

## Transformation Plan Initial Progress Report Template

### AllCare Coordinated Care Organization

*This form is a pre-populated template for AllCare's Transformation Plan Initial Progress Report requirement. (Be aware that OHA has moved the due date of this report from the first of the year to January 31, 2014.) Use of this form is not required, but the elements outlined below do represent the required elements for reporting for each Transformation Area. You are welcome to use your Innovator Agent to assist you in the completion of this report.*

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

**Transformation Area 1: Integration of Care (due to the 4<sup>th</sup> quarter claims run off not being complete, data reflects claims payment through 01/23/2015)**

Benchmark 1	Increase the number of Members in Service Area who have a diagnosis of Severe and Persistent Mental Illness (SPMI) conditions and a diagnosis of diabetes who had HgbA1C and LDL laboratory tests.
How Benchmark will be measured (Baseline to July 1, 2015)	Utilizing data obtained from community mental health agency in Service Area, identify the # of Members diagnosed with SPMI and utilize the Contractor claims database to identify those Members with SPMI and diabetes who have claims/encounters processed (appropriate Current Procedure Terminology (CPT) codes) for a HgbA1C and LDL laboratory tests in 2012.
Milestone(s) to be achieved as of July 1, 2014	Contractor attains 10% improvement over Baseline measurement.
Benchmark to be achieved as of July 1, 2015	Contractor attains 20% improvement over Baseline measurement.

**1. 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.**

Activity <i>(Action taken or being taken to achieve milestones or benchmarks)</i>		Outcome to Date	Process Improvements
1.	In mid-2014, a dedicated business analytics staff was created consisting of a manager, two business analysts and one provider education liaison dedicated with the task of the development of dashboard required reports.		
2.	Using encounter data from the Community Mental Health Agencies (CMHPs), in Josephine, Jackson, Curry counties and cross-walking with the State list, identified AllCare members with severe, persistent mental illness (SPMI).	564 unique members diagnosed with SPMI	Using previously developed and validated source code, identified members with severe, persistent mental illness and compared to the State list. Communicated with OHA discrepancies.
3.	Using CCO data, cross-walked those members diagnosed with SPMI and diabetes.	118 or 21%	
4.	Using CCO data, cross-walked those members diagnosed with SPMI and diabetes who had a lab test, HgbA1C	74 or 63%	Improvement of more than 5% for members diagnosed with SPMI and diabetes.
5.	Using CCO data, cross-walked those members diagnosed with SPMI and diabetes who had a lab test LDL	75 or 64%	Improvement of 2% for members diagnosed with SPMI and diabetes.
6.	Using the combined data, determined of those AllCare members diagnosed with SPMI, diabetes, how many had both of the lab tests HgbA1C and LDL.	63 or 53%	Improvement of 2% for members diagnosed with SPMI and diabetes who had both HgbA1C and LDL tests.

7.	Using the combined data, determined of those AllCare members diagnosed with SPMI, diabetes and who also had a primary care visit during 2014.	524 or 93%	<b>Year</b>	<b>Mbrs dx SPMI</b>	<b>SPMI with 1 PCP visit</b>	<b>Compliance</b>
			2012	518	401	77.4%
			2013	567	431	76.0%
			2014	564	524	93.0%
			Significant Improvement in primary care visits – 17% from 2013.			
8.	Ongoing recruitment in outpatient mental health/physical health clinic at Options of Southern Oregon (CMHP) in Josephine County (now have two nurse practitioners). In Jackson County, monetary support and task force participation in the creation of the Birch Grove Clinic (September 2014) – a clinic that addresses physical health problems as well as mental health and A & D issues (located in the Jackson County DHS building where the outpatient mental health clinic is located).					
9.	The list of members diagnosed with SPMI will be distributed to the care coordinators and CMHP staff in all three counties.		Reports will be generated that identify those members not being seen for the needed chronic condition and preventative care.			

**1 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.**

- a. **Physical Health Barriers:** 1. Staff in the physical health office may feel uncomfortable/anxious with patients with active symptoms (delusions, hygiene). Members may not be compliant with care – missed appointments, longer appointment times. 2. Lack of open communication between physical health and mental health providers. 3. Physical Health providers educated regarding the need to address preventative and chronic condition care.
- b. **Member Barriers:** 1. Stigma – the members may be uncomfortable being in a physical health office with “Normies” and hygiene could contribute. 2. Transportation to physical health office – multiple appointments in different locations, different dates. 3. Symptomology of illness: paranoid, delusional, anxiety, disorganized (missed appointments), not able to verbalize physical health complaints, trauma phobias. 4. Substance abuse
- c. **Data – 1.** Improved in 2014, but still discrepancies in the patient list at the CMHP, AllCare and the State.

**1 c.) Describe any strategies you have developed to overcome these barriers and identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.**

The number and element correspond with the barriers identified above in 1 b.

- a. **Physical Health Barriers:** 1. Provide Office Training for staff and provider on how to manage patients with SPMI. Continue to develop mobile units or locate outpatient physical health clinics in the outpatient mental health clinic settings. 2. Case Management or peer wellness supports accompany member to appointments. Encourage office to allow a longer appointment time for SPMI patients. Encourage and facilitate communication with CMHP providers and physical health providers through alternative payment methodologies and shared savings. 3. Deploy the Business Analytics Provider liaison to primary care offices to educate the staff and the provider about the importance of addressing preventative care and chronic condition care. Re-emphasize the need to notify CCO to help support the treatment plan and provided support services to the patient and the provider.
- b. **Member Barriers:** 1. Case Managers or peer wellness supports accompany the member to physical health appointments. 2. Mental Health or Physical Health Providers in a mobile unit or an integrated care system where a physical health provider is located at the outpatient mental health clinic. CCO care coordinators to assist with arranging transportation to appointments. 3. Allow the CMHP to treat for co-occurring A & D and SPMI conditions.
- c. **Data** – 1. It was agreed between CMHPs, AllCare CCO to ‘true up’ our lists with the State list. Our Innovator Agent helped to facilitate the discussion.

**1 d.) How was the Community Advisory Council involved in the activities for this transformation area?**

With the completion of the CHAs (Community Health Assessments – March 2014) and CHIPs (Community Health Improvement Plans July 1, 2014), the focus on the second half of 2014, was devoted to the development of Work Groups (with Consumers as leads) to address the 3 major areas of the 3 counties we serve. For “Healthy Living – Mental Health and Substance Abuse” across all three counties, one of the high level interventions includes “Increase the CAC understanding of mental health integration efforts and Identify opportunities for future CAC engagement in improving mental health integration and access”. The CACs are leading and driving the Work Groups formed in mid-2014.

<b>County</b>	<b>Healthy Beginnings</b>	<b>Healthy Living</b>	<b>Health Equity</b>
Curry County	Early Investment, Healthy Food and Physical Activity, School Based Health Centers	Mental Health and Substance Abuse, Built Environment	Transportation, Oral Health and Food Insecurity
Jackson County	Early Investment, Adverse Childhood Experiences/Trauma, Health Food and Physical Activity	Chronic Pain, Prescription Drug Use and Abuse, Mental Health	Housing, Food Insecurity and Cultural Competency and Language Access
Josephine County	Early Investment, Adverse Childhood Experiences/Trauma, Health Food and Physical Activity	Chronic Pain, Prescription Drug Use and Abuse, Mental Health	Housing, Food Insecurity and Cultural Competence and Language Access

**1 e.) How was the CAC informed of the outcomes for activities in this transformation area?**

The Quality Director and CCO Coordinator give quarterly updates to the CACs in all three counties. The latest report that includes the final data for 2014 will be presented once the data reflects the 2014 claims run out – March 2015. The AllCare Board of Directors, Quality Committee and internal CCO executive staff receive quarterly reports.

**Transformation Area 2: PCPCH (due to the 4<sup>th</sup> quarter claims run off not being complete, data reflects claims payment through 01/23/2015)**

Benchmark 2	Increase the # of Members assigned to a recognized PCPCH.
How Benchmark will be measured (Baseline to July 1, 2015)	The number of Members assigned and engaged with a PCPCH Jackson, Josephine and Curry counties as measured by one visit (CPT 99201-99205, 99211-99215 or 99381-99387, 99391-99397) during 2012 with a corresponding reduction in Emergency Department (ED) utilization (ED codes 99281-99285) during 2012.
Milestone to be achieved as of July 1, 2014	Contractor ensures that 60% of Members in Jackson, Josephine and Curry counties are assigned to a PCPCH with at least one PCPCH visit; and  Contractor ensures a 5% reduction in ED utilization over Baseline.
Benchmark to be achieved as of July 1, 2015	Contractor ensures that 70% of Members in Jackson, Josephine and Curry counties who are assigned to a PCPCH with at least one PCPCH visit; and  Contractor ensures an 8% reduction in ED utilization over Baseline.

1. 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.	Beginning in 2011, the Health Plan embraced OHA’s delivery system transformation plan by supporting a multi-physician practice and a single physician practice office site as pilot projects. This started the process of implementing the PCPCH model of care	60% of PCPCH members engaged and ED visits are 42.0	Year	2012	2013	2014
			PCPCH rate	62%	60%	72%
			ED rate	616/1000	420/1000	492/1000
			Improvement	baseline	-2%	+12%
			AllCare CCO has attained and exceeded the July 1, 2015.			
2.	The Health Plan retained the services of a consultant to lead the project of creating PCPCH learning modules that would be free to any physician or nurse practitioner wanting to be PCPCH certified.		PCPCH learning modules went live in mid-2012 and in 2014, updates to the modules occurred reflecting revisions to the requirements. These learning modules are available state-wide.			
3.	In mid 2012, 6 independent nurse practitioners and 1 physician met monthly as a learning collaborative coaching and worked through flow changes.		All 7 practitioners attained Level 3 recognition.			
4.	2012 – 2013, the Health Management Services case managers and care coordinators provided direct support to the PCP offices.		Case Management Staff alerted PCPs when their patients were in the ED, inpatient setting or discharged to a nursing home.			
5.	2013, Patient Education Sheets were developed for PCP offices.		AllCare used a regional collaborative aimed at reducing readmissions as a forum to distribute the Red, Yellow, Green patient education sheets to hospitals, PCP offices, skilled nursing facilities, home health agencies.			
6.	Mid 2013, AllCare retained the services of a consultant to assist Women’s Health Center (sole 7 OB providers in Josephine County) in becoming a Maternal PCPCH.		Women’s Health Center attained Tier 3 recognition in August 2013.			
7.	In 2014, 4 more provider offices in Jackson County attained Tier 3 recognition and 2 in Curry County are in the process of becoming recognized as Tier 3.		AllCare’s Alternate Payment Methodology provides additional payment – the APM will be rolled out in Jackson County in 2015.			

	AllCare continues to pay PCPCH fees quarterly.		
8.	AllCare is assisting Options of Josephine County (CMHP) to become a Mental Health PCPCH.		Work has begun training and coaching the CMHP.
9.	In January 2015, the CEO, Quality Director and Consultant met with Southern Oregon University – exploring the possibility of SOU becoming a “University Health Home”.		

**2 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.**

Jackson and Curry Counties were the areas where the greatest improvement could be attained in 2014. The goal of OHA to have 100% of our membership in PCPCH is difficult given that AllCare CCO contracts with 97% of the primary care providers in the three counties we serve. Other CCOs primarily utilize FQHCs for their OHP membership – AllCare provides choice but the choice includes small offices (single to two providers). Though these offices provide critical access to primary care, some are not interested in becoming certified.

**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.**

AllCare continued to provide and support the PCPCH training modules (updated in 2014 to reflect requirement changes) in addition to providing face-to-face consultant time to conduct a gap analysis in identifying the processes already in place versus what is needed for PCPCH recognition. In January 2014, an Alternate Payment Methodology for Primary Care in Josephine County was initiated. For the Quality Measures portion, there are incentive measures that reflect PCPCH requirements thereby additional monies are paid (outside the quarterly) for the PCPCH provider.

**2 d.) How was the Community Advisory Council involved in the activities for this transformation area?**

The CACs were not involved in this process, but were informed of the projects.

**2 e.) How was the CAC informed of the outcomes for activities in this transformation area?**

The CACs, Board of Directors, Quality Committee were informed through quarterly reports. The CCO Executive Staff are kept updated daily and weekly as offices are identified as willing to go through the training.

**Transformation Area 3: Alternative Payment Methodologies PCPCH (due to the 4<sup>th</sup> quarter claims run off not being complete, data reflects claims payment through 01/23/2015)**

Benchmark 3	Reward successful Primary Care Providers (PCPs) via a shared savings program, as measured by each PCP’s 2012 PCP visits/1000 and ED costs for the PCP’s assigned Members in the Service Area recognizing care delivered in a PCP setting leads to better health outcomes and avoidable transitions of care.
How Benchmark will be measured (Baseline to July 1, 2015)	Utilize Contractor Provider Profile (claims data) to measure Member engagement in terms of PCP visits/1000 and ED costs for the two time periods to measure savings .
Milestone to be achieved as of July 1, 2014	Contractor attains an 8% increase in the rate of PCP visits/1000 with resulting ED cost savings to be shared with PCP or PCPCH
Benchmark to be achieved as of July 1, 2015	Contractor attains a 12% increase in the rate of PCP visits/1000 with resulting ED cost saving to be shared with PCP or PCPCH

**1. 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.	Beginning in 2011 through 2012, the Health Plan started to gather Primary Care Provider data elements that included risk scores (using the States methodology), ED visits, PCP visits, preventative care utilization, lab and radiology utilization, narcotic utilization by their patients. The data was compiled in such a way that the PCPs could see how their “scores” compared to their peers. The data was broken down by physicians, nurse practitioners –		The Chief Medical Officer, CCO Manager, Quality Director, Provider Services Manager met with each primary care office in the 3-county service area to review the reports and get feedback from the providers. The “review report” is generated annually.

	looking at offices with > 50 members.						
2.	Beginning in early 2013, the Board of Directors led the discussion to address Medicaid expansion access, the focus on quality outcomes in provider offices and how to ensure PCPs are getting adequately compensated.			The Board the Physician Compensation Committee was formed and was comprised of 5 physicians, CEO, CCO Director, CMO, Quality Director and support staff.			
3.	Spring 2013, AllCare submitted a Transformation Grant proposal focused on the development of alternative payment methodologies that would reward providers for access, member risk scores, panel size, meeting specific utilization targets (↑PCP visits, ↓ED use, ↑Preventative Care visits)			AllCare's Transformation Grant proposal was accepted.			
4.	From October – December 2013, further refinement of the Quality Outcomes portion of the methodology occurred.			The Board of Directors approved the Provider Compensation Methodology in December 2013.			
5.	Beginning January 1, 2014, the Josephine County Primary Care Alternate Payment Methodology (APM) pilot project was initiated. Several revisions had to be made primarily due to the difficulty in reporting data regularly.			Year	2012	2013	2014
				PCP visits/1000 and ED PMPM costs	2493 PCP visits/1000 and ED PMPM costs \$11.18	1790 PCP visits/1000 and ED PMPM costs \$10.69	3422 PCP visits/1000 with ED PMPM costs \$10.62
				Results	Baseline	-703 visits/.49 ED PMPM cost	+1632 PCP visits/1000 with ED PMPM costs -.04
6.	July 1, 2014, the Josephine County Pediatric APM was launched.						

**2 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.**

The barriers encountered with the development and roll out of the Primary Care providers APM had to do with ensuring the practicality and ease in generating monthly, quarterly and annual reports. The three elements: Access (open/closed, size of panel, and number of new OHP members), Utilization (ED rate, ED rate of Level 1 and Level 2, PCP visit rate, generic medication prescribing rate, preventative visits) and Quality Measures (align with Quality Incentive measures, End of Life planning, Access, Screening, Disease Management and Medication Management). Also, provider feedback indicated that many offices were still struggling with SBIRT, adolescent well-child visits. The offices were resistant to one of the Quality Measures that had to do with Consumer Surveys conducted on a regular basis – the surveys addressed access and satisfaction with the care received. The offices were resistant to this

**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.**

In as much as it is practical, the physician-led APM Committee aligned the Quality Measures with the CCO Quality Incentive measures. The addition of the Business Analytics Team greatly advanced the development of reports and helped to support the feedback that the data was too difficult to pull and not practical. The Business Analytics Team also went directly to providers' offices and conducted SBIRT training and in depth training regarding the quality measures.

Our Innovator Agent has been kept apprised of the progress and has been helpful in arranging opportunities for AllCare to share our program (through the CCO Summit).

**2 d.) How was the Community Advisory Council involved in the activities for this transformation area?**

The CAC was not directly involved with this project.

**2 e.) How was the CAC informed of the outcomes for activities in this transformation area?**

The CAC will receive the annual update and report of the Transformation Plan measures.

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

Benchmark 4	Completion of a Community Health Improvement Plan (CHIP) for Josephine, Jackson and Curry counties.
How Benchmark will be measured (Baseline to July 1, 2015)	Through collaboration with community partners, stakeholders and other CCOs whose coverage includes Jackson, Josephine and Curry counties, Contractor develops the Community Health Needs Assessment and CHIP.
Milestone to be achieved as of July 1, 2014	Contractors submits completed CHIP for Josephine, Jackson and Curry counties
Benchmark to be achieved as of July 1, 2015	Contractor defines strategies to implement CHIP and update as appropriate.

1. 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.	AllCare stakeholders in the development of the Consumer Advisory Council (CAC) charter, decided to have a CAC in each county. It was thought that each county had unique strengths and challenges and the development of the Community Health Assessments should be the responsibility of the CACs and reflect the communities we serve.	CHAs were prepared and approved by the Josephine, Jackson and Curry CACs and all were submitted to OHA in December 2013.	Since AllCare has competing CCOs in each county, it was mutually decided upon that the CHAs in Josephine and Jackson County would be a collaborative activity conducted by a special task force made up of CAC members of both Jackson Care Connect and Primary Health. Curry County's CAC was ahead of the others due to the county undergoing a transition from county to a non-profit agency in 2012.
2.	Early 2013 AllCare, Jackson Care Connect and Primary Health retained the services of a facilitator.		The facilitator had experience in Douglas County in coaching, organizing and mobilizing the CAC in this work.
3.	Throughout the Spring 2013, the facilitator organized focused groups, team building meetings, received		The process was transparent; CAC members were included and led the process in every phase of

	feedback for the data elements the CACs would like to have in the development of the CHA.		development.
4.	The Facilitator arranged educational meetings for the CACs.		CAC members enthusiastically participated in those opportunities.
5.	In December 2013, the CHAs were completed for Josephine/Jackson Counties and Curry County.		The CACs in all three counties, the AllCare Board of Directors approved the CHAs and the CHAs were submitted prior to December 31 <sup>st</sup> .
6.	Between March and July 2014, significant consumer input was obtained and utilized in the development of the CHIPs.		Targeted focus groups helped gather information for the CHA process about health disparities of specific groups. Public input meetings and paper/online surveys spread a broad net to gather input from people that lived in Josephine, Jackson and Curry counties. 751 people took the survey, 1320 unique suggestions and a 97% completion rate of the survey across the three counties we serve.
7.	Prior to the July 1, 2014 deadline, Community Health Improvement Plans (CHIPs) were submitted for Curry, Josephine and Jackson Counties.		
8.	Between August and December, specific work groups were formed to address the key areas (big rocks) in each community.		
9.	The facilitator utilized during the CHA and CHIP process was retained to facilitate the CAC Work Groups in the three counties we serve.		
10.	Core Planning Principles were developed to 'guide' the process and create consistency in the organization process.		<b>Core Planning Principles:</b> Strategies that meet a need and address health disparities, Meets OHA and Public Health Accreditation rules and mandates, Evidence-informed, Strategies that are balanced across all ages, Emphasizes coordination and leveraging local assets, programs and resources, Incorporates voices of those we serve including members of the Oregon Health Plan, Engages the CAC members and provides activities for consumers to be involved in improving the health of their communities, Based on the 2013

			CHA, Creates positive, measureable changes in the health of individuals and/or the communities and Strategies that can be built upon, over the 1-3 year timeline.
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**2 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.**

Due to the complexity of working with three communities, it was resource intensive to organize the surveys, town hall meetings, etc.

**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.**

AllCare’s Innovator Agent has provided significant support in this process and assisted in any way possible. She has attended all CAC meetings, Town Hall meetings in all three counties. AllCare opted to retain the services of the facilitator utilized in the CHA and CHIP process – as her skillset includes organization of complex projects and a variety of participants.

**2 d.) How was the Community Advisory Council involved in the activities for this transformation area?**

The process was transparent; CAC members were included and led the process in every phase of development and are Work Group Leads. The Leads give monthly reports and help to identify opportunities in the communities.

**2 e.) How was the CAC informed of the outcomes for activities in this transformation area?**

The CACs are fully engaged in the next phase which is the implementation of the strategies developed in the CAC Work Groups supporting the completed Community Health Improvement Plans (CHIPs)

**Transformation Area 5: EHR, HIE and meaningful use**

Benchmark 5	Percentage of Participating Providers in Josephine and Curry counties that use the Greenway Electronic Medical Records software and access Greenway’s PrimeDataCloud technology for information sharing across care settings..
How Benchmark will be measured (Baseline to July 1, 2015)	Utilizing reports generated by the Greenway Electronic Health Records (EHR) systems tracking data exchange transactions for 2013.
Milestone to be achieved as of July 1, 2014	Contractor attains a 10% increase of eligible Greenway EHR users sharing data across care settings as measured by the number of data exchange transactions per

	Participating Provider, compared to Baseline.
Benchmark to be achieved as of July 1, 2015	Contractor attains a 20% increase over the Baseline of eligible Greenway EHR users sharing data across care settings as measured by the number of data exchange transactions per Participating Provider.

**1. 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.	In Southern Oregon, there is a regional Jefferson Health Information Exchange (JHIE) that started meeting in 2011. The JHIE is comprised of CCOs, hospitals, physicians and other stakeholders. Their purpose is to have a regional approach to the development of data “clouds” and facilitate inter-connectivity of information systems.	AllCare has representation on the Board of Directors of Jefferson Health Information Exchange (JHIE) and is one of the major financial contributors	AllCare has provided sizeable monetary contributions since 2011. Our CEO, CFO, eHealth Medical Director, and IT Director participate in the meetings with representation on the Board of Directors.
2.	A Work Plan has been developed		By 2 <sup>nd</sup> Quarter 2014, the JHIE had only created a process that connected providers with the hospitals.
3.	Adoption of EHRs	As of the latest OHA update (released 01/22/15) 76.9% of AllCare’s providers have EHRs compared to 69% 2013.	eHealth Services continues to subsidize provider offices in implementing PrimeSuite Greenway EHR. 24/7 Support and real time assistance is provided to the offices.

**2 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.**

The same challenges exist as the last report, which includes the following: the JHIE work is costly and is currently funded by AllCare, Jackson Care Connect and the hospitals, “starts and stops”, HIPAA regulatory concerns and have all stakeholders able to agree on the work plan and timelines.

**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.**

In 2014, OHA’s staff participated in discussions surrounding the capability and lagging timeline. OHA has offered technical assistance and It is imperative that we continue to be involved as communication of health services is key to taking the Transformation work to the next level. Administrative staff’s attendance is crucial to ensuring that there are “equal” contributions from hospital stakeholders. AllCare has representation on the BOD and at the meetings.

However, due to JHIE not meeting work plan expectations, the “pulling” of data for the Transformation Plan is challenging and requires the Business Analysts to work directly with each clinic and provider office.

**2 d.) How was the Community Advisory Council involved in the activities for this transformation area?**

The CAC was not involved with this project.

**2 e.) How was the CAC informed of the outcomes for activities in this transformation area?**

Annually, a report of the Transformation Plan measures is provided to the CAC members.

**Transformation Area 6: Communications, Outreach and Member Engagement (due to the 4<sup>th</sup> quarter claims run off not being complete, data reflects claims payment through 01/23/2015)**

Benchmark 6	Through targeted Member materials and outreach utilizing the community health worker skilled and focused on Members, Contractor increases the number of Members aged 6-18 in the Service Area who receive a well child check up from a PCPCH or PCP.
How Benchmark will be measured (Baseline to July 1, 2015)	Identify Members aged 6-18 on the 834 file who have had a well child check up (utilizing appropriate CPT codes) in 2012.
Milestone to be achieved as of July 1, 2014	Contractor attains an improvement of 20% over Baseline number of Members aged 6-18 age who have received an annual well child check up from PCPCH or

	PCP.
Benchmark to be achieved as of July 1, 2015	Contractor attains an improvement of 30% over Baseline number of Members aged 6-18 who have received an annual well child check up from PCPCH or PCP.

**1. 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.	Transformation Plan measure: Increase the number of well child visits with a PCP for children between the ages of 6 – 18 years of age – 20% over baseline.					
2.	A Barrier Analysis was performed as this is also a quality incentive measure. Statewide the numbers are low.		PCPs and Pediatricians provided feedback that they were shocked at the numbers and data.			
3.	Created a pilot project with a large group family practice office		Distributed iTunes gift cards to the office. 20 kids were scheduled by the end of December 2013. From December 2013 through February 2014, 75 adolescents had appointments schedules, kept their appointments and received the iTunes incentive gift card.			
4.	For 2014, AllCare is exploring the feasibility of a pilot project with a large group pediatric office where a community health worker is placed to target this population. The CHW would identify barriers for parents in keeping scheduled well-child checkups.		Job descriptions, employment ads are being developed.			
5.	In December 2014, the pilot was expanded to include four additional large provider offices		Year	2012	2013	2014
			Well Child visits age 6 - 18	22%	19%	24%
			Improvement	baseline	-3%	+5%
			Demonstrated improvement			

**2 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.**

A barrier analysis was performed and includes the following identified barriers and challenges with this measure: It is difficult to get this age group in unless they are ill, the kids are dependent upon their parents to make the appointments and get them there. Also, due to staff turnover, traction was lost as the offices are dependent upon AllCare staff to provide the iTunes cards.

**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.**

Follow up for the strategies developed in 2013 need to be revisited. The following will be implemented in 2015: The Quality Director will explore the opportunity to work closely with the School Based Health Systems in Josephine, Curry and Jackson County to see if this place of service could contribute and help provided needed well child visits for this population. The task of buying iTunes Gift cards was transitioned to the Business Analytics Team in December 2014.

**2 d.) How was the Community Advisory Council involved in the activities for this transformation area?**

The CACs discussed this age group in the development of the Community Health Assessments and subsequent development of the CHIPs. In Curry County, there is a high rate of suicide, obesity and asthma and low rate of students graduating from high school in this demographic. The CHIPs reflect thoughtful prioritization when reviewing the data. All agreed that this is an age group that should be assessed for high risk behaviors and experimentation with sex, drugs, alcohol, tobacco – but based on the success of the iTunes project, projects must be creative to reach this age group.

**2 e.) How was the CAC informed of the outcomes for activities in this transformation area?**

The CACs were involved in the creation of the Community Health Improvement Plan which addressed this specific age group and will be kept apprised of AllCare’s progress with this measure. The CAC work groups are used to identify community opportunities.

**Transformation Area 7: Meeting the culturally diverse needs of Members**

Benchmark 7	Increase the number of PCP, PCPCH or obstetrician (OB) practice sites completing cultural diversity training programs.
How Benchmark will be measured (Baseline to July 1, 2015)	Perform a Baseline survey (by 7.1.2013) and subsequent surveys in 2014 and 2015 to measure training program participation.
Milestone to be achieved as of July 1, 2014	Contractor attains improvement of 15% over the Baseline percentage rate of cultural diversity program completion by PCPs, PCPCHs or OBs.

Benchmark to be achieved as of July 1, 2015	Contractor attains improvement of 30% over the Baseline percentage rate of cultural diversity program completion by PCPs, PCPCHs or OBs.
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**1. 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.	A Baseline Survey was sent to all Primary Care Providers, PCPCHs and OB providers in Josephine, Jackson and Curry Counties. The purpose was to identify the number of practices completing a cultural diversity training program.	The survey was sent in July 2013 to 103 primary care providers comprised of MDs, DOs, FNPs and ANPs across the 3-county service area.	22% response rate with 15 offices indicating that they had completed the appropriate training.
2.	The survey will be sent out again in 2014.		Resources will be developed and made available to the offices so that their staff can participate in on-line training modules.
3.	Additional efforts are underway to reach primary care providers, PCPCH and OB providers in the counties we serve.		A list of resources were distributed to the offices.
4			

**2 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.**

Offices cite time, staff turnover and not having access to user-friendly resources as barriers to not completing training requirements.

**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.**

AllCare has developed a list of resources for the PCP, PCPCH and OB offices to utilize. In 2013, there were no certified clinical Spanish interpreters. In 2014, three certified clinical Spanish interpreters were identified for our region.

**2 d.) How was the Community Advisory Council involved in the activities for this transformation area?**

The CACs were informed of the project and will be provided an annual update on the Transformation Plan measures.

**2 e.) How was the CAC informed of the outcomes for activities in this transformation area?**

The CACs will be provided the annual update of the Transformation Plan measures.

**Transformation Area 8: Eliminating racial, ethnic and linguistic disparities (due to the 4<sup>th</sup> quarter claims run off not being complete, data reflects claims payment through 01/23/2015)**

Benchmark 8	Identification of pregnant Members that use any substance that can have an adverse impact on fetus or newborn baby and enhance referral process to appropriate community treatment program(s) for their substance abuse issues.
How Benchmark will be measured (Baseline to July 1, 2015)	Utilize the 834 file to identify pregnant Members and develop a process or tool to assess substance abuse in pregnant Members. Implement this tool in OB and Family Practice offices that provide prenatal care to pregnant Members and obtain appropriate referrals to treatment programs.
Milestone to be achieved as of July 1, 2014	Contractor establishes an identification process and develops a Baseline identifying those Members who are pregnant and need substance abuse intervention
Benchmark to be achieved as of July 1, 2015	Contractor obtains appropriate referrals for 15% of pregnant Members with substance abuse issues.

**1. 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.	The Transformation measure: To identify pregnant members who use any substance that can have an adverse effect on the fetus and/or newborn and enhance the referral process to community treatment programs.	In Josephine County, an identification process has been established.	In August 2013, a certified doula was hired to be embedded in the Women’s Health Center located in Josephine County. This is the sole provider of OB care in Josephine County.

2.	AllCare to sponsor a regional conference in February 2013.		AllCare sponsored a regional conference “Perinatal Opioid Abuse: A Cry for Help” Invitations to PCPs, OBs, Pediatric offices and Early Head Start. Over 200 individuals attended this conference.
3.	In early 2013, AllCare paid for a consultant to work with the OB office, Women’s Health Center to apply to become a recognized PCPCH.		In August 2013, Women’s Health Center was certified as a Tier 3 PCPCH Maternal Home.
4.	Replicate the pilot project in Jackson County		Due to the large number of OB offices in Jackson County, exploring the feasibility of using the WIC office to conduct screenings and embed appropriate credentialed staff to address MH and A & D issues.
5.	December 2013, AllCare’s Medical Director was one of the leaders in the further development of the Opioid Prescribing Task Force in Josephine and Jackson Counties.		AllCare paid for and retained the services of an outside consultant to create an on-line physician provider training series at no cost to providers. The on-line training utilizes Opioid prescribing guidelines using evidence-based approaches – using the University of Washington’s model.
6.	Sponsor SBIRT Training for providers		AllCare sponsored SBIRT training in Josephine County with over 35 providers and staff in attendance.
7.	SBIRT and 5Ps assessment template for Greenway offices		AllCare’s eHealth Director for the Greenway product, created SBIRT and 5Ps assessment tools for the offices utilizing Greenway EHR - >300 users have access to this screening tool.
8.	Josephine County and Curry County maternal programs in jeopardy of not being funded.		AllCare supported Curry County Health by providing monies to support 1 and .25 employees to conduct in-home visits to identify high risk mothers.

9.	Incent pregnant members to keep needed A & D, MH, dental and OB appointments.		Opened the BABE store in Jackson County. Items are donated by staff (home-made baby quilts), diapers, onesies, bibs, books. OB providers, WIC, MH, A & D vendors, Dental providers distribute “vouchers” to pregnant women who keep their scheduled appointments. These vouchers can be traded for items in the BABE store. The “store” is respectful and has a “boutique” feel. Over 300 women have visited the store.
10.	AllCare co-sponsored provider training on Opioid use in mid-May 2013.		AllCare cosponsored a conference “A Thoughtful Approach to Pain Management” on May 3, 2013. This training was targeted at providers, PCPs, OBs, specialty providers, mental health and A & D counselors – over 250 attended in a 6 county area.
11.	AllCare co-sponsored provider training on Opioid use in early June 2014.		The Conference was well-attended.
12.	The Business Analytics Staff and Behavioral Health Staff applied best practices from LaClinica to MVFP in Grants Pass.		Out of 15 patients screened, over 50% met the referral requirements.
13.	The Business Analytics Staff conducted direct SBIRT training in over 7 provider offices		

**2 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.**

Provider Offices voiced the SBIRT process too onerous and time consuming, if the results of the screening were representative of the whole patient population, frustration over A & D and Mental Health access was voiced. Even though screenings for pregnant women increased, the negative outcomes increased as well. The latest data from the A & D, law enforcement agencies point out that since opioid prescribing is being closely monitored and decreased, there is an dramatic increase in heroin use in the three counties we serve.

**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.**

The pilot project in Josephine County where a doula assesses every pregnant woman (regardless of payer), resulted in over 900 women being screened with over 40% being referred to tobacco cessation, A & D, MH or domestic violence in the home. There has also been a decrease in women accepting and getting signed up for WIC vouchers. In Jackson County, in the WIC department, an LCSW has been placed to assess pregnant women. A BABE store will be opened by April 1, 2015 in the Siskiyou Community Health Center Home Visiting program. AllCare pays for one of the Home Visiting staff positions.

**2 d.) How was the Community Advisory Council involved in the activities for this transformation area?**

The CACs reviewed and endorsed the Transformation Plan measures and for this particular measure it is also a Project Improvement Plan. The CACs were involved in the formation of the CHIP which ties into the Kindergarten Readiness initiatives.

**2 e.) How was the CAC informed of the outcomes for activities in this transformation area?**

The CACs will continue to be involved in the development of the CAC Work Groups. The CACs will be provided an annual update of the Transformation Plan measures and the PIPs.