HEALTH SYSTEM TRANSFORMATION PLAN

PART I: NARRATIVE

Phil Greenhill
Chief Executive Officer

Western Oregon Advanced Health, LLC
PO Box 1096
Coos Bay, Oregon 97420
541.269.7400

February 2013

HEALTH SYSTEM TRANSFORMATION PLAN

Table of Contents

Summary of Contractual Measures submitted separately as “WOAH Transformation Plan Exhibit K”

HEALTH SYSTEM TRANSFORMATION PLAN

Setting the Stage

In 2010, social innovation researchers at Stanford University undertook a retrospective study purposed at identifying the common elements shared by highly structured coordinated efforts that achieved substantial impact on large-scale social problems, such as environmental clean-up, improving the community's public education system, and childhood obesity. The researchers concluded that each of these coordinated efforts shared five key conditions that distinguished them, and the researchers termed this set of five co-occurring conditions as *collective impact*. The five conditions that distinguish *collective impact* include: a common vision; shared measurements; mutually reinforcing activities; continuous communication; and a lead backbone organization.

Western Oregon Advanced Health's knowledge of *collective impact* has informed the design of its *Transformation Plan.* It is known that *transformation* will not be possible until all participants, including providers and Members, have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions. The truth is, of course, that this shared vision – the most essential element of *transformation* – exists only as an ideal espoused in the form of tomes of professional literature and ambitious legislation. While many providers of health care services have embraced the need for health care *transformation*, others, perhaps more jaundiced, perceive health care *transformation* as simply the next iteration in a litany of successive public policy efforts to constrain their practices or profits. They recall, with no degree of fondness, the transitions from *lateral integration* to *weighted work units* to *vertical integration* to *diagnostic resource groups* to *clinical pathways* to *managed care* with its promise for *shared savings* and *capitated payments* that were to eliminate the need for *HCFA 1500 forms,* and perceive *accountable* and *coordinated care organizations* as simply the next passing phase. All too many Members are passive consumers of health care services and believe that health care is something that happens to them, often at the hands of a provider, rather than something that happens within them as the result of their own initiative. Health system *transformation* will not come about until a *shared vision* is achieved, and the attainment of a *shared vision* – much akin to a decided shift in culture, norms, and beliefs – cannot and will not be produced as the result of a *Transformation Plan*, howsoever well intended and ambitious such a plan may be. In fact, literature and research tells us that organizational and strategic planning is ineffective when it is undertaken primarily to meet the expectations and dictates of others.

Because the Triple Aim entails ambitious improvements at all levels of the health care system, the Institute for Healthcare Improvement advocates a systematic approach to change. Based on six phases of pilot testing with over 100 organizations around the world, the Institute for Healthcare Improvement recommends a change process that includes: identification of target populations; definition of system aims and measures; development of a portfolio of project work that is sufficiently strong to move system-level results; and rapid testing and scale-up that is adapted to local needs and conditions. To a significant extent, these four change processes are reflected throughout Western Oregon Advanced Health's *Transformation Plan.*

Western Oregon Advanced Health believes that to do this work effectively, it's important to harness a range of community determinants of health, empower individuals and families, and substantially broaden the role and impact of public health and primary care. In the final analysis, prevention is the principle means for achieving two legs of the Triple Aim: improving health outcomes and reducing costs. Achieving both the potential and the promise requires large-scale, long-term changes in which wellness must be the focus. The challenge of prevention today has shifted from such public health initiatives as hand washing, refrigeration, and clean water, to helping people eliminate the risk factors that lead to chronic disease. The ultimate goal of prevention should not only be to control and manage risk factors, but to prevent the onset of risk factors in the first place. However, when the target population is characterized by disproportionate risk factors evident over decades and life spans, the attainment of *transformation* mandates concurrent foci and resource allocation to addressing existing needs and disparities while working to prevent the onset of new risk factors that lead to health inequities – and it is amid this mix that the new *shared vision* must be carefully nurtured.

Western Oregon Advanced Health is prepared to serve as the rock-solid and experienced backbone organization that will lead *Health System Transformation* in Coos and Curry Counties of Southern Oregon through multi-pronged approaches with participating providers, organizations, stakeholders, and Members. But to do so, Western Oregon Advanced Health cannot blindly adhere to a series of strategic actions that have been committed to writing in a planning document, but rather must reserve the absolute right to be flexible in order to nimbly respond to on-the-ground issues, challenges, changes, and circumstances as they arise. Western Oregon Advanced Health is committed to this end, and pursuant to the rules of *collective impact*, will collect data and measuring results consistently across all provider sites to ensure that efforts remain aligned and participants hold each other accountable. Although providers' activities may be differentiated, they will still be coordinated through mutually reinforcing strategies. Consistent and open communication is needed across the many players to build trust, assure the attainment of mutual objectives, and create common motivation. Western Oregon Advanced Health believes that, by applying the five conditions of *collective impact,* the coordinated care organization will have a more powerful and realistic paradigm for health care transformation and the most important *deliverable* will be that which cannot be documented, but rather sensed: a *shared vision for health*.

Rather than to create a philosophical and theoretical planning white paper that will sit on the shelf and collect dust, Western Oregon Advanced Health sets forth its *Health System Transformation Plan* as a portfolio of project work, as recommended by the Institute for Healthcare Improvement. For each major element of *transformation*, Western Oregon Advanced Health has: provided an abbreviated environmental scan (or status report); identified one or more core strategies; developed a corresponding strategy-specific and time-framed work plan; and estimated budget impacts (which may, or may not, preclude the performance of the corresponding strategy).

Special Notes to the Reader: Throughout this document: (1) the term *behavioral health* is operationally defined to include mental, emotional, and addictive disorders. (2) certain metrics that have been developed for internal use will be notated as such and will not be carried forward to the contract amendment template.

Western Oregon Advanced Health

I. A. The Transformative Plan for Integrating Physical, Mental, and Behavioral Health Care – Four-Quadrant Model

Environmental Scan	(1) Through the CCO Application and Readiness Review processes, Western Oregon Advanced Health adopted the National Association of Community Behavioral Healthcare's *Four Quadrant Model* as the primary protocol for the attainment of integrating physical, mental, and behavioral health care, including services to people with severe and persistent mental illness. (2) Consistent with the Oregon Health Authority's guidelines and requirements, Western Oregon Advanced Health has also embraced the *Patient-Centered Primary Care Medical Home* model. This model supports improved coordination of care across agencies where complete integration is not yet achieved.
Core Strategies	1. Orient all providers to the *Four Quadrant Model* 2. As appropriate, "fourth quadrant" patients are assigned to a health navigator
Performance Period	31 January 2013 to 30 June 2015

Work Plan

Action Step	Responsible Party	Deliverable (If Any)	Due Date
Orient all providers to *Four Quadrant Model*	CCO Medical Director Mental Health Directors ADAPT Director	Attestations	02-28-2013
As appropriate, "fourth quadrant" patients, including those with severe and persistent mental illness, are assigned to the services of a health navigator	County Mental Health Directors	Attestations	06-30-2013

Budget Impact

Strategy	Budget Impact
Orientation of providers to *Four Quadrant Model*	Neutral
Fourth Quadrant patients assigned to a health navigator	[Cost of Navigators]

Western Oregon Advanced Health

I. B. The Transformative Plan for Integrating Physical, Mental, and Behavioral Health Care – Early Intervention

Environmental Scan	Coos County Mental Health currently out-stations mental health professionals at the two largest primary care practices in Coos County, and contracts with Waterfall Community Health Center to provide similar services using their own employees. Mental health professionals are absent from primary care practice settings in Curry County. ADAPT currently out-stations one behavioral health care consultant and addiction specialist at the two largest primary care practices in Coos County and participates in the Pain Committee at Waterfall Community Health Center. All WOAH members have an identified primary care provider (PCP) identified.
Core Strategies	1. Embed mental health and addiction professionals in primary care practices 2. Annually screen patients for mental health and addiction needs 3. As appropriate, develop integrated treatment plans, including those for people with severe and persistent mental illness. 4. Application of SBIRT (Screening, Brief Intervention, and Referral to Treatment) as Evidence-Based Best Practice Model
Performance Period	1 August 2012 to 30 June 2015

Work Plan

Action Step	Responsible Party	Deliverable (If Any)	Due Date
Coos County Mental Health and ADAPT to out-station behavioral health professionals in all PCPCHs with > five primary care providers (or, the case of Waterfall CHC and Bandon RHC, to contract for similar services)	Coos County Mental Health Director; ADAPT Director	Attestation of Coos County Mental Health & ADAPT Directors	03-31-2013
Curry County Mental Health to out-station mental health professionals in all PCPCHs with > three primary care providers	Curry County Mental Health Director	Attestation of Curry County Mental Health Director	04-30-2013
PCPs and Mental Health/Addictions professionals to annually screen all established and new patients (in these settings) for mental health and addiction needs	Patient Centered Primary Care Homes and PCPs, Coos and Curry Counties Mental Health Directors, ADAPT Director	Encounter data with appropriate screening codes	Continuous
Screening results are reviewed with appropriate providers and patient; Internal or external referrals are made, as needed; Barriers to care are identified	PCPCH and PCPs, Coos and Curry Counties Mental Health Directors; ADAPT Director	Referral reports from Mental Health and Addictions treatment programs; PCPCH activity logs	Continuous
Integrated treatment plans are completed for all referred patients including those with severe and persistent mental illness, and specifically address barriers to care and health goals	PCPCH and PCPs, Coos and Curry Counties Mental Health Directors; ADAPT Director	Completed and Updated Treatment Plans	Continuous
Crisis services are provided as needed	Coos and Curry Counties Mental Health Directors; ADAPT Director	Service reports from Crisis agencies	Continuous

I. B. The Transformative Plan for Integrating Physical, Mental, and Behavioral Health Care – Early Intervention -- Continued

Internal Measures

	Screening for Clinical Depression
How Benchmark Will be Measured [Baseline to 1 July 2015]	**Numerator:** Patients screened using standardized tool with follow-up plan documented in the clinical record **Denominator:** All patients, age 12+, seen during measurement year as indicated by appropriate CPT code
Milestones to be Achieved [As of 1 July 2014]	5% Improvement Over Baseline
Benchmark to be Achieved [As of 1 July 2015]	10% Improvement Over Baseline

	Substance Abuse - SBIRT
How Benchmark Will be Measured [Baseline to 1 July 2015]	**Numerator**: Number of patients SBIRT-screened, per Code H0049 or H0050 **Denominator**: All patients, age 12+, seen during year, per CPT Codes
Milestones to be Achieved [As of 1 July 2014]	5% Improvement Over Baseline
Benchmark to be Achieved [As of 1 July 2015]	10% Improvement Over Baseline

Budget Impact

Strategy	**Budget Impact**
All associated costs are currently included in sub-global budget contract agreements with Coos and Curry County Mental Health Departments and ADAPT	Neutral

Western Oregon Advanced Health

I. C. The Transformative Plan for Integrating Physical, Mental, and Behavioral Health Care – Care Coordination and Case Management

Environmental Scan	At present, the preponderance of patients who are in need of case management services receive those case management services, but these services are delivered by a wide variety of case managers who are affiliated with multiple agencies and organizations, some of which do not currently interface with the health care setting. The objective is to consolidate the care for such patients under the coordinating guidance (and enforcement) of Super Case Managers.
Core Strategies	Patients with complex medical, mental health, and addiction issues, including those with severe and persistent mental illness when appropriate [e.g., Fourth-Quadrant patients], will receive the services of a *Super Case Manager*, as explained and illustrated in detail in Western Oregon Advanced Health's CCO Application and related Readiness Review documents. The Super Case Manager is responsible for tracking goals, assuring that responsible parties fulfill their obligations to the patient, and enforcing time-frames established in written treatment and care plans. A "care team" will be involved with this classification of patients, so there will be multiple parties with separate (unique) responsibilities for providing care and follow-up.
Performance Period	

Work Plan

Action Step	Responsible Party	Deliverable (If Any)	Due Date
Identify and/or Retain Super Case Managers	Lonnie Scarborough	Roster of Super Case Managers	04-30-2013
Orient Super Case Managers to Roles and Authorities	Lonnie Scarborough	Attestation of Orientation	05-31-2013
Supervise the Work of Super Case Managers	Lonnie Scarborough	Supervision Notes	Continuous
Evaluate the Effectiveness of Super Case Management, with Corresponding Program Adjustments, as Needed	WOAH Board of Directors	Written Evaluation Findings & Minutes of Board Meeting	06-30-2014

Internal Measures

	Follow-Up After Hospitalization for Mental Illness
How Benchmark Will be Measured [Baseline to 1 July 2015]	**Numerator:** MH outpatient or partial hospitalization enc/claim that occurs within 7 days of discharge **Denominator:** Number of discharges from acute inpatient settings with principal mental health diagnosis in patients aged 6 and older
Milestones to be Achieved [As of 1 July 2014]	10% Improvement Over Baseline
Benchmark to be Achieved [As of 1 July 2015]	Objective Attained at > 90%

	Mental & Physical Health Assessments for Children in DHS Custody
How Benchmark Will be Measured [Baseline to 1 July 2015]	**Numerator:** MH and PH assessment within 60 days of DHS custody date **Denominator:** Children, age 4+, taken into custody within a given timeframe who remained in DHS custody for 60 days
Milestones to be Achieved [As of 1 July 2014]	10% Improvement Over Baseline
Benchmark to be Achieved [As of 1 July 2015]	Attained at the rate of > 90%

Budget Impact

Strategy	**Budget Impact**
Year 1 - Super Case Managers: In Year 1, there will be three Super Case Managers, who are employed with existing resources, at Coos County Mental Health, Curry Health Network, and Southwestern Oregon IPA. A PDSA cycle will occur during Year 1 to determine if there is a need for more or less Super Case Managers in Year 2	Neutral
Year 2 – Super Case Managers:	To Be Determined

Western Oregon Advanced Health

I. D. The Transformative Plan for Integrating Physical, Mental, and Behavioral Health Care – Intensive Services Array for Children

Environmental Scan	The ISA transformation plan for Western Oregon Advanced Health in Coos County involves building on existing capacity to develop an array of services and supports that will maximize the number of children with serious behavioral disorders who are able to remain at home and/or in the county, while establishing integrated linkages with community partners as well as out of county resources that from time to time may be necessary. The plan will establish a community system of care, with wraparound as its planning process, utilizing global budget and case rate financing mechanisms, with ongoing process and outcome measurement. The plan builds on existing systems and strengths in the community and implements key findings of the wraparound and system of care assessment performed by community partners earlier this year, as organized by the Addictions and Mental Health Division. The following outlines the key elements of the transformation plan.
Core Strategies	**I. System of Care** **A.** The design, implementation, and ongoing performance of the integrated service array will be overseen by an advisory committee, titled for the purposes of this plan as the System of Care Advisory Council. Currently there are two advisory committees regarding children's mental health services in Coos County. One is The Children's Community Mental Health Advisory Committee, and the other is the Coastline Advisory Committee. The Coastline Advisory Committee functions as an external quality assurance committee, but also is a venue at which children's system issues are addressed. The Children's Community Advisory Committee was established in response to the children's system change initiative and similarly addresses children's system issues. These two committees will merge, upon mutual approval. The combined participation will encompass child serving organizations from all the systems-Mental Health, Child Welfare, Juvenile Justice, Education, physicians, the tribes, Early Learning, CCO, CASA, etc. Additionally family members and youth participate and the newly formed committee will have a provision for 51% family member, youth, consumer, advocate presence. This new system of care oversight committee will review quality data from Coos County Mental Health and other interested children's services providers, and provide input to the service provision. The committee will help align the health plan and community allied services for children's mental health. **B.** This committee will be subsidiary to the WOAH Community Advisory Committee and will forward issues as it sees fit to that group for consideration by the CCO. **C.** The System of Care Committee will develop more complete protocols for interaction between the partners, to guide ongoing system development. **D.** A youth advisory council, consisting of young people receiving services in the community will be established. It will be led by a Peer Support Specialist who will receive training in facilitating such activities from Youth MOVE Oregon. This council will provide feedback and input directly to the children's mental health providers or on more systemic issues to the System of Care Advisory Council and/or the WOAH Community Advisory Committee. **II. Service Design** **A.** Child and Family Teams- The fundamental planning process will be a high-fidelity wraparound process through which Child and Family Teams (CFT) are convened and wraparound service coordination plans are designed. This will build on the initial wraparound capacity that has been developed within the county. Additional training and consultation will be provided to physician or physician representative, wraparound facilitators/care coordinators, typically and not necessarily exclusively, staff of the community mental health program.

B. Health Navigators/Support Specialists- Family and Peer Support Specialists will be recruited and trained to work with child and family teams and with individual children, youth, and families as part of their Individualized Services and Support Plan (ISSP), as designed by the wraparound teams. It is anticipated that these individuals will initially be employed through a partnership between Coos County Mental Health (CCMH) and its selected vendors.

C. Flexible Response Capacity

1. The Integrated Service Array (ISA) will consist of ICTS services provided in home, in school, and in other community settings, psychiatric day treatment, and psychiatric residential treatment.
2. A pool of Skills Trainers will be established to help implement the service design. These individuals will be able to be deployed flexibly to assigned children and families across settings.
3. In-home and in-school services will be provided predominantly by skills trainers based on the ISSP designed by the child and family team. In-school ICTS services may involve supporting a child for several hours a day in the school setting as an alternative to placement in day treatment.
4. ICTS services will be provided at appropriate levels of intensity in treatment foster homes and foster homes.
5. Day treatment services will focus from the initial comprehensive assessment on mainstreaming, assessing the timing at which a youth can be mainstreamed with day treatment staff support, with education provided and/or coordinated by the day treatment instructor, with a goal of discharge to in-school ICTS services.
6. Children and youth whose mental illness may necessitate residential treatment will be assessed either in the community or through a psychiatric assessment and evaluation stay at a PRTF program. When at all possible intensive in-home services will be substituted for psychiatric residential services. This will involve providing therapy and skills training in the home setting, including the potential of awake overnight skills trainer in the home. This will also include utilizing Family and Peer Support Specialists to work with children and families in their home. The endeavor will be to create an in-home psychiatric residential capacity that will obviate the need for many children to be sent out of county to a psychiatric residential facility.
7. It is proposed that ICTS, psychiatric day treatment, and psychiatric residential treatment will be flexibly available through a global budget/case rate contract with a selected entity, such as Kairos, which will assume responsibility and with agreed upon risk corridors for ensuring appropriate response as guided by the child and family team. Psychiatric residential beds will be guaranteed for emergency placements as well as brief residential respite for all children as part of any such agreements. Enhanced treatment foster care will be utilized as available as an alternative to psychiatric residential treatment, with in home work also available to families.
8. It is proposed that residential respite as well as crisis respite will be available through the Pony Creek resource already operated through a partnership between CCMH, and entities such as Kairos and Columbia Care. Skills Trainers will be available to Pony Creek to support children working in conjunction with the foster parents. Family and peer support will be available as well.
9. A planning process will be convened with Bay Area Hospital to develop algorithms through which children brought to the ER in psychiatric and/or behavioral emergency can be served at the Pony Creek facility alternatively. The algorithms will delineate eligibility criteria for Pony Creek, required contact with CCMH crisis workers as well as on-call staff, placement logistics, necessary consents, and post-placement coordination.

D. Evidence-Based Practices- All services will be evidenced-based, with Collaborative Problem Solving being the fundamental approach, taught to child and family teams and staff, along with important aspects of the Neurosequential Model of Therapeutics. Dialectical Behavioral Therapy will be utilized as prescribed by the Child and Family Team in instances in which emotional regulation and mindfulness are critical needs.

III. System Developments and Training

	A. Parents will be offered training along with treatment foster parents. **B.** Training in collaborative problem solving, family support, youth support, wraparound, neurobiology, and other pertinent topics currently made available in the community will be coordinated and organized through the System of Care Advisory Committee and will also be made available to family members, youth, as well as professionals across all systems. **IV. Family and Peer Support** **A.** As noted above, Family and Peer Support Specialists will be made available in some capacity to the child and family teams and to work with individual youth and families. **B.** A parent support group will be organized by CCMH its partners. **C.** A multi-family group for psycho-educational purposes will also be made available. **D.** Parents and relatives will be offered the opportunity to receive training in conjunction with treatment foster parents. **V. Physician Integration** **A.** The pediatrician or primary care physician will be invited to be members of the Child and Family Team. Alternatively, they will be asked if the "super case manager" or another representative from their office or clinic can attend CFT meetings. **B.** Physicians will be provided summaries of progress and outcomes of the CFT meetings. **C.** Efforts will be made to develop an OPAL-K type consultation capacity, utilizing child psychiatrists from CCMH, potentially Kairos, and North Bend Medical Center/OHSU (telemedicine). **VI. Alignment with Social Service System/Social Determinants** **A.** The Family Resource Manager or other representatives of the Early Learning Council will be invited to join Child and Family Teams, as will educators, child welfare workers, etc. **B.** Social marketing efforts will be made to inform the community of the importance of children's mental health supports and services, and outreach will be made to religious organizations and other community entities inviting participation on individual Child and Family Teams as well as the System of Care Advisory Committee.
Performance Period	30 April 2012 to 30 June 2015

I. D. The Transformative Plan for Integrating Physical, Mental, and Behavioral Health Care – Intensive Services Array for Children – Continued

Work Plan

Action Step	Responsible Party	Deliverable (If Any)	Due Date
Establish a projected global budget; [Implementation is contingent upon this step and the attainment of start-up funds, itemized below]	Ginger Swan and Bob Lieberman, with Approval by Phil Greenhill	Negotiated Contractual Agreement	04-30-2013
Establish a Projected ISA utilization cohort	Ginger Swan and Bob Lieberman	Utilization Cohort Summary Document	05-31-2013
Solicit and secure start-up funds through grants and other available mechanisms	Bob Lieberman	Start-Up Cash-on-Hand (Amount to be Determined)	01-31-2014
Coordination of efforts with potential statewide resource enhancement opportunities	Bob Lieberman	Letters of Agreement	02-28-2014
Recruitment and training of a pool of Skills Trainers	Bob Lieberman	Personnel Records	03-31-2014
Recruitment and training of Family and Peer Support Specialists	Bob Lieberman	Personnel Records	03-31-2014
Establish protocols for integration of child and family teams across systems	Bob Lieberman	Written Protocol Document	03-31-2014
Establish mechanisms for using staff flexibly across service and support settings	Bob Lieberman	Written Protocol Document	03-31-2014
Collaborate with family and peer support organizations for creation of family support guidelines	Bob Lieberman	Written Family Support Guidelines	05-31-2014

Budget Impact

Strategy	Budget Impact
It is proposed that the ISA Transformation Plan will be financed using a global budget methodology. It is proposed that case rates will be established through which the contracted ISA service provider is accountable for a band of services and supports, and outcomes within negotiated and agreed-upon risk corridors.	Total costs have not yet been determined, but must be a sub-set of the sub-global mental health allocation
The global budget financing model may provide for flex funds to be used in support of ISSP;s that may require innovative services	Included in the above

Western Oregon Advanced Health

I. E. The Transformative Plan for Integrating Physical, Mental, and Behavioral Health Care – Improving Diabetes Outcomes for Adult Patients with Severe and Persistent Mental Illness by Optimizing Medication Management

Environmental Scan	(1) Case managers who serve adults with severe and persistent mental illness consistently report that their patients have unrestricted access to quality primary health care services, and primary care providers and case managers alike report that services, while separate, are reasonably well coordinated. Nonetheless, the CCO is exploring, but has not yet determined, whether or not there is a need to co-locate primary and behavioral health care services for adults with severe and persistent mental illness. [Reference I.F, following.] (2) Significant and recent professional literature in peer-reviewed journals is convincingly concluding that certain psychotropic medications contribute to the onset of diabetes among adults with severe and persistent mental illness, and that the mental illness, in turn, complicates the care of diabetic patients.
Core Strategies	Western Oregon Advanced Health will establish a program of Medication Therapy Management (MTM) for adult patients with severe and persistent mental illness that will have multiple objectives, among them the improvement of diabetes management.
Performance Period	1 May 2014 to 31 December 2014

Work Plan

Action Step	Responsible Party	Deliverable (If Any)	Due Date
Identify Pilot Pharmacy and Pharmacist	Caryn Mickelson	Agreement	07-01-2013
Identify Pilot Target Population: Diabetic Adults with Severe and Persistent Mental Illness	Caryn Mickelson	File Notes	07-01-2013
Pilot Project Implementation Phase	Caryn Mickelson	Process Notes	08-01-2013 07-30-2014
Replication and Dissemination Phase	Caryn Mickelson	Process Notes	Thereafter

Contractual Measure

Benchmark 1	**INTEGRATING PHYSICAL AND BEHAVIORAL HEALTH CARE: Optimal Diabetes Care Among Adults with Persistent and Chronic Mental Illness**
How Benchmark Will be Measured [Baseline to 1 July 2015]	**Numerator:** Individuals, aged 18-75, who are concurrently diagnosed with severe and persistent mental illness and diabetes who met all three D 3 goals: BP < 140/90; LDL <100 mg/di; A1c <9% **Denominator:** Individuals, aged 18-75, who are concurrently diagnosed with severe and persistent mental illness and diabetes who have at least 2 claims for this diagnosis in the last two years with one claim in the last 12 months (Technical specifications subject to change based on statewide measure)
Milestones to be Achieved [As of 1 July 2014]	5% Improvement Over Baseline
Benchmark to be Achieved [As of 1 July 2015]	10% Improvement Over Baseline with Minimum Score of 20%

Western Oregon Advanced Health

I. F. The Transformative Plan for Integrating Physical, Mental, and Behavioral Health Care – Enhanced Integrated Clinical Services

Environmental Scan	During its developmental phase, multiple concepts have emerged among Western Oregon Advanced Health's membership and board of directors for clinically enhanced integrated care services, including, but not limited to: Creation of a fully integrated primary, mental health, and addiction care clinic; Establishing a chronic pain management program; Establishing a contracted care program; Embedding mental and/or behavioral health professionals on certain hospital wards and emergency departments and in obstetrical programs; and, Including multidisciplinary personnel in some aspects of hospital utilization review procedures.
Core Strategies	Under the leadership of the medical director, seat a time-limited Blue Ribbon Committee to determine the need, cost-efficacy, and outcome-efficacy for the prioritized development of future or potential enhanced integrated clinical services.
Performance Period	1 February 2013 to 31 December 2013

Work Plan

Action Step	Responsible Party	Deliverable (If Any)	Due Date
Medical Director to seat a Blue Ribbon Committee	Medical Director	Committee Roster	04-30-2013
Blue Ribbon Committee to make recommendations regarding needs, cost-efficacies, and outcome efficacies to WOAH's board of directors	Blue Ribbon Committee, minimally comprised of Muday, Swan, Laird, Piper, a BAH representative, and two physicians	Minutes of Committee Meetings Final Written Recommendations	08-31-2013
Board of directors to determine which, if any, of the Committee's recommendations to implement	Board of Directors	Minutes of Board Meeting	09-30-2013
Medical Director will establish separate work plan implementation steps and measures for any board-approved enhanced clinical integration services or programs	Medical Director	Hard Copies of Separate Work Plans	12-31-2013
Work plan, if any, is implemented	Medical Director		

Budget Impact

Strategy	Budget Impact
Cost disclosure and cost-to-benefit analysis to be determined as a component of Committee recommendations to the Board of Directors; Board of Directors to authorize funds for any project or program selected for implementation	To be determined

Western Oregon Advanced Health

II. The Transformative Plan for Patient-Centered Primary Care Medical Homes

Environmental Scan	Western Oregon Advanced Health 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 Patient Centered Home (PCPCH) at Tier 2, and Waterfall Community Health Center is a state-recognized PCPCH at Tier 3.
Core Strategies	Western Oregon Advanced Health will provide technical assistance to those practices that have not attained PCPCH certification, such that 100 percent of primary care providers are affiliated with state-recognized PCPCHs by the conclusion of calendar year 2014. Moreover, Western Oregon Advanced Health will provide technical assistance to those practice groups that are recognized at Tier 2 and encourage matriculation to Tier 3.
Performance Period	1 August 2012 to 31 December 2014

Work Plan

Action Step	Responsible Party	Deliverable (If Any)	Due Date
Bay Clinic with 8 PCPs to be state-certified as a PCPCH at Tier 1	Lonnie Scarborough	Copy of State Recognition Letter	08-30-2013
Bandon Community Health Center with 3 PCPs to be state-certified as a PCPCH at Tier 1	Lonnie Scarborough	Copy of State Recognition Letter	09-31-2013
Remaining six (6) PCPs to be state-certified as a PCPCH at Tier 1	Lonnie Scarborough	Copy of State Recognition Letter	12-31-2014
North Bend Medical Center to matriculate from Tier 2 to Tier 3	Lonnie Scarborough	Copy of State Recognition Letter	12-31-2014

Contractual Measures

Benchmark 2	**Patient-Centered Primary-Care Home (PCPCH)**
How Benchmark Will be Measured [Baseline to 1 July 2015]	**Numerator:** The number of PCPCH-enrolled members by tier (weighted as follows: Tier 1 x 1; Tier 2 x 2; Tier 3 x 3) **Denominator:** All enrolled members, weighted x 3
Milestones to be Achieved [As of 1 July 2014]	10% Improvement Over Baseline
Benchmark to be Achieved [As of 1 July 2015]	100% of patients served by PCPCHs by 12-31-2014

Budget Impact

Strategy	Budget Impact
Allocated Staff Resources	$40,000

Western Oregon Advanced Health

III. The Transformative Plan for Alternative Payment Methodologies

Environmental Scan	(1) Western Oregon Advanced Health, through Southwestern Oregon Independent Practice Association has, since October, 2011, been engaged in Alternate Payment Methodology (APM) discussions with South Coast Hospital Alliance (comprised of: Bay Area Hospital, a DRG facility; Coquille Valley Hospital and Southern Coos Hospitals, both Type A&B facilities; and Curry General Hospital, a Critical Access facility), the objective of which is to address unsustainable PPS payment rates that are currently in place at three of the four facilities represented by South Coast Hospital Alliance. (2)Western Oregon Advanced Health's payment structure with Bay Area Hospital is that of a fully-capitated and at-risk model that has been in effect for seven (7) years, demonstrating that this APM works. (3) Southwest Oregon Independent Practice Association has entered into modified all-inclusive capitation arrangements with Waterfall Community Health Center (a federally qualified health center) and Bandon Community Health Center (a participating Rural Health Clinic with FQHC aspirations), with payment terms that are favorable to these charitable safety net clinics. Further, these safety net clinics operated School-Based Health Centers in Powers, Coos Bay, and Port Orford, and alternative payment arrangements are in-place to support the unique roles of SBHCs. (4) Most primary health care services are currently capitated.
Core Strategies	1. In order to address economic conditions, dialogue, leading to a workable agreement, must take place with hospitals that remain on a cost-based reimbursement payment basis if the CCO is to attain cost efficacies, manage budget constraints, and achieve the Triple Aim. 2. In a concerted effort to more clearly and purposefully align alternative payment methodologies with improved quality and/or improved health outcomes, develop primary care provider performance dashboards, as a first step to linking pay-for-performance that may complement capitation payments to primary care providers. 3. Further explore the potential use of case rates for some medical specialty services, along the lines that are currently in use for maternity care.
Performance Period	1. August 1, 2012, through December 31, 2014

Work Plan

Action Step	Responsible Party	Deliverable (If Any)	Due Date
Negotiate workable agreement with critical access hospitals for an alternative payment methodology that is not predicated upon cost-based reimbursement.	CCO CEO	Hard Copy of Negotiated Agreement	12-30-2013
Develop and Introduce Primary Care Provider Dashboards for Selected Indicators (e.g., Patient Retention), as the first step in a sequence of events that will ultimately link alternative payment methodologies with quality outcomes	CCO CEO	Representative Dashboards	01-31-2014
Potentially implement case rate payments for selected medical specialties	CCO CEO	Case Rate Agreement	06-30-2014
Potentially implement Primary Care Pay-for-Performance to augment capitation rates for selected indicators	CCO CEO	Pay-for-Performance Policy Document	12-31-2014

Contractual Measures

Benchmark 3	Alternative Payment Methodologies
How Benchmark Will be Measured [Baseline to 1 July 2015]	**Numerator:** Total Cost per Member Month for Period 01-01-2015 to 06-30-2015 **Denominator:** Total Cost per Member Month for Period 01-01-2013 to 06-30-2013
Milestones to be Achieved [As of 1 July 2014]	Develop and Introduce Primary Care Provider Dashboards for Selected Indicators (e.g., Patient Retention), as the first step in a sequence of events that will ultimately link alternative payment methodologies with quality outcomes
Benchmark to be Achieved [As of 1 July 2015]	There will be a 2% reduction in Total Cost per Member Month in the first one-half of CY 2015, when compared the first one-half of 2013. At the same time, there will be no decrease in quality assurance measures, between baseline and 06-15-2015, as measured by OHA-established incentive metrics.

Budget Impact

Strategy	Budget Impact
Estimate of costs involved	To Be Determined
Estimate of cost savings involved	2% Over 2 Years

Environmental Scan	(1) A Community Health Assessment Study (CHAS) was completed and included with WOAH's CCO application. (2) The Community Advisory Council for Coos County (CAC-Coos) has met six times since June, 2012, and has reviewed the CHAS, the County Health Rankings, and rates of chronic diseases specific to OHP Members in Coos and Curry Counties. (3) CAC-Coos has formed an Assessment Subcommittee, comprises of CAC members, public health, AAA agency, and hospitals, to review additional data and to update the CHAS-Coos in preparation for development of the Community Health Improvement Plan for Coos County (CHIP-Coos). (4) Leadership for the CAC-Curry has not yet been identified.
Core Strategies	(1) CAC-Coos will engage community partners in updating the CHAS-Coos, with public input, as necessary to meet the requirements for public health accreditation and the IRS requirements for hospitals' community benefit, as described in OAR 410-141-3015 (7-9) and OAR 410-141-3145 (1-11). (2) CAC-Curry has accepted the CHAS-Curry. (3) The CAC-Coos and CAC-Curry will develop and recommend a Community Health Improvement Plan to WOAH's board of directors that must: (1) Provide primary or secondary (universal or targeted) prevention; (b) Include evidence-based practices; and (c) Focus on one or two CDC-recommended community transformation strategies (e.g., tobacco cessation; active living and healthy eating; social and emotional wellness; high-impact clinical preventive care; or environmental health).
Performance Period	1 June 2012 to 31 December 2014 (and continuously thereafter)

Work Plan

Action Step	Responsible Party	Deliverable (If Any)	Due Date
CAC-Coos will prepare and present updated CHAS-Coos, inclusive of survey data garnered from OHP Members, to WOAH board of directors	Frances Smith	Updated CHAS-Coos Document	03-31-2013
CAC-Coos will prepare CHIP-Coos for submission to WOAH board of directors.	Frances Smith	CHIP-Coos Document	05-31-2013
CAC-Curry will prepare CHIP-Curry for submission to WOAH board of directors.	Jan Kaplan	CHIP-Curry Document	06-30-2013
CHIP-Coos will be implemented as submitted or modified by WOAH board of directors.	Frances Smith	Process Documentation	06-30-2013
CHIP-Curry will be implemented as submitted or modified by WOAH board of directors.	Jan Kaplan	Process Documentation	07-31-2013
Mid-term data will be reviewed to determine the degree of milestone attainment, if any, for CHIP interventions.	CAC-Coos CAC-Curry Lonnie Scarborough	Written Summary of Initial and Mid-Term Findings	04-30-2014
Retrospective review of CHIP interventions, including cost and power analyses, to determine if CHIP strategies should remain in place, be modified, or replaced.	Contractor (Optional) Lonnie Scarborough	Written Summary of Findings with Recommendations	12-31-2014

IV. The Community Health Needs Assessment and Health Improvement Plan -- Continued

Contractual Measures

Benchmark 4	**Community Health Assessment and Community Health Improvement Plan**
How Benchmark Will be Measured [Baseline to 1 July 2015]	Hard copies of board-adopted documents will serve as the method of measurement.
Milestones to be Achieved [As of 1 July 2014]	The Community Health Assessment will be completed by 03-31-2013. The Community Health Improvement Plan will be completed by 08-31-2013
Benchmark to be Achieved [As of 1 July 2015]	The Community Health Assessment will be updated by 03-31-2015. The Community Health Improvement Plan will be updated by 07-01-2015

Budget Impact

Strategy	Budget Impact
Allocation for Community Health Improvement Plan in Coos County	To Be Determined
Allocation for Community Health Improvement Plan in Curry County	To Be Determined
Allocation for Contractor for Retrospective Evaluation of Health Improvement Plan Strategies	To Be Determined

Western Oregon Advanced Health

V. The Transformative Plan for Electronic Health Records, *Meaningful Use*, and a Health Information Exchange

Environmental Scan	1. An estimated 94 of 99 physicians on the panel of Western Oregon Advanced Health are currently using certified electronic health records (AllScripts at North Bend Medical Center; EPIC at Waterfall CHC; Cerner at Bay Clinic; and McKesson Paracon at Southern Coos Hospital]. The EMR system at Bay Area Hospital is accessible by providers. 2. All mental health providers affiliated with Coos County Mental Health use ECHO, an EMR system designed for mental health services. 3. The following entities have attested to *meaningful use* at Year 0 or 1: North Bend Medical Center; Bay Clinic; and Waterfall Community Health Center. 4. Western Oregon Advanced Health, in concert with the other Coordinated Care Organizations that received Certification in Wave One, have appealed to the Governor and the Oregon Health Authority to develop a statewide Health Information Exchange, as the redundant costs for so doing on a CCO-by-CCO basis are beyond the capabilities of the CCOs. 5. PolyCom-based telemedicine capacity currently exists at Waterfall Community Health Center, the SBHC at Marshfield High School, the SBHC at the Powers School District, North Bend Medical Center (linked to OHSU), and Coquille Valley Hospital. HRSA grants have been received to expand this system to include Bandon Community Health Center, the SBHC at Pioneer High School in Port Orford, Sunset Middle School in Coos Bay, and the Myrtle Point School District by June of 2013. Waterfall and Bandon Community Health Center are members of the Southern Oregon Rural Telepresence Alliance (SORTA). Other SORTA assets, in partnership with Southwest Oregon Regional Airport, include the deployment of six additional PolyCom units for placement at rural fire districts and shallow-draft ports in Coos and Curry Counties by late-2013.
Core Strategies	1. By December 31, 2013, increase by fifty percent (50%) the proportion of medical providers who have access to electronic health records, from a baseline measure to be established in January, 2013. 1. By December 31, 2013, increase by fifty percent (50%) the proportion of mental health and addiction providers who have access to electronic health records, from a baseline measure to be established in January, 2013. 3. By June 30, 2014, increase from X (baseline to be established in June, 2013) to Y the proportion of dental providers who have access to electronic health records. 4. By December 31, 2013, increase by fifty percent (50%) the proportion of medical providers who have attested for *meaningful use* at any level, from a baseline measure to be established in January, 2013. 5. WOAH plans to participate in statewide HIE initiatives. WOAH may also pursue a local HIE solution in conjunction with these efforts.
Period	1 January 2013 through 31 December 2014

Work Plan

Action Step	Responsible Party	Deliverable (If Any)	Due Date
Bay Area Community Health Information Alliance continues to problem-solve and identify resources to support a local Health Information Exchange	Bay Area Community Health Information Alliance		Continuous Until Resolved

Contractual Measures

Benchmark 5	**EHR Composite**
How Benchmark Will be Measured [Baseline to 1 July 2015]	**Numerator:** Per CMS composite formula, based on 3 *Meaningful Use* measures **Denominator:** Per CMS composite formula, based on 3 *Meaningful Use* measures
Milestones to be Achieved [As of 1 July 2014]	10% Improvement Over Baseline
Benchmark to be Achieved [As of 1 July 2015]	20% Improvement Over Baseline

Budget Impact

Strategy	Budget Impact
Potential costs associated with developing and implementing a Health Information Exchange	$1,000,000

Western Oregon Advanced Health

VI.A The Transformative Plan for Communication - General

Environmental Scan	Elements of Western Oregon Advanced Health's initial communication plan at 90 percent completed, with ongoing notifications to new Members as needed.
Core Strategies	1. All Members will receive *Welcome Letters*, mailed at the time of enrollment, that introduce Members to the CCO and provide interim communication information: (1) Office address and phone number for assigned primary care provider; (2) Business hours telephone contact information for routine questions; and (3) 24/7 afterhours contact information. In addition, the *Welcome Letter*, which may be multiple pages in length, will address all OHA-required criteria. 2. At the time of each Member's initial visit to their primary care provider, after 1 August 2012, Members will be provided with a *PCPCH Brochure* that identifies the professionals that comprise the Member's primary health care team, encourages engagement, and provides guidelines on how and when to contact the patient-centered primary-care medical home. 3. Beginning on November 1, 2012 (after such time as information about the dental program can be included), and continuously thereafter, hard copies of the *Member Handbook* will be mailed to all Members at the time of enrollment with the CCO. These *Member Handbooks* will also be mailed to Members who received *Welcome Letters* between 1 August and 1 November 2012. *Member Handbooks* will: • Provide a general orientation to the CCO; • Provide reference information for routine and after-hours telephone inquiries; • Provide information about the interactive Web Site for Members; • Introduce the CCO's grievance policies; • Provide information about health promotion and wellness activities; and, • Encourage responsible health utilization and Member engagement. 4. In order to provide additional outreach especially to members with low literacy, WOAH will continue to provide in-person new member orientation sessions to disseminate the information described above. WOAH will collaborate with other community agencies to deliver this information in conjunction with other programs in which our members frequently participate, such as the job training sessions at South Coast Business Education Corporation, DHS services at the Newmark Center, various locations in Curry county, and with other community programs as needed. 5. WOAH will work with community partners to offer additional outreach to members with specific cultural and linguistic needs to assure that there are no disparities in member engagement. 6. WOAH will consider recommendations from the Community Advisory Committee regarding ways to provide effective communication and outreach and achieve member engagement.
Performance Period	July 20, 2012, through December 31, 2013

Work Plan

Action Step	Responsible Party	Deliverable (If Any)	Due Date
Initial draft of Member *Welcome Letter*	CCO COO		20 July 2012
Final draft of Member *Welcome Letter*	CCO COO		5 August 2012
Initial draft of *PCPCMH Brochure*	CCO COO		15 January 2013
Final draft of *PCPCMH Brochure*	CCO COO	Hard Copy	1 February 2013
Develop interactive Member Web Site with FAQs	CCO COO	Web Login	15 September 2012
Develop initial draft of *Member Handbook*	CCO COO		1 February 2013
Vet initial draft of *Member Handbook* with CAC	CCO COO		20 October 2012
Develop final draft of *Member Handbook*	CCO COO	Hard Copy	1 November 2012
Disseminate *Member Handbook*	CCO COO		Ongoing > 1 November 2012
In-person Member orientations	Customer Svc		Ongoing
Outreach to community partners to develop futher communication plan	Customer Svc, Quality Director		July 2013
Review recommendations from CAC to improve communication and member engagement	CAC, Customer Svc, Quality Director	CAC Recommendations	July 2013

Internal Measures

	CAHPS Composite: Health Plan Information and Customer Service
How Benchmark Will be Measured [Baseline to 1 July 2015]	**Numerator:** Responses of *Always* or *Usually* per queried variable **Denominator:** Number of all respondents to queried variable Data will be compared across groups to ensure no specific disparities by race, ethnicity, or disability status.
Milestones to be Achieved [As of 1 July 2014]	If disparities among groups are identified at baseline, the disparity will be decreased by half (e.g. If 90% of all respondents respond that they are always or usually available to get the information that they need, but only 70% of a specific group respond this way, the gap of 20% will be decreased to a gap of only 10% by 2014.)
Benchmark to be Achieved [As of 1 July 2015]	Minimum Score of 85% with no statistically significant differences among groups by race, ethnicity, or disability status.

Budget Impact

Strategy	Budget Impact
Actual cost of developing, printing, and mailing letters, brochures, and handbooks	$ 25,228.08
Estimated cost of developing, hosting, and updating interactive Member web site	$ 4,100.41
Additional staff time and travel for possible new outreach programs	To Be Determined

Western Oregon Advanced Health

VI.B. The Transformative Plan for Communication with Members with Limited English Proficiency and/or Communication Disabilities

Environmental Scan	(1) At the time of CCO certification, WOAH was serving 101 households with Limited English Proficiency; All such households contained native Spanish speakers. No other foreign languages were represented. (2) Among Western Oregon Advanced Health's provider panel, twenty (20) providers are conversant in languages other than English, including Spanish, Vietnamese, Tagalog, Italian, and Japanese.
Core Strategies	1. At the time of enrollment, or the initial encounter with the Patient-Centered Primary Care Medical Home, whichever shall later occur, Members shall be queried about language preferences and communication disabilities, and a master list of Members who require communication assistance shall be maintained by the CCO's Chief Operating Officer, along with the type of assistance that is required. 2. All Members who require language assistance/adaptive communication assistance shall receive same. 3. Printed *PCPCMH Brochures* and *Member Handbooks* shall be made available in the Spanish language and audio formats, and staff will be trained to assist members with low literacy who need information in verbal or other formats.. 4. WOAH, and each hospital emergency department affiliated with WOAH, shall maintain on-call access to certified American Sign Language interpreters, TTY or TDD services, and certified Spanish Language Health Care Interpreters. WOAH will continue to provide access to the Language Line for access to translations services for other languages not available locally. 5. All patient activation and health promotion activities that are sponsored by WOAH shall be provided in a place and manner that is accessible to people with disabilities. 6. Every provider organization that is affiliated with WOAH shall ensure that at least one staff member annually completes HRSA's on-line course, *Effective Health Care Communication 101*, that consists of five training modules that address Cultural Diversity, Low Health Literacy, and Limited English Proficiency (available at www.hrsa.gov/;ublichealth/healthliteracy). Documentation of same must be submitted to WOAH by 31 October, annually. 7. WOAH shall annually sponsor an in-service training activity on the CCO's alternative communication formats, and every provider organization affiliated with WOAH shall ensure that at least one staff annually member completes this training.
Performance Period	July 20, 2012, through October 31, 2013

VI.B The Transformative Plan for Communication with Members with Limited English Proficiency and/or Communication Disabilities -- Continued

Work Plan

Action Step	Responsible Party	Deliverable (If Any)	Due Date
1. Identify a central phone and e-mail contact for Providers and Members who need to access alternative formats for communication	CCO COO	Copy of Contract	20 July 2012
2. Identify Provider staff members or others with American Sign Language certification, and establish a process for accessing ASL services on an "as needed" basis during normal business and after-hours	CCO Medical Director	At Time of Re-Credentialing	Ongoing
3. Identify and subscribe to telephone and/or television (TTY, TDD) services for Members with hearing and speech disabilities	CCO COO	Copy of Contract	20 July 2012
4. Translate *Welcome Letter* to Spanish Language	CCO COO	Hard Copy	30 July 2012
5. Translate *PCPCMH Brochure* to Spanish Language	CCO COO	Hard Copy	15 March 2013
6. Translate *Member Handbook* to Spanish Language	CCO COO	Hard Copy	1 November 2012
7. Identify and contract with an entity that is qualified to modify printed materials for use by people with cognitive or visual disabilities (i.e., large print, audio format, Braille, electronic format, oral presentation) and convert the *PCPCMH Brochure* and *Member Handbook* to one or more of these formats.	CCO COO	Hard Copy	15 October 2012
8. Provider office staff complete on-line HRSA course on *Effective Health Care Communication* and submit documentation of same	CCO Medical Director	Completion Document	31 October 2013
9. WOAH convenes first in-service training for internal and external staff members (at least one per provider organization) on alternative communication policies, procedures, formats, and tools	CCO Medical Director	Syllabus	31 October 2013
10. First due date for biennial review process	CCO CEO		31 October 2013

Contractual Measures

Benchmark 6	**CAHPS Composite: Health Plan Information and Customer Service**
How Benchmark Will be Measured [Baseline to 1 July 2015]	**Numerator:** Responses of *Always* or *Usually* per queried variable **Denominator:** Number of all respondents to queried variable Data will be compared across groups to ensure no specific disparities by race, ethnicity, or disability status
Milestones to be Achieved [As of 1 July 2014]	If disparities among groups are identified at baseline, the disparity will be decreased by half (e.g. If 90% of all respondents respond that they are always or usually available to get the information that they need, but only 70% of a specific group respond this way, the gap of 20% will be decreased to a gap of only 10% by 2014.)
Benchmark to be Achieved [As of 1 July 2015]	Minimum Score of 85% with no statistically significant differences among groups by race, ethnicity, or disability status.

Budget Impact

Strategy	Budget Impact
HRSA Online *Effective Health Care Communication* Course	Staff time

Western Oregon Advanced Health

VI.C. The Transformative Plan for Member Engagement

Environmental Scan	The degree of Member Engagement and Member Activation is unknown; only anecdotal information exists and is widely varied.
Core Strategies	(1) Patients will be encouraged and assisted to engage in Self-Management Programs (2) CAHPS Survey Instrument will be administered to Members of PCPCHs to learn of ways in which Member Engagement and Member Activation can be improved (3) Data will be compared across groups to ensure no specific disparities by race, ethnicity, or disability status
Performance Period	1 January 2013 through 31 December 2014

Work Plan

Action Step	Responsible Party	Deliverable (If Any)	Due Date
WOAH will contract with Coos County Public Health (for Coos County) and a yet-to-be-determined vendor in Curry County, for the delivery of *Living Well* – an evidence-based model for chronic disease self-management	Phil Greenhill	Copies of Contracts	06-30-2013 For Coos Co 03-31-2014 For Curry Co
To serve as broad an audience as possible, other evidence-based models, such as CHIP by Loma Linda University, will be considered	Clinical Advisory Panel	Minutes of Meeting	12-31-2013
As a cost-savings strategy, volunteers may be recruited to participate in Train the Trainer programs for *Living Well*, *CHIP,* or other selected evidence-based curricula	Quality Director and Vendors	File Notes	03-31-2014
CAHPS will be administered annually to assess performance with respect to Member Engagement and to determine logical next steps for improvement	Quality Director	Survey Results	Annually by December 31
Data will be compared across groups to ensure no specific disparities by race, ethnicity, or disability status.	Quality Director	Survey Results Program Rosters	03-31-2013

Internal Measures

	HEDIS Ambulatory Care: Outpatient and ED Utilization measure
How Benchmark Will be Measured [Baseline to 1 July 2015]	**Numerator:** Number of ED visits and outpatient visits **Denominator:** Per 1,000 member months
Milestones to be Achieved [As of 1 July 2014]	5% Improvement Over Baseline in ratio of outpatient to ED visits
Benchmark to be Achieved [As of 1 July 2015]	10% Improvement Over Baseline in ration of outpatient to ED visits

Budget Impact

Strategy	Budget Impact
Contractual costs for the delivery of selected evidence-based programs and curricula	$25,000

Western Oregon Advanced Health

VI.D. The Transformative Plan for Outreach and Non-Traditional Health Workers

Environmental Scan	(1) Coos County Mental Health currently employs 10 case managers, 5 are trained at the masters level and 5 at the bachelors level. Curry County Mental Health currently employs 5 case managers, 1 trained at the masters level, 3 at the bachelors level, and one is a para-professional. Case managers are competent to perform Health Navigator functions. (2) Coos County Public Health currently employs 10 persons who fill combined roles as community health workers and personal health navigators: 5 are public health aides; 5 are public health nurses. Curry County Public Health currently employs 4 persons who fill combined roles as community health workers and personal health navigators.
Core Strategies	1. Community Health Outreach and Eligibility Assistance Workers will be employed and deployed by Curry Health Network, Bandon Community Health Center, and Waterfall Community Health Center, at the expense of each entity. 2. Peer Wellness Specialists will be employed and deployed by Curry County Mental Health, Coos County Mental Health, and ADAPT, at the expense of, respectively, Curry and Coos County Mental Health programs and ADAPT. 3. An internal training program will be developed for Health Navigators in roles that are unique to Western Oregon Advanced Health Coordinated Care Organization.
Performance Period	1 January 2013 to 31 December 2013

Work Plan

Action Step	Responsible Party	Deliverable (If Any)	Due Date
Community Health Outreach Workers will be continuously employed by Waterfall and Bandon CHC and County Public Health settings	Kathy Laird; Linda Maxon; Frances Smith; Jan Kaplan	Attestation	Continuously
Peer Wellness Specialists will be continuously employed by County Mental Health settings	Ginger Swan Jan Kaplan	Attestation	Continuously
WOAH will develop a localized curriculum for the training and local certification of Health Navigators	Lonnie Scarborough	Copy of Curriculum	07-31-2013
Every practice location with >3 providers will employ the services of at least one locally certified Health Navigator	Lonnie Scarborough	Roster of Locally Certified Health Navigators	12-31-2013

Internal Measures

	CAHPS Composite: Getting Care Quickly
How Benchmark Will be Measured [Baseline to 1 July 2015]	**Numerator:** Number of *Always* or *Usually* responses, per queried variable **Denominator:** Universe of respondents, per queried variable Data will be compared across groups to ensure no specific disparities by race, ethnicity, or health status
Milestones to be Achieved [As of 1 July 2014]	If disparities among groups are identified at baseline, the disparity will be decreased by half (e.g. If 90% of all respondents respond that they are always or usually available to get care as soon as they thought they needed, but only 70% of a specific group respond this way, the gap of 20% will be decreased to a gap of only 10% by 2014.)
Benchmark to be Achieved [As of 1 July 2015]	10% Improvement Over Baseline with Minimum Score of 85% with no statistically significant disparities between groups by race, ethnicity, or health status.

Budget Impact

Strategy	Budget Impact
Estimated costs related to development of local Navigator training curriculum, and time expended in delivering curriculum on multiple occasions in multiple settings to Navigators-in-Training: 80 Hours @ $50 per Hour	$4,000

Western Oregon Advanced Health

VII. The Transformative Plan for Meeting the Needs of Culturally Diverse Members

Environmental Scan	(1) At the time of CCO certification, WOAH was serving 101 households with Limited English Proficiency; All such households contained native Spanish speakers. No other foreign languages were represented. (2) Among Western Oregon Advanced Health's provider panel, twenty (20) providers are conversant in languages other than English, including Spanish, Vietnamese, Tagalog, Italian, and Japanese. (3) Effective immediately, WOAH's Quality Improvement Plan calls for collecting data from each participating provider, at the time of re-credentialing, about languages, literacy, and cultures in which they feel competent. (4) There are currently no certified health care interpreters, for any language, in Coos or Curry Counties. (5) The next available course for Health Care Interpreters begins in the First Quarter of 2013
Core Strategies	1. Effective 15 June 2014, Western Oregon Advanced Health shall make the services of certified health care interpreters available in any county in which it operates in which there are thirty-five (35) or more enrolled Member households that are characterized by Limited English Proficiency and that speak the same native language. 1.b. The services of certified health care interpreters will be made available throughout all clinical, dental, behavioral, pharmacy, scheduling, and health promotion activities that are supported by the Coordinated Care Organization.
Performance Period	January 1, 2013, through June 15, 2014

Work Plan

Action Step	Responsible Party	Deliverable (If Any)	Due Date
WOAH shall identify at least two persons from Coos County who are bi-lingual and bi-literate in the Spanish language, and who are willing to complete required academic and internship experiences, leading to Certification as a Health Care Interpreter (drawing first from among those persons who are currently under the employ of the CCO or its providers, and secondly from the community-at-large).	Board of Directors		1 April 2013
WOAH shall pay all fees and costs associated with the academic preparation, internship experience, and oral and written examinations for the two persons identified above, and shall arrange for such persons to be enrolled in a formal training program by not later than …	CCO COO		1 September 2013
Candidates for Certification as Health Interpreters shall take and pass the required examination	Participants	Certification(s)	31 May 2014
Recently-certified Health Interpreters shall be deployed throughout the CCO in Coos County	CCO CEO		15 June 2014
[This process will be repeated in Curry County, or in any county, upon the occasion that 35 Member households are identified that speak a common native language other than English]			

VII. The Transformative Plan for Meeting the Needs of Culturally Diverse Members Continued

Contractual Measures

Benchmark 7	**CAHPS Composite: Getting Care Quickly**
How Benchmark Will be Measured [Baseline to 1 July 2015]	**Numerator:** Number of *Always* or *Usually* responses, per queried variable **Denominator:** Universe of respondents, per queried variable Data will be compared across groups to ensure no specific disparities by race, ethnicity, or disability status
Milestones to be Achieved [As of 1 July 2014]	If disparities among groups are identified at baseline, the disparity will be decreased by half (e.g. If 90% of all respondents respond that they are always or usually available to get care as soon as they thought they needed, but only 70% of a specific group respond this way, the gap of 20% will be decreased to a gap of only 10% by 2014.)
Benchmark to be Achieved [As of 1 July 2015]	Minimum Score of 85% with no statistically significant differences among groups by race, ethnicity, or health status.

Budget Impact

Strategy	Budget Impact
Estimate the cost for training two persons as Certified Health Interpreters:	
Registration @ $910 per Person x 2 Persons	$ 1,820
Travel Expenses @ $225 per Person x 2 Persons	450
Wages @ $400 per Person x 2 Persons	800
Total	**$ 3,070**

Environmental Scan	1. While ethnicity, along with its concomitant issues of language and literacy, is often a disparate condition, at the time of CCO certification, WOAH was serving 101 households with Limited English Proficiency; all such households contained native Spanish speakers. No other foreign languages were represented. Persons of Hispanic or Latino origin represent 2.9 percent of the general population. 2. The entire range of Coos and Curry Counties is home to 1,367 American Indians and Alaskan Natives, representing 1.62 percent of the entire population. However, the local Indian Health Clinic is not a member of the CCO, and each of its Medicaid patients is "carved out" of the CCO, and assigned to the Indian Health Clinic on an "open card" basis. 3. The greatest disparity in Coos and Curry Counties is the presence of a disproportionately high aging population. Fully 26 percent of all residents are aged 65 and older, compared to national norms of 13 percent. However, these individuals are eligible for inclusion in the Medicare population and are not represented in any great numbers in the Medicaid program unless dually eligible. 4. The most prominent disparity is that of low income status. Fully 65 percent of all persons in Coos and Curry County live at or below 200 percent of the federal poverty index. Nonetheless, the Oregon Health Authority has asked CCOs to discuss quality improvement in relationship to a specific targeted subgroup, and not the overall OHP population. The statistical inability of the CCO to dichotomize its members into categories of "extreme poverty" *vs.* "poverty" is not practical. 5. Therefore, the primary significant disparity is that of "rurality." While the entire range of Coos and Curry Counties are classified by the federal Office of Rural Health Policy as "rural," there are some areas within the Counties that are more rural than others. An extensive array of professional literature documents the catastrophic array of health disparities that are evidenced by rural populations when compared to metropolitan and urban counterparts [*Rural Healthy People 2010*]. Among the greatest disease-specific conditions encountered disproportionately by rural populations (excluding exposure to pesticides) are: cancer; diabetes; cardiovascular disease; poor pregnancy outcomes; and mental disorders. For these reasons, and with the assistance of OHA, Western Oregon Advanced Health will dichotomize the values for targeted incentive measures into two classifications: those for members living within either the Coos Bay/North Bend "urban cluster" or the "Coquille Valley" urban cluster (as defined by the U.S. Bureau of Census); and those members residing in all other zip codes.
Core Strategies	1. WOAH will retain the services of a Quality Assurance Director through whom the CCO will develop and implement a Quality Assurance and Performance Improvement Program for the services that it furnishes to its Medicaid Members. WOAH will implement quality assurance and performance improvement measures, with specific treatment for data sets derived from "more rural" members, that demonstrate the methods and means by which it carries out planned or established mechanisms for: a. Establishing a compliant Grievance and Appeals resolution process, including how that process is communicated to Members and providers; b. Establishing and supporting an internal Quality Improvement committee that develops and operates under the annual quality strategy and work plan with feedback loops; c. Implementing an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols and policies, while maintaining mechanisms to detect both underutilization and overutilization of services; d. Having mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs; e. Conducting evaluation of the impact and effectiveness of its annual quality strategy and work plan; and, f. Participating in the Oregon Health Authority's Quality and Performance Improvement Work Group. 2. WOAH will seat a Clinical Advisory Panel 3. In the first year as a CCO, WOAH will undertake two Performance Improvement Projects (PIPs): one under the leadership of the Medical Director; and the other under the leadership of the Coos County Mental Health Department's Director. a. The PIP under the leadership of the Medical Director will be *Safe Prescribing of Opiates*, will fall under the category of "Public Health Issues," and will involve multiple participating organizations, including the Oregon Prescription Drug Monitoring Program and Coos County Public Health Department
Period	1 January 2013 through 31 December 2013, with Continuous Quality Improvement efforts thereafter

Work Plan

Action Step	Responsible Party	Deliverable (If Any)	Due Date
Verify data capture capacity for metrics and zip codes shared with OHA	Chief Information Officer		08-01-2012
Data capture quality systems check for metrics shared with OHA	Chief Information Officer		03-31-2013
Medical Director identifies medical PIP/PDSA	Medical Director		03-31-2013
Mental Health Director identifies mental health PIP/PDSA	Mental Health Director		03-31-2013
Appoint Clinical Advisory Panel	Medical Director and Director of Quality Management		02-01-2013
Director of Quality Management develops comprehensive data-driven quality improvement plan and related procedures	Director of Quality Management		04-30-2013
Medical PIP/PDSA on Opiate Prescribing Commences	Medical Director		04-30-2013
Mental health PIP/PDSA Commences	Mental Health Director		10-30-2013
Comprehensive data-driven quality improvement plan is administratively linked with outcome-based alternative payment strategies for medical, mental health, addiction, and dental	Director of Quality Management & Board of Directors		03-15-2014
Comprehensive data-driven quality improvement plan is clinically linked with incentive measures that are tracked for disparate rural populations	Director of Quality Management & Board of Directors		03-15-2014

Contractual Measures

Benchmark 8.1	**Developmental Screening by Age 36 Months**
How Benchmark Will be Measured [Baseline to 1 July 2015]	**Numerator:** Children in denominator who had a claim with CPT Code 96110 by their birthday in the measurement year **Denominator:** The children who turn 1, 2, or 3 years of age in the measurement year and who were covered by Medicaid/CHIP continuously for 12 months between last birth date, regardless if they had a medical/clinical visit or not in the measurement year. Comparison of screening rates will be made between children residing in rural vs. Coos Bay/North Bend zip codes, with the goal of eliminating disparities for rural residents.
Milestones to be Achieved [As of 1 July 2014]	5% Improvement Over Baseline, with any gap in percentage screened decreased by half.
Benchmark to be Achieved [As of 1 July 2015]	10% Improvement Over Baseline with Minimum Score of 50%, with no statistically significant difference in screening rates for rural zip codes.

Benchmark 8.2	Colorectal Cancer Screening
How Benchmark Will be Measured [Baseline to 1 July 2015]	**Numerator:** Individuals who had an appropriate screening if a submitted enc/claim contains appropriate CPT code **Denominator:** All eligible members meeting enrollment criteria and age 50-75 during measurement year Screening rates will be compared between members residing in rural vs. Coos Bay/North Bend zip codes, with the goal of eliminating disparities for rural residents.
Milestones to be Achieved [As of 1 July 2014]	5% Improvement Over Baseline, with any gap in percentage screened decreased by half.
Benchmark to be Achieved [As of 1 July 2015]	10% Improvement Over Baseline with Minimum Score of 61.34%, with no statistically significant difference in screening rates for rural zip codes.

Budget Impact

Strategy	Budget Impact
Estimated costs associated with new Quality Management position	Significant
Estimated costs associated with supporting the CAP and its activities	Significant