduced disease burden, and increased survival rates.

The information in "Keeping Oregonians Healthy" comes from a variety of sources, including the Behavioral Risk Factor Surveillance Survey (BRFSS). This is an annual, random telephone survey among Oregon adults that tracks rates of chronic disease and related behaviors. The "Oregon Healthy Teens" survey (OHT) is an annual, random school-based survey of Oregon 8th and 11th graders that tracks behaviors such as smoking, physical activity and eating habits.

Specific Chronic Diseases:

Cancer: Continued advances in cancer research, detection, and treatment have resulted in a decline in both the incidence and death rates of all cancers. Among people who develop cancer, more than half will be alive in five years. Yet cancer remains a leading cause of death in the United States, second only to heart disease. It is the leading cause of death in Oregon.

Many cancers are preventable by reducing risk factors such as eliminating tobacco use, increasing physical activity, improving nutrition, reducing obesity, and reducing exposure to ultraviolet light. Other cancers can be prevented through vaccination and screening is effective in identifying some types of cancer, including breast cancer through mammography, cervical cancer through PAP tests, and colorectal cancer through colonoscopy and sigmoidoscopy.

Between 2005 and 2007, there was an annual average age-adjusted cancer mortality rate of 186 deaths per 100,000 population in the service area. This is similar to the statewide rate and the federal rate. However, it falls short of the Healthy People 2020 benchmark rate of 161 deaths per 100,000. Josephine County remains an outlier with 196 cancer deaths per100,000 and lung cancer remains the leading cause of death in the service area. As shown in the following table, the local rate of lung cancer deaths is higher than both the state and national rates. The local prostate cancer death rate is nearly identical to the state but higher than the national rate. The female breast cancer death rate is higher than the state of Oregon but lower than the national rate. And the colorectal cancer death rate is lower than both the state and federal rate.

Age-Adjusted Cancer Death Rates by Geography and Site Type of Cancer

(2005-2007 Annual Adjusted Average Deaths per 100,000 population)

Type of Cancer	Service Area	Oregon	US	HP2020
Lung Cancer	55.2	52.4	51.6	45.5
Prostate	25.7	25.6	23.9	21.2
Female Breast Cancer	23.9	22.1	23.5	20.6
Colorectal Cancer	15.2	16.6	17.2	14.5

(Cited in Asante 2012 Community Health Needs Assessment)

The American Cancer Society recommends that both men and women receive a cancer-related check-up during their regular annual physical. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as counseling on tobacco use, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.

Cancer screening data was collected across the service area as part of the Asante Community Health Needs Assessment. Additional screening data was extracted from the Oregon Behavioral Risk Factor Surveillance Survey (BRFSS) for Curry County. As shown in the following table, cancer screening rates across the service area should be targeted for improvement as the rates fall short of the Health People 2020 targets in all areas for which a target is identified.

Service Area Cancer Screening Rates

Type of Cancer Screening	Curry	Jackson	Josephine	Oregon	US	HP 2020
PAP Smear for women aged 18 – 65	79.8%	76.4%	71.7	74.9%	84.7%	93% or higher
Prostate Screening in last two years, men 50+	NA	80.8%		NA	70.5%	NA
Colorectal Screening in past 5 years for 50 -75 year olds	61.9%	54,6%	48.6%	56.8%		70.5% or higher

Mammograms within last 2 years for women aged 18 – 65	65.9%	70.6%*	72.2%	75.9%	79.9	81.1% or higher

Oregon BRFSS data for Curry County and for missing data from the Asante survey
All other: Asante 2012 CMNA survey because it's more recent – 2010 - 2011

Cardiovascular Disease: Heart disease is the leading cause of death in the United States and the second leading cause of death in Oregon, with stroke following as the third leading cause. Together heart disease and stroke are among the most widespread and costly health problems today, accounting for more than $500 billion in healthcare expenditures and related expenses across the nation in 2010. Fortunately, they are also among the most preventable. The leading controllable risk factors for heart disease and stroke, include:

- High Blood Pressure
- High Cholesterol
- Smoking
- Diabetes
- Diet
- Physical Activity
- Obesity

The burden of cardiovascular disease is disproportionately distributed across the population. There are significant disparities among gender, age, race/ethnicity, geography, and socioeconomic status. This is attributed to prevalence of risk factors, access to treatment, appropriate and timely treatment, treatment outcomes, and mortality. (Asante)

Mortality Rates for Heart Disease – Deaths per 100,000

Disease	Jackson	Josephine	Oregon	US	HP 2020
Heart Disease	151.01	74.2	162.0	200.9	152.7
Stroke	48.5	50.8	49.5	44.2	33.8

Source: Asante 2012 CHNA (excluded Curry County)

Jackson and Josephine County compare favorably to the Health People 2020 target for heart disease but need to improve performance on stroke prevention services. The prevalence of heart disease (morbidity) is lower in Jackson County even though the death rate is higher than Josephine County. There are also disparities across subpopulations. Persons over 40 years of age are more likely to die of heart disease, particularly those over 65. Men and persons of color also have higher prevalence rates.

On the other hand, Josephine County has higher prevalence rate (4.3%) for stroke compared to Jackson County (2.7%), the state (2.5%) and the US (2.7%). Those aged 65 and over as well as low income individuals had the highest rates of 7.6% and 6.0% respectively. (Asante)

According to the BRFSS data for Oregon Counties, Curry County had a prevalence rate for heart disease of 4.4% and for stroke 1.5%.

Risk Factors of Cardiovascular Disease: High blood pressure affects approximately one in three adults in the US and more than half of Americans with high blood pressure do not have it under control. Across our service area, 93.9% of adults had their blood pressure tested in the past two years which is on target (90.7%) for Healthy People 2020. In addition, 87.6% had their cholesterol checked in the last five years which exceeds the Healthy People target of 82.1%. As shown in the following table, high blood pressure for the most part meets or exceeds national targets whereas high cholesterol remains a problem a problem that needs to be addressed as part of a comprehensive prevention initiative.

Prevalence of High Blood pressure and High Cholesterol

Risk Measure	Curry	Jackson	Josephine	Oregon	HP 2020
High Blood Pressure	25.8%	26.8%	34.3%	25.8%	26.9% or Lower
High Cholesterol	32.6%	35.5%	42.7%	33.0%	13.5% or lower

Oregon BRFSS data 2006 - 2009

There are differences across sub-populations in the prevalence of high blood pressure. Persons 65 and over have the highest rate at 53.6% in our service area, followed by persons aged 40 – 64 (40.5%) and women (37.0%). The target set by Healthy People 2020 is 26.8%, indicating that this particular risk measure needs focus to improve performance.

Diabetes: Diabetes affects an estimated 23.6 million people in the US and is the 7th leading cause of death. It lowers life expectancy by 15 years; increases the risk of heart disease by 2-4 times; and is the leading cause of kidney failure, lower limb amputations, and adult onset blindness. Due to the steady rise in the number of persons with diabetes, there is growing concern about the possibility that the number of persons and the complexity of their care could overwhelm existing healthcare systems.

People from minority populations are more frequently affected by type 2 diabetes. Minority groups constitute 25% of all adult patients with diabetes and represent the majority of children and adolescents with type 2 diabetes.

According to the BRFSS Oregon data, the rate of diabetes in the service area was 6.1% in Curry County, 6.4% in Jackson County, and 5.8% in Josephine County. This compares to a statewide rate of 6.8%. However, the data prepared for the Asante 2012 CHNA showed a much higher rate of 10.5% for the service area, compared to 7.2% statewide and 10.1% nationally. This report also listed the mortality rate for diabetes to be 21.6 deaths per 100,000 across the service area which is higher than the Healthy People 2020 target of 19.6. There are differences

across subpopulations. The prevalence of diabetes increases with age, is higher among whites in our service area, and is higher among women.

Diabetes is the most common cause of kidney failure. Death from kidney disease across the service area is 5.6 per 100,000 in Jackson County and 11.5 per 100,000 in Josephine County. This compares to a statewide rate of 8.8 and a national rate of 14.5 deaths per100,000. Both counties compare favorably to national mortality rates and Jackson compares favorably to the rest of the state. (BRFSS Oregon data)

Respiratory Disease: Asthma and Chronic Obstructive Pulmonary Disease (COPD) are significant public health problems across our service area. Asthma is a chronic inflammatory disorder of the airways characterized by reversible episodes of breathing problems due to airway narrowing and obstruction. COPD is a preventable and treatable disease characterized by airflow limitation that is not fully reversible. The airflow limitation is usually progressive and associated with an abnormal inflammatory response of the lung to noxious particles or gases (typically from exposure to cigarette smoke).

Currently, more than 23 million Americans have asthma and approximately 13.6 million adults have been diagnosed with COPD. The prevalence of asthma has increased since the 1980s while the death rate has declined. The causes of asthma are both genetic and environmental.

COPD is the fourth leading cause of death in the US. In nearly 8 out of 10 cases, COPD is caused by exposure to cigarette smoke. In addition, other environment exposures, such as those in the workplace, may cause COPD.

CLRD: Between 2005 and 2007, there was an average rate of 55.4 deaths per 100,000 for chronic lower respiratory disease in our service area. This is higher than statewide (46.4) and national (41.5) rates by over 20%.

Flu/Pneumonia: For flu and pneumonia, the service area compared favorably next to statewide and national trends. Locally, the average death rate for flu or pneumonia was 9.6 per 100,000 whereas the state average is 12.9 and national average is 18.1. However, Jackson County's rate was almost 40% higher than Josephine county at 10.4 and 7.5 respectively.

Lung disease: A total of 10.2% of service area adults suffer from chronic lung disease. This is higher than the national average by 21%. There are differences between the two major counties. Jackson County has a lower rate of 9.2% of the adult population with lung disease compared to 12.5% for Josephine County.

Asthma: Approximately 10% of the service area adults suffer from asthma. This is somewhat higher than state rates of 9.5% and national rates of 7.5%. There are disparities across

subpopulations. Almost 29% of non-white minorities have asthma and 20% are low income. Women have higher rates than men while age does not seem to be a factor among adults. Approximately 6% of children have asthma, somewhat lower than national averages of 6.8%.

Mental Health and Mental Disorders: Mental disorders are the most common causes of disabilities and account for 25% of all years of life lost caused by disability and premature mortality. It is estimated that people with serious and persistent mental illness die 25 years earlier than the rest of the population. This is due to the existence of other co-morbid conditions that often go undiagnosed and untreated. According to the National Institutes of Mental Health, one in seventeen people have a seriously debilitating mental illness.

Mental health and physical health are inherently connected. Mental health plays a key role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

A total of 13% of service area adults believe their overall mental health is fair or poor. This is similar to nationally reported data of 11.7%. There are differences however within the service area. Jackson County reported only 9.3% of respondents with fair to poor mental health whereas Josephine County reported 14.4%, significantly higher than Jackson and somewhat higher than national averages. There are disparities across subpopulations in the service area. The group most likely to assess their mental health as fair or poor are non-white (26%) and low income (19.6%).

Depression: A total of 15% of the service area adults have been diagnosed with major depression by a physician or other healthcare professional compare to 12% nationally. The percentages increase among non-white populations (26.5%), low income (25.7%), and women (18.7%).

Chronic Depression: A total of 31.5% of service area adults reported symptoms of chronic depression, involving two or more years when they felt depressed or sad on most days. There are differences between counties. About 28% of Jackson County respondents reported chronic depression while Josephine respondents reported 34.6%. This compares to a national average of 26.5%.

Among adults with diagnosed depression, about 80% acknowledged that they have sought professional help for a mental or emotional problem. This is similar to national findings and similar to Health People 2020 target of 75% or higher.

Suicide: Between 2005 and 2007 there was an annual average age-adjusted suicide rate of 18.5 deaths per 100,000 in Jackson County and 20.8 deaths per 100,000 in Josephine County. This is much higher than national rates (11.1) and does not satisfy the Health People 2020 target of 10.2 deaths per 100,000 or lower.

The Asante 2012 Community Need Assessment included focus group interviews that discussed mental health in the community. The focus group described the mental health system as "broken" and believed that a continuum of care is necessary to provide the best treatment of mental health clients. They expressed worry that client's ability to access mental health resources was constrained because of the limited number of providers and facilities available across the service area. Most times, hospital emergency rooms are the only option because psychiatric facilities are full with waiting lists and interventional services are not in place. This was more problematic for children's mental health needs.

Alzheimer's Disease: Alzheimer's disease is the6th leading cause of death among adults age 18 and older. Experts suggest that 5.1 million Americans age 65and over have Alzheimers. These numbers are predicted to increase to more than double by 2050 unless more effective ways to treat and prevent the disease are found.

Between 2005 and 2007 there was an annual average mortality rate attributed to Alzheimers of 22.1 deaths per 100,000 population in the service area. The numbers were significantly different between counties. Josephine County's rate was 24.2 while Jackson County's rate was 37.6 deaths per 100,000, a 55% increase. The average for Oregon is 29.0 and nationally it is 22.7. Clearly Jackson County is an outlier and future performance improvement efforts should focus on this subpopulation.

6. **Social Determinants of Health** *(Source: HealthyPeople.gov)*

The range of personal, social, economic, and environmental factors that influence health status are known as *determinants of health*. Determinants of health fall under several broad categories:

Policymaking: Policies at the local, State, and Federal level affect individual and population health. Increasing taxes on tobacco sales, for example, can improve population health by reducing the number of people using tobacco products.

Some policies affect entire populations over extended periods of time while simultaneously helping to change individual behavior. For example, the 1966 Highway Safety Act and the National Traffic and Motor Vehicle Safety Act authorized the Federal Government to set and regulate standards for motor vehicles and highways. This led to an increase in safety standards for cars, including seat belts, which in turn, reduced rates of injuries and deaths from motor vehicle accidents.

Social: Social determinants of health reflect social factors and the physical conditions in the environment in which people are born, live, learn, play, work and age. Also known as social and physical determinants of health, they impact a wide range of health, functioning and quality of life outcomes. Examples of *social determinants* include:

- Availability of resources to meet daily needs, such as educational and job opportunities, living wages, or healthful foods
- Social norms and attitudes, such as discrimination
- Exposure to crime, violence, and social disorder, such as the presence of trash
- Social support and social interactions
- Exposure to mass media and emerging technologies, such as the Internet or cell phones
- Socioeconomic conditions, such as concentrated poverty
- Quality schools
- Transportation options
- Public safety
- Residential segregation

Examples of *physical determinants* include:

- Natural environment, such as plants, weather, or climate change
- Built environment, such as buildings or transportation
- Worksites, schools, and recreational settings
- Housing, homes, and neighborhoods
- Exposure to toxic substances and other physical hazards
- Physical barriers, especially for people with disabilities
- Aesthetic elements, such as good lighting, trees, or benches

Poor health outcomes are often made worse by the interaction between individuals and their social and physical environment. For example, millions of people in the United States live in places that have unhealthy levels of ozone or other air pollutants. In counties where ozone pollution is high, there is often a higher prevalence of asthma in both adults and children compared with State and National averages. Poor air quality can worsen asthma symptoms, especially in children.

Health Services

Both access to health services and the quality of health services can impact health. Healthy People 2020 directly addresses access to health services as a topic area and incorporates quality of health services throughout a number of topic areas. Lack of access, or limited access, to health services greatly impacts an individual's health status. For example, when individuals do

not have health insurance, they are less likely to participate in preventive care and are more likely to delay medical treatment. Barriers to accessing health services include:

- Lack of availability
- High cost
- Lack of insurance coverage
- Limited language access

These barriers to accessing health services lead to:

- Unmet health needs
- Delays in receiving appropriate care
- Inability to get preventive services
- Hospitalizations that could have been prevented

Individual Behavior

Individual behavior also plays a role in health outcomes. For example, if an individual quits smoking, his or her risk of developing heart disease is greatly reduced. Many public health and health care interventions focus on changing individual behaviors such as substance abuse, diet, and physical activity. Positive changes in individual behavior can reduce the rates of chronic disease in this country. Examples of individual behavior determinants of health include:

- Diet
- Physical activity
- Alcohol, cigarette, and other drug use
- Hand washing

Biology and Genetics

Some biological and genetic factors affect specific populations more than others. For example, older adults are biologically prone to being in poorer health than adolescents due to the physical and cognitive effects of aging. Sickle cell disease is a common example of a genetic determinant of health. Sickle cell is a condition that people inherit when both parents carry the gene for sickle cell. The gene is most common in people with ancestors from West African countries, Mediterranean countries, South or Central American countries, Caribbean islands, India, and Saudi Arabia. Examples of biological and genetic social determinants of health include:

- Age
- Sex
- HIV status
- Inherited conditions, such as sickle-cell anemia, hemophilia, and cystic fibrosis

- Carrying the BRCA1 or BRCA2 gene, which increases risk for breast and ovarian cancer
- Family history of heart disease

B. Qualitative Review

1. Community Perceptions of Health and Quality of Life (citations)

According to the 2012 Community Health Needs Assessment prepared by Professional Research Consultants, Inc. on behalf of Asante Health System, 75% of survey respondents rated the local health system in Jackson and Josephine Counties as good, very good, or excellent. However, 25% rated the local system as fair or poor which is less favorable than reported nationally. The poor ratings were much higher in Josephine County and in the secondary service area that included Curry County. Individuals that perceived the local health system to be fair or poor were most likely to be low income (42%), under age 40 (30%) and uninsured (39%). There was no difference between non-white and white respondents at 25%.

2. Knowledge of Community Resources and Assets

Community resources and assets involving an inventory of physical health, mental health, dental health, and community based services is available in the AllCare CCO Application, its contracting partners, and its provider tables. However, there are other assets that directly and indirectly impact our ability as a CCO to create healthier communities. As we prepare and update our Community Health Needs Assessment over the years we will address the following structural and foundational concepts that lead to improved population health, improved individual health, and reduced health care per capita costs.

1. Examination of Root Determinants:
    a. Equity and social justice issues that impact the distribution of resources (health, social, economic, cultural, educational and environmental resources) within a given population
    b. Societal resources that measure and evaluate the essential public and private capacities and collective resolve to meet basic needs of the communities we serve, including:
        i. Standards of living
        ii. Culture and history
        iii. Social institutions
        iv. Built environments
        v. Political structures
        vi. Economic systems
        vii. Technology

2. Over-riding Goals and Intermediate Objectives to Improve Community Resources that Positively Impact Health through Improved:
    a. Neighborhood living conditions

b. Community Development and employment opportunities
c. Social cohesion, civic engagement, and collective efficacy
d. Prevailing community norms, customs, and processes
e. Opportunity for learning and developing capacity
f. Health promotion, prevention, and care opportunities

C. Collaboration Between Public Health and the Health System

1. Current Collaborations

AllCare Health Plan (and its predecessor MCO) has a multiyear history of collaboration with local public health departments on behalf of our OHP enrollees. These collaborations are designed to rationalize public dollars by harmonizing programs and services across the continuum of care. This includes working with public health to provide flu and pneumonia vaccinations for our more vulnerable and at-risk members; we refer our members to child and women's health programs such as WIC, immunization, and early childhood development; and we collaborate with public health and other community based programs on health and wellness programs such as nutrition, smoking cessation, parenting, food bank, and other community based services. AllCare Health Plan is in the process of designing new policies, procedures, and protocols for the integration of physical health and mental health in three ways:

- Embedding mental health case managers within our recognized Primary Care Medical Home practices on a regular basis
- Embedding a primary care medical home into selected behavioral health centers for the treatment of the severe and persistently mentally ill who also have comorbid chronic conditions – program design and policies and procedure development is underway
- Collaborating at the health plan level on reducing unnecessary and avoidable emergency room visits and readmissions among the seriously mentally ill. Since implementing this program in Fall, 2011, there has been a 13% reduction in unnecessary emergency room visits and preliminary data indicate a reduction in avoidable hospital readmissions in Josephine County. Plans are underway to expand this program initiative to Curry and Jackson County later this year.

Our CCO Stakeholder group embodies the kind of collaboration we expect as a CCO across the continuum of care. The Stakeholder group will sunset as the MCO transitions to a CCO and many if not all stakeholders that are involved now will transition as well, becoming members of our standing committees for ongoing governance of the organization. We are proud of the transparent process we have nurtured throughout the CCO certification process and our structure is designed to maintain an inclusive working environment for ongoing CCO growth and development.

2. Use of Nationally Recognized Performance Standards

As demonstrated in our summary of the current health status of our population, we are using the Healthy People 2020 targets for screening and prevention of specific chronic conditions with

an eye on reducing overall mortality and morbidity of preventable and treatable disease. There are also county-specific criteria and benchmarks that are reflected in each county's annual public health plan that will be incorporated into the CCOs community goals and objectives as appropriate. We will emphasize evidence based benchmarks and goals established by the National Institute for Mental Health, Substance Abuse and Mental Health Services Administration (SASMHA), Agency on Healthcare Research and Quality (AHRQ), HEDIS, CAHPS, and CHIPRA, state program and policy initiatives, as well as national trade associations such as the American Medical Association, the American Hospital Association, the Primary Care Medical Home Collaborative and others.

D. Current Health Status and Health Needs of the Population

1. **Racial and Ethnic Communities:** Please refer to Section A above that addresses disparities in health status where disparities have been identified.

2. **Tribal members:** There are 125 OHP members within our MCO that identify themselves as Native American. They are represented by many different tribes as there are no tribes resident in our service area. There are no Indian Health Services Clinic in the area; however, there are two IHS clinics located in Klamath County which are the closest geographically. There are no 638 Tribal Clinics in our service area. The closest clinic is operated by the Cow Creek Tribe in Roseburg. At this time, our tribal members have access to their assigned primary care physician and participate in the current MCOs quality improvement, prevention, wellness, and chronic disease management programs the same as all OHP members. As our care coordination capabilities increase as part of our primary care home recognition ramp-up, they too will have access to integrated team-based care in culturally sensitive settings.

3. **Older Adults aged 65 and over:** Please refer to Section A above that describes the current health status of older adults, particularly identified disparities due to age.

4. **People with Disabilities:**

Current Developmentally Disabled Enrollment and Resources

AllCare Health Plan Service Area	Children	Adults	Total
Number of Individuals Living with Developmental Disabilities			
• Curry	35	81	116
• Jackson	284	663	947
• Josephine	133	344	477
• Total	452	1,088	1,540
Number of Individuals who Live in Licensed/Certified Homes (Group Homes, Foster Care, etc.)			

• **Curry**	**3**	**39**	**42**
• **Jackson**	**30**	**220**	**250**
• **Josephine**	**21**	**141**	**162**
• **Total**	**54**	**400**	**454**
Number of Adults in Support Service Brokerage			
• **Curry**	**--**	**35**	**35**
• **Jackson**	**--**	**370**	**370**
• **Josephine**	**--**	**80**	**80**
• **total**	**--**	**485**	**485**
Foster Care Providers			
• **Curry**	**--**	**6**	**6**
• **Jackson**	**11**	**34**	**45**
• **Josephine**	**13**	**24**	**37**
• **Total**	**24**	**64**	**88**

As part of our ongoing Community Health Needs Assessment and planning process, the needs of our developmentally disabled enrollees will be woven into the conversation.

5. **LGBT Populations:** To be developed

6. **Uninsured and Underinsured**: Please refer to Section A for a description of the health status and health disparities of our low income population.

E. **Environmental Scan of External Forces that Impact Promotion and Protection of the Public's Health: To be developed**

F. **Document Use of Public Health Accreditation Board Standards and Measures:** To be developed

G. **Document Process for conducting an environmental scan (including community member engagement):** To be developed