DRAFT Transformation Plan Initial Progress Report Template
Western Oregon Advanced Health

Please send your completed Transformation Plan Initial Progress Report to the CCO Contract Administrator, David Fisher (DAVID.H.FISCHER@dhsoha.state.or.us) by no later than 5:00 pm on Friday, January 31, 2014.

Transformation Area 1: Integration of Care

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 July 1, 2015)	**Contractor will participate in the statewide Performance Improvement Project (PIP), proposed to measure:** **Numerator:** Members, aged 18-75, who are concurrently diagnosed with severe and persistent mental illness and diabetes who met all three National Committee for Quality Assurance (NCQA) Comprehensive Diabetes Care and as aligned with NQF measure #1934 focuses on measures testing rates for both HbA1c and LDL-C. **Denominator:** Members, aged 18-75, who are concurrently diagnosed with severe and persistent mental illness and diabetes who have at least two visits for this diagnosis in the last two years with one visit in the last 12 months.
Milestone(s) to be achieved as of July 1, 2014	5% Improvement over Baseline. Baseline and method of calculation to be determined and mutually agreed upon between Contractor and OHA.
Benchmark to be achieved as of July 1, 2015	10% Improvement over Baseline with minimum score of 20%. Baseline and method of calculation to be determined and mutually agreed upon between Contractor and OHA.

1. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, please describe the outcome and any associated process improvements. The mental health records for all patients diagnosed with severe and persistent mental illness were cross-referenced with the medical records for all patients diagnosed with diabetes to arrive at a cohort of 100 percent of individuals diagnosed with both conditions. Using the Four Quadrant Model, additional patients were added to the cohort who are characterized by concurrent high physical health needs and high mental health needs (i.e., those who fell within the "fourth quadrant"). Each Member in the expanded cohort has been continuously provided with intensive case management and care coordination, and medical laboratory monitoring occurs at the time of each encounter, regardless of whether that encounter occurs in the mental health system or physical health system. For those patients who are more comfortable in the mental health system, arrangements have been made for blood draws and urinalysis sampling in the mental health system, with all laboratory results forwarded to the patients' primary care providers. There has been a 100 percent compliance with all protocols established for this service element, which represents significant process improvement.

1 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area. Integrated behavioral and medical cooperation has been outstanding, and no barriers have been identified that would impede the attainment of established benchmarks.

Transformation Area 2: PCPCH

Benchmark 2	**Patient-Centered Primary-Care Home (PCPCH)**
How Benchmark will be measured (Baseline to July 1, 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 PCPCH-enrolled Members, weighted x 3
Milestone to be achieved as of July 1, 2014	10% Improvement over Baseline
Benchmark to be achieved as of July 1, 2015	100% of Members enrolled with a PCPCHs by 12-31-2014

2. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements. The actions taken, or being taken, are continuous in nature, and do not "fit" neatly into a tabular reporting format. Rather, on a continuous and ongoing basis, Western Oregon Advanced Health's (WOAH's) Director of Quality Improvement, Lonnie Scarborough, R.N., has provided a series of advocacy, mentoring, coaching, and technical assistance services to primary care providers and/or primary care provider groups to assist them in securing State recognition as Patient-Centered Primary Care (Medical) Homes (PCPCH). As of August 31, 2013, 45 percent of all CCO Members were enrolled in a PCPCH at Tier 2 (N = 7,054) or Tier 3 (N = 614). [This represented a decrease of .7 percent below baseline, but this deviation is attributable to an increase in Member enrollment rather than a decline in the number of providers participating in the PCPCH model.] As of December 31, 2013, Bay Clinic, which represents a large provider group, attained state recognition as a PCPCH at Tier 3, meaning that 62 percent of Western Oregon Advance Health's Members are now enrolled in primary-care patient-centered medical homes. As of December 31, 2013, WOAH exceeded the established benchmark which had been set at 60 percent PCPCH participation. The ultimate goal is to have 100 percent of Members enrolled in PCPCHs, and the process improvement strategy is to continue to work with those primary care providers and primary care provider groups who have not yet embraced the PCPCH model. Bandon Community Health Center was admitted to the family of federally qualified health centers in October, 2013, and will become the next target for PCPCH implementation.

2 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area. Two barriers have been identified, each of which is beyond the control of the CCO. The first barrier has been the unwieldy process implemented by OHA through which PCPCHs may recover (significantly delayed) incentive payments, and the second has been OHA's decision to sunset PCPCH incentive payments. A substantial volume of profession literature in the field of medical economics confirms that the PCPCH model increases costs to primary care providers while saving costs at the tertiary level of care.

2 c.)Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies. While WOAH cannot offset the PCPCH barriers and disincentives that reside with OHA, it can use an alternate payment methodology that re-distributes cost savings at the tertiary level of care to offset PCPCH costs to providers at the primary level of care. To a significant extent, WOAH's end-of-year cost savings distribution accomplishes this end. Concurrently, incentives that have been made by the Oregon Health Authority for State employees who elect to receive their care within the context of a PCPCH model have been helpful.

Transformation Area 3: Alternative Payment Methodologies

Benchmark 3	**Alternative Payment Methodologies**
How Benchmark will be measured (Baseline to July 1, 2015)	**Numerator:** Total Cost Per Member Per Month (PMPM) for Period 01-01-2015 to 06-30-2015 **Denominator:** Total cost PMPM for Period 01-01-2013 to 06-30-2013
Milestone to be achieved as of July 1, 2014	Develop and introduce Primary Care Provider (PCP) Dashboards for selected indicators (e.g., patient retention), as the first step in a sequence of events that will ultimately link Alternative Payment Methodologies with quality outcomes
Benchmark to be achieved as of July 1, 2015	There will be a 2% reduction in total cost PMPM in the first one-half of contract year 2015, when compared the first one-half of 2013. At the same time, there will be no decrease in quality assurance measures, between baseline and 06-15-2015, as measured by OHA-established incentive metrics.

3. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements. Once again, the nature of this transformation area's initiatives do not lend themselves to a tabular reporting format, as each action taken required an extensive and sequential series of sub-actions (such as negotiations) and each sub-action re-informed, and potentially revised, the intended action according to a process that is best described as a series of feedback loops. With respect to "outcomes to date;" (1) WOAH is funding an after-hours walking clinic, in a concerted effort to reduce inappropriate and costly emergency department visits, as an alternative payment methodology; (2) WOAH has realigned its contractual agreement with Bay Area Hospital, to include capitation payments with incentive arrangements, as an alternative payment methodology; and, (3) WOAH has entered into a sub-global budget arrangement with the Ear-Nose-Throat (ENT) specialty group that calls for resource sharing as an alternative payment methodology. A similar arrangement may be negotiated with orthopedic providers.

3 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area. One barrier that has emerged with respect to the alternative payment agreement with Bay Area Hospital has been the lack of analytics data. One barrier that has emerged with respect to the ENT alternative payment agreement with the ENT specialty group has been the lack of budget validation data.

3 c.)Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies. WOAH is anticipating that internal enhancements to analytics data, as was made possible through the Transformation Fund Grant, will result in barrier-reduction and/or elimination.

Transformation Area 4: Community Health Assessment and Community Health Improvement Plan

Benchmark 4	**Community Health Assessment and Community Health Improvement Plan**
How Benchmark will be measured (Baseline to July 1, 2015)	Hard copies of documents adopted by Contractor board of directors will serve as the method of measurement.
Milestone to be achieved as of July 1, 2014	The Community Health Assessment (CHA) will be completed by 03-31-2013.The Community Health Improvement Plan (CHIP)will be completed by 08-31-2013
Benchmark to be achieved as of July 1, 2015	The CHA will be updated by 03-31-2015.The CHIP will be completed by 07-01-2015

4. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements. WOAH included a comprehensive community health assessment as an attachment to its original CCO Application (Second Quarter. 2012). The Community Advisory Council has since revised and updated the Community Health Assessment (Second Quarter, 2013) and this work is considered to be complete, although it is scheduled for updating and revision in 2015. The Community Advisory Council, well ahead of schedule, completed its Draft Community Health Improvement Plan on August 31, 2013. The document is now pending review and approval by WOAH's board of directors.

4. b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area. None.

4 c.) Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies. Not Applicable

4 d.) How was the Community Advisory Council involved in the activities for this transformation area? The Community Advisory Council (CAC) was directly involved in the approval of the methodology for the development of the Community Health Assessment and the Community Health Improvement Plan and held approval authority over the resultant documents. Western Oregon Advanced Health's board of directors has also approved both documents, and on January 16, 2014, the Community Health Improvement Plan was submitted to the Board of County Commissioners in Coos County for their ultimate review and adoption, thereby merging the County's Public Health Plan with the Community Health Improvement Plan. The resultant consolidated Plans represents process improvement in that it serves to focus the efforts of both Public Health and the CCO.

4 e.) How was the CAC informed of the outcomes for activities in this transformation area? The Community Advisory Council was actively involved in every step, including ultimate approval of the documents. After Plan adoption, the Community Advisory Council seated a "super committee," comprised of a wide array of community stakeholders, who meet on a semi-monthly basis to monitor the implementation of the Community Health Improvement Plan. The PDSA rapid improvement process will be used in the event that implementation barrier or challenges arise.

Transformation Area 5: EHR, HIE and meaningful use

Benchmark 5	**Electronic Health Record Composite**
How Benchmark will be measured (Baseline to July 1, 2015)	**Numerator:** Per Centers for Medicaid and Medicare Services (CMS) composite formula by increasing the proportion of providers adopting and using EHRs. **Denominator:** Per CMS composite formula based on increasing the proportion of providers adopting and using EHRs.
Milestone to be achieved as of July 1, 2014	10% Improvement over Baseline. Baseline and method of calculation to be determined and mutually agreed upon between Contractor and OHA.
Benchmark to be achieved as of July 1, 2015	20% Improvement over Baseline. Baseline and method of calculation to be determined and mutually agreed upon between Contractor and OHA.

5. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements. At the time of its inception as a Coordinated Care Organization, the Electronic Health Record (EHR) adoption (baseline) rate for Western Oregon Advanced Health was 18 percent. Western Oregon Advanced Health established an EHR benchmark of 49.2 percent, to be achieved by July 1, 2015. As of August 31, 2013, the EHR adoption rate among Western Oregon Advanced Health's providers had soared to 60.9 percent, thereby exceeding performance expectations. Concurrent with the release of Transformation Grant Funds, Western Oregon Advanced Health entered into contractual agreements with Covisint and AT&T for the development of a Health Information Exchange (HIE) to included advanced risk stratification modeling and integrated clinical analytics. Reporting for HIE progress and outcomes occurs separately, pursuant to the Transformation Grant Fund contractual modification in place between WOAH and OHA.

5 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area. Internally, there have been no barriers; the milestones have been attained and the benchmarks exceeded. Externally, the constant revision of metrics by the Oregon Health Authority has made it extremely difficult to embed metrics for the purposes of data extraction from the software being developed for the HIE.

5c.) Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies. There have been no barriers to overcome. For some small, or individual, provider practices, the adoption of Electronic Health Records is costly and must be evaluated on the basis of cost-to-benefit. Given the disproportionately high percentage of seniors who reside within the service delivery area, and Medicare's time-phased requirements for the adoption of Electronic Health Records and resultant *meaningful use*, it is believed that the providers who have not yet done so, will engage in EHR adoption over the course of the next eighteen months.

Transformation Area 6: Communications, Outreach and Member Engagement

Benchmark 6	**Consumer Assessment of Health Providers & Systems (CAHPS) Composite: Health Plan Information and Customer Service**
How Benchmark will be measured (Baseline to July 1, 2015)	**Numerator:** Responses of *Always* or *Usually* per queried variable derived from Member survey **Denominator:** Number of all Member respondents to queried variable Data will be compared across Member groups to ensure no specific disparities by race, ethnicity, or disability status
Milestone to be achieved as of July 1, 2014	If disparities among groups are identified at baseline, the disparity will be decreased by half (e.g. If 90% of all Member respondents respond that they are always or usually available to get 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 July 1, 2015	Minimum Score of 85% with no statistically significant differences among groups by race, ethnicity, or disability status.

6. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	Welcome Letters distributed to Members, August 2012	Completed	
2.	*PCPCH Brochure* developed, February 2013	Completed	
3.	*Member Handbook* distributed, November 2012 and Ongoing	Completed	
4.	Central phone number and e-mail contacts provided for Members who need access to alternate formats for communication, July 2012 and Ongoing	Completed	
5.	TTY and TDD services available to Members, Ongoing	Completed	
6.	Spanish language Welcome Letters and Member Handbooks available July 2012 and Ongoing	Completed	
7.	Provider offices (and, newly added, Customer Service Representatives and Case Managers) complete HRSA's on-line *Health Care Communication* training	In Progress	
8.	Health Care Interpreter Training and Certification	Area of Focus for Jan-June, 2014	
9.	*Living Well* is continuously available as a Member-engagement strategy	Ongoing	

6. b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area; and 6.c) Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies. To date, no barriers have been identified.

Transformation Area 7: Meeting the culturally diverse needs of Members

Benchmark 7	**CAHPS Composite: Getting Care Quickly**
How Benchmark will be measured (Baseline to July 1, 2015)	**Numerator:** Number of *Always* or *Usually* responses, per queried variable **Denominator:** Universe of Member respondents, per queried variable
Milestone to be achieved as of July 1, 2014	If disparities among groups are identified at baseline, the disparity will be decreased by half (e.g. If 90% of all Member respondents respond that they are always or usually available to get care as soon as they thought they needed, but only 70% of a specific group respond this way, the gap of 20% will be decreased to a gap of only 10% by 2014.)
Benchmark to be achieved as of July 1, 2015	10% Improvement over Baseline with minimum score of 85%. The 10% improvement over Baseline will be achieved after the disparities groups are identified at Baseline. Thus the gap of 20% will be decreased to a gap of only 10% by 2014 and achievement will be reached with a minimum score of 85%.

7. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	Spanish language Welcome Letters and Member Handbooks available July 2012 and Ongoing	Completed	
2.	Provider offices complete HRSA's on-line *Health Care Communication* training	In-Progress	
3.	Health Care Interpreter Training and Certification	Area of Focus for Jan-June, 2014	
4.	Training and Certification for Non-Traditional Health Workers to Include Ethnic Minority and Indigenous Persons	Area of Focus for Jan-June, 2014	

7. b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area. (1) Although not truly a barrier, Western Oregon Advanced Health elected to await final adoption of Oregon Administrative Rules related to the training and certification of *traditional health workers* before engaging its workforce in the required training and certification process. Those Administrative Rules (410-180-0325 and 410-180-0326) were scheduled for hearing on December 18, 2013, paving the pathway for adoption. This schedule "fits" with WOAH's plans to provide training leading to certification during the period January to June, 2014. (2) The "disparate groups" may be based on *rurality*, as determined by zip code. Accordingly, WOAH will rely on OHA to dichotomize CAHPS responses by ethnicity and by zip code. (3) We may encounter issues related to *survey fatigue* as Members may be asked to complete CAHPS-like surveys for PCPCH recognition processes, Medicare, and Medicaid. (4) The constant change of metrics is an external barrier.

7. c.)Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies. Minor barrier will be removed concurrent with full adoption of the OARs cited above.

Transformation Area 8: Eliminating racial, ethnic and linguistic disparities

Benchmark 8.1	**Developmental Screening by Age 36 Months**
How Benchmark will be measured (Baseline to July 1, 2015)	**Numerator:** Member children in denominator who had a claim with CPT Code 96110 by their birthday in the measurement year **Denominator:** The Members 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 Member children residing in rural vs. Coos Bay/North Bend zip codes, with the goal of eliminating disparities for rural residents.
Milestone to be achieved as of July 1, 2014	5% Improvement over Baseline, with any difference/gap in percentage screened decreased by half. Baseline and method of calculation to be determined and mutually agreed upon between Contractor and OHA.
Benchmark to be achieved as of July 1, 2015	10% Improvement over Baseline with minimum score of 50%, with no statistically significant difference in screening rates for rural zip codes. Baseline and method of calculation to be determined and mutually agreed upon between Contractor and OHA.
Benchmark 8.2	**Colorectal Cancer Screening**
How Benchmark will be measured (Baseline to July 1, 2015)	**Numerator:** Members who had an appropriate screening if a submitted Encounter Claim contains appropriate CPT code **Denominator:** All eligible Members meeting enrollment criteria and age 50-75 during measurement year
Milestone to be achieved as of July 1, 2014	5% Improvement over Baseline, with any gap/difference in percentage screened decreased by half. Baseline and method of calculation to be determined and mutually agreed upon between Contractor and OHA.
Benchmark to be achieved as of July 1, 2015	10% Improvement over Baseline with minimum score of 61.34%, with no statistically significant difference in screening rates for rural zip codes. Baseline and method of calculation to be determined and mutually agreed upon between Contractor and OHA.

8. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements. Core actions to be undertaken included: filling a new employment position for a Director of Quality Management; seating a Clinical Advisory Panel; and, participating in PIPs (with implementation of PDSA rapid improvement cycles, as indicated). The Director of Quality Management position has been filled and the Clinical Advisory Panel has been seated and is active. PIPs and PDSAs are ongoing clinical improvement processes and tools.

When WOAH's Transformation Plan was under development, it was noted that Coos and Curry Counties are communities that are characterized by the absence of racial and ethnic diversity. For this reason, and at the advice of the Transformation Center, the disparate population in Coos and Curry Counties was defined to be *rural residents.* While the entire range of Coos and Curry Counties is classified as *rural* by both the Oregon Office of Rural Health and the federal Office of Rural Health Policy, for the purposes of the above-stated objectives, *distant-rural* was defined to be the outlying areas of Coos and Curry Counties, to include the zip codes of Port Orford and Agnes in Curry Counties, and the zip codes of Powers, Langlois, and Lakeside in Coos County.

With respect to Benchmark 8.1, related to developmental screening by age 36 months, as of August 31, 2013, there had been a 50 percent improvement (from a baseline of 21.2 percent, to 49.1 percent) for the population as a whole. However, it is not known whether or not this trend holds true in targeted and operationally-defined rural zip codes. With respect to Benchmark 8.2, related to colorectal cancer screening, there was a 3 percent decrease (from a baseline rate of 10.7, to a rate of 6.6) for the population as a whole. However, it is not known whether or not this trend holds true in targeted and operationally-defined rural zip codes.

8. b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area. The most significant barrier to determining whether or not progress is being made with respect to reducing health disparities, WOAH must be able to determine whether those trends that hold true for the population-at-large also hold true for persons residing in targeted and rural-remote zip codes. Relevant data are not available at the zip-code specific level.

8. c.)Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies. WOAH will work through its (rather excellent) Innovator Agent to acquire data from OHA that is dichotomized at the zip-code level.

INVOLVEMENT OF THE COMMUNITY ADVISORY COUNCIL
[With Respect to Transformation Areas 1, 2, 3, 5, 6, 7, and 8]

Background: To the best of Western Oregon Advanced Health's knowledge, the enabling legislation that created Coordinated Care Organizations, (e.g., SB-1580), while describing and detailing the composition and roles of Community Advisory Councils (CACs), are silent as to the involvement of CACs with respect to Transformation Plans. Amendment #3 to Western Oregon Advanced Health's Service Contract #139073 with the Oregon Health Authority (i.e., the *Transformation Amendment*), while detailing the requirements and procedures for the preparation, submission, and adoption/acceptance of Transformation Plans, is similarly silent as to any role or involvement of Community Advisory Councils. Exhibit K – Attachment 1 – Transformation Deliverables and Benchmarks, makes a single-sentence reference to CACs, to wit: *Contractor shall also describe how its Community Advisory Council (CAC) was involved in the process and informed of the outcomes in each transformation area.* It is specifically noted that Western Oregon Advanced Health's contractual obligation is to describe how the CAC was involved and informed, if at

all. The contractual mandate is not *to involve* or *to inform.* [In fact, with the exception of Transformation Area 4, to have contractually required the involvement of CACs in the Transformation Plan would have overstepped the duties and roles legislatively assigned to CACs by the enabling legislation.] WOAH may further assert that the nature of Transformation Area 3 is proprietary and beyond the scope of Community Advisory Council activities.

How was the Community Advisory Council involved in the activities for this transformation area? How was the CAC informed of the outcomes for activities in this transformation area? Notwithstanding the foregoing, the Community Advisory Council was provided with a true and exact copy of WOAH's Transformation Plan, following board adoption, very early in 2013. Since that time, through the person of Lonnie Scarborough, R.N., Western Oregon Advanced Health has provided the Community Advisory Council with verbal reports regarding its Transformation Plan activities and outcomes-to-date at every monthly meeting of the Community Advisory Council, and the minutes for all meetings will reflect this fact. In addition, the Community Advisory Council was informed of the outcomes-to-date for the Transformation Plan via a written document and at their regularly-scheduled meeting of 2 January 2014. In addition, Western Oregon Advanced Health paid all costs for, and supported three consumer Members of the CAC to attend and participate in the statewide CAC Summit convened on December 5, 2013. The CAC's active involvement in Transformation Area 4 is detailed separately above.