# Western Oregon Advanced Health (WOAH)

*Transformation Plan Summary*

## Background

Western Oregon Advanced Health's (WOAH) knowledge of Collective Impact informed the design of its Transformation Plan. The 2010 Stanford University study focused on identification of common elements shared by highly structured coordinated efforts that achieved substantial impact on large scale social problems and concluded that five co-occurring conditions, known as Collective Impact, were critical to achieving true system change. The five conditions that distinguish Collective Impact include; a common vision; shared measurements; mutually reinforcing activities; continuous communication; and a lead backbone organization. WOAH used the creation of its Transformation Plan as an opportunity to commit itself to true system change. WOAH is prepared to serve as the rock-solid backbone organization that will lead Health System Transformation in Coos and Curry Counties.

Rather than creating another white paper that will sit on the shelf, WOAH set forth its Transformation Plan as a portfolio of project work. As recommended by the Institute for Healthcare Improvement, for each major element of transformation WOAH included an abbreviated environmental scan; identified one or more core strategies; developed a corresponding strategy-specific and time-framed work plan; and estimated budget impacts.

## Transformation Initiative Descriptions

***(1) Area of Transformation:*** *Developing and implementing a health care delivery model that integrates mental health and physical health care and addictions and dental health, when dental services are included. This area of transformation must specifically address the needs of individuals with severe and persistent mental illness.*

WOAH's Transformative Plan for Integration of Physical, Mental and Behavioral Health has six project areas to achieve integration. These are:

- Use of the Four-Quadrant Model as the primary protocol to improve coordination of care across agencies where complete integration is not yet achieved. Providers will be trained and as appropriate, "fourth quadrant" patients will be assigned the services of a health navigator.
- Early Intervention through co-location of physical/mental health providers, annual screenings for depression and substance abuse, and integrated treatment plans.
- Use of Super Case Managers to coordinate case management for high needs patients, specifically those identified as Fourth Quadrant members.
- Planning for Intensive Services Array (ISA) for children through creation of the System of Care Advisory Council which will report to WOAH's Community Advisory Council. The System of Care Council will review quality data from Coos County Mental Health

and provide input to the service provision. The ISA service design includes Child and Family Teams through which high fidelity wraparound services are coordinated, use of Health Navigators or Support Specialists when appropriate, flexible response capacity, evidence-based practices, family and peer support, physician integration and steps towards greater alignment with social service system/social determinants.

- Improving diabetes outcomes for adult patients with Severe and Persistent Mental Illness by optimizing medication management through establishment of a Medication Therapy Management Program.
- Creation of a time-limited Blue Ribbon Committee to make recommendations to the WOAH Board regarding the need, cost-efficacy and outcome-efficacy for the development of future enhanced integrated clinical services. Based on WOAH Board direction, a separate work plan will be designed and implemented.

Benchmark to be achieved by July 2015 is consistent with the Statewide Performance Improvement Project and will focus on improving diabetes outcomes for adults with Severe and Persistent Mental Illness and will show a 10% improvement over baseline.

***(2) Area of Transformation:** Continuing implementation and development of Patient-Centered Primary Care Home (PCPCH).*

WOAH is served by 55 primary care providers. Of these, 38 (69 percent) are affiliated with North Bend Medical Center and Waterfall Community Health Center. North Bend Medical Center is a state-recognized Primary Care Medical Home at Tier 2 and Waterfall Community Health Center is state-recognized at Tier 3.

WOAH's Quality Improvement Coordinator will function as lead staff to provide specific and focused technical assistance to those practices that have not attained PCPCH certification and to those at Tier 2 to encourage matriculation to Tier 3.

Benchmark to be achieved by July 2015 is 100% of WOAH members will be served by a PCPCH.

***(3) Area of Transformation:** Implementing consistent Alternative Payment Methodologies that align payment with health outcomes.*

WOAH will seek to negotiate a workable agreement with critical access hospitals for an alternative payment methodology that is not predicated upon cost-based reimbursement. Additionally WOAH will develop and introduce Primary Care Provider Dashboards for selected indicators as a first step in linking alternative payment methodologies with quality outcomes. WOAH may implement case rate payments for selected medical specialties and Primary Care Pay-for-Performance to augment capitation rates for selected indicators.

Benchmark to be achieved as of July 1, 2015 is a 2% reduction in total cost PMPM in the first one half of contract year 2015, when compared to the first one-half of 2013. At the same time, there will be no decrease in quality assurance measures between baseline and 06-15-2015, as measured by OHA-established incentive metrics.

***(4) Area of Transformation:*** *Preparing a strategy for developing Contractor's Community Health Assessment and adopting an annual Community Health Improvement Plan consistent with SB 1580 (2012), Section 13.*

The Community Health Needs Assessment which was completed and included in WOAH's initial CCO application will be updated to include additional data and presented to both the Community Advisory Council (CAC) and WOAH Board.

The CAC will develop and recommend a Community Health Improvement Plan and submit to WOAH Board.

Benchmark to be achieved as of July 1, 2015: the Community Health Assessment will be updated by 03-31-2015 and the Community Health Improvement Plan will be completed by 07-01-2015.

***(5) Area of Transformation:*** *Developing a plan for encouraging Electronic Health Records; health information exchange; and meaningful use.*

WOAH will actively research and pursue a local Health Information Exchange solution that will support information sharing across many Electronic Medical Record (EMR) systems. Included in this work is evaluation of potential costs and financial commitment to the endeavor. Additionally, WOAH will participate in statewide Health Information Exchange initiatives and workgroups to move towards an effective system.

Benchmark to be achieved as of July 1, 2015 is 20% increase over baseline in the proportion and adoption of providers using Electronic Medical Records

***(6) Area of Transformation:*** *Assuring communications, Outreach, Member engagement, and services are tailored to cultural, health literacy, and linguistic needs.*

WOAH will have access to certified American Sign Language interpreters, TTY or TDD services, and Language Link. Printed materials will be made available in Spanish and audio formats. In order to provide additional outreach to members with low literacy, WOAH will continue to provide in-person orientations in collaboration with social service agencies to deliver the information in conjunction with other programs in which members frequently participate.

WOAH shall annually sponsor in-service training for its providers on alternative communication formats. WOAH will work with community partners and the Community Advisory Council to assure there are no disparities in member engagement and to gather input on effective ways to communicate and achieve member engagement.

To further encourage member engagement, WOAH will support Living Well, Oregon's name for Stanford's Chronic Disease Self Management Program. Other evidence based models may also be considered. Additionally, WOAH plans to develop training for Non-Traditional Health

Workers and will work with local entities to build upon current resources related to the training and use of Non-Traditional Health Workers.

Benchmark will be based on the Consumer Assessment of Health Providers & Systems (CAHPS) Composite: Health Plan Information and Customer Service. Baseline will use responses of *Always* or *Usually* per queried variable derived from Member survey. Data will be compared across Member groups to ensure no specific disparities by race, ethnicity, or disability status. Benchmark to be achieved as of July 1, 2015: Minimum Score of 85% with no statistically significant differences among groups by race, ethnicity, or disability status.

***(7) Area of Transformation:*** *Assuring that the culturally diverse needs of Members are met (Cultural Competence training, provider composition reflects Member diversity, non-traditional health care workers composition reflects Member diversity).*

At the time of CCO certification, WOAH was serving 101 households with limited English proficiency; all of which were native Spanish speakers. As part of its Quality Improvement plan, WOAH will collect data from each participating provider at the time of re-credentialing about languages, literacy, and cultures in which they feel competent. WOAH will make the services of certified health care interpreters available in any county in which there are thirty-five or more enrolled Member households that are characterized by Limited English Proficiency and that speak the same native language. WOAH shall identify and sponsor at least two persons from Coos County who are bi-lingual and bi-literate to complete the required academic and internship experiences leading to certification as a Health Care Interpreter. This process will be repeated in Curry County upon the occasion that the threshold of 35 Member households is met.

Benchmark will utilize responses to the CAHPS Composite: Getting Care Quickly If disparities among groups are identified at baseline, there will be a 10% improvement over baseline by July 2015.

***(8) Area of Transformation:*** *Developing a Quality Improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes.*

WOAH will develop a Quality Improvement plan through the hiring of a Quality Assurance Director, seating a Clinical Advisory Panel, and undertaking two Performance Improvement Projects, one under the direction of the CCO Medical Director and the other under the leadership of Coos County Mental Health Department's Director.

WOAH's Transformative Plan for Quality Improvement identifies a focus on disparity of care of rural members and will compare utilization patterns between rural and more urban members in two areas: Developmental Screening by Age 36 Months and Colorectal Cancer Screening for members 50-75 years of age. Utilization rates of Members residing in rural vs. Coos Bay/North Bend zip codes will be compared, with the goal of eliminating disparities for rural residents.

Benchmark will be 10% improvement over baseline with a minimum score of 50% for Developmental Screening and 61.34% for Colorectal Cancer Screening of rural members.