Cascade Health Alliance, LLC

Cascade Health Alliance
Transformation Plan

Integrated Mental Health (MH), Substance Use Disorder (SUD) & Physical Health (PH)

(1) Developing and implementing a health care delivery model that integrates mental health and physical health, addictions, and dental health, when dental services are Included 2014. This plan must specifically address the needs of individuals with severe and persistent mental illness.

Plan: Cascade Health alliance (CHA) believes that integrating the social and medical components of Medicaid recipients' care is incredibility important to assisting them in maintaining their independence and overall well-being.

Where we are:

1. Providers often have separate systems at separate sites, but engage in only sporadic communication about shared patients. This communication is mostly through limited faxes, telephone conversation, and letters without face-to-face interaction or real-time exchange of information. Limited and specific patient issues drive all communication. Mental and physical health professionals view each other as resources, but they operate in their own systems with little understanding of each other's culture. There is little sharing of power and responsibility. There are few active referral linkages across systems, and these are inconsistently applied, at best.

2. When persons who have dual or multiple diagnoses with moderate biopsychosocial interplay are co-managed effectively (for example, a patient with both diabetes and bipolar disease), the management of both problems proceeds relatively well. Patient centered outcomes are achieved (greater functionality, fewer emergency department visits, less need for hospitalization, etc.). When such persons are not co-managed among the various healthcare team members, especially when the medical and mental health management is separated, outcomes are not as good.

3. Historically, thru September 1, 2013, the Substance Use Disorder (SUD) and Behavioral Health services available to clients in Klamath County were segregated by the previous Community Mental Health Program (CMHP) according to client age. IN the case of entire families requiring services, the parents and children were not permitted to use the same facility. This was true across the entire system, regardless of payer. Children and adolescents requiring SUD and Behavioral Health services were referred to one facility, parents and other adult family members were required to use a different provider/facility.

Where are we going in 3 years?

1. Mental health and other healthcare professionals will still operate in largely separate systems, related to administrative rules and AMH requirements, but share the same physical plant/facility. They engage in regular communication about shared patients, including face-to-face and real-time interaction during care conferences for complicated clients or those with pressing psychosocial issues. Cascade Health Alliance (CHA) will foster appreciation of the importance of each stakeholder's role, the sense of being part of a larger team, and sharing a common language and an in-depth understanding of each other's system culture. Primary Care Physicians (PCPs) will coordinate case management decisions with collaboration from all involved providers.

2. The statewide PIP for members with Severe and Persistent Mental Illness (SPMI) and Diabetes will be used to facilitate the integration process for mental health providers and Patient Centered Primary Care Homes (PCPCHs)/Primary Care Physicians (PCPs), and Dental Health providers.

3. Mental health and SUD providers in Klamath County will be encouraged to provide services across all age groups within their facilities. The segregation of member services by age will change under the CCO model from this historical model maintained by the previous CMHP. CHA will facilitate the integration of these services.

4. Promote the completion of and coding SBIRT services as standard screening tools in PCPCH/PCP provider facilities in Klamath County. There is currently consideration of including expanded SBIRT services in the relevant Incentive Metric. These would potentially include those performed by Behavioral Health (but not SUD) facilities. The facilitation by CHA of this activity may expand.

5. Availability to a Behavioral Health staff in every PCPCH to allow interaction with the targeted members by personnel depending on when members are having a visit. MH & SUD staff establishes a schedule within the PCPCH clinics for appointments/screenings. Qualified professionals would conduct full assessments when a screening reveals a cause for concern. MH, SUD providers have staff available onsite or by phone for all providers, PCPCH clinics and community agencies.

6. Promote and assist in the development of the Health Information Exchange that would be utilized by all providers in CHA's provider panel area with an EMR, including all currently designated PCPCH facilities and to include (in the future) all Mental Health, SUD and Dental providers. (See EHR development section).

7. Formalize and codify the understanding that all Physical Health, Mental Health, SUD and Dental healthcare providers are expected to share patient/client information amongst providers in accordance with CFR 42 using a countywide system health information exchange.

8. Health Navigators to be available to each PCPCH/PCP to assist in management of targeted members in optimizing their healthcare.

9. Quarterly problem solving committee with MH, SUD, Medical Provider staff and CHA case management staff.

10. Quarterly trainings from MH, SUD and medical Providers to educate on each other's "LINGO". Universal list of definition's, example "stable condition."
11. RN Case coordination with MH case managers & linkage with PCPCH/ ancillary services and trainings in case management methods to all providers staffs annually.

12. RN case managers to assist in coordination of care for chronic disease management program and Intensive Case Management (ICM) members with Transitions of care to and from all levels of care.

13. RN Maternity Case Manager (MCM) coordinates care for all high-risk mothers, to assure early prenatal care, prevention, education, screening and treatment referral for mental health, tobacco use and or substance abuse.

14. Utilization of a Doulas program within our community.

15. Continue "Project Changes" an alcohol, tobacco, and other drug prevention program in the schools. Evidence-based Practices will be used to engage services to school districts for children of all ages.

16. Collaborating with our Local Mental Health Authority and the Community Mental Health Program to ensure the community has access to safety net services.

17. Development of Mobile Crisis Teams to serve members in the community during crisis events not limited to the emergency department of the area's only hospital as has occurred historically.

To date, CHA is working with our new CMHP, our only Medical Center, <u>all</u> of the County's Law Enforcement and Fire agencies, and all other Behavioral Health stakeholders to bring this system change online by mid-2014 (see below).

Timeline:

1. Year 1(September 2014):
    a) Increase the number of members identified by diagnosis to be Severe & Persistently Mentally ill and diabetes have annual HbA1c and LDL-C testing to begin integration and coordination at the provider level. A 10% improvement over baseline data will be tracked.

    b) Intensive case management services to selected members as identified by high ER utilization with low PCPCH utilization. Members that are identified as complex cases, SPMI, DM etc that do not utilize or follow through with their PCP, will be referred to CCO ICM services to assist with coordination of care as

indicated. Integrated treatments plans with MH, SUD, Physical and dental integration will be implemented and available for all treatment partners.

c) All Medical providers familiar with SBIRT tools, coding and referral process for positive full screen. CHA will see a 15% increase in application of SBIRT's.

d) Mobile crisis teams in place that are available to respond to community locations, provider offices, with EMS and Law Enforcement for MH & SUD crisis events.

2. Year 2 (January 2015):
   a) Integrated Care plans developed for 80% of members receiving ICM level of services.

   b) Screening with SBIRT & a Depression screening tool to be increased to 25% of enrolled CHA members as appropriate.

   c) CHA has established a 24-hour, seven-day-a-week mobile crisis team in the Service Area. The purpose of establishing a Mobile Crisis Team will be to make the transition from the ED crisis response model with a service delivery model that will provide a mobile, on-site, face-to-face therapeutic response to Members experiencing a behavioral health crisis that identifies, assesses, treats and stabilizes the situation. This will be measured by the number of crisis services delivered as noted by the place of service with 50% delivered in the community.

Benchmarks:

1. 2014:
   a. CHA will have a 10% increase in the number of members with SPMI diagnosis and diabetes that receive HbA1c and LDL testing from the December 2012 baseline: HbA1c = 72.73% LDL-C= 72.73%.

   b. Members referred for ICM services will have an integrated treatment plan for coordinated care. CHA will have a 50% increase in integrated treatment plans.

   c. SBIRT screenings increase from 0 to 15% as identified by procedure codes as listed on the SBIRT metric specifications.

   d. Mobile crisis team that is operationally available to the community, PCPCH/PCP clinics and ED facilities. CHA will increase response from this team from 0% to 25% of services provided outside of the ED setting.

2. 2015:
   a. CHA will have a 20% increase in the number of members with SPMI diagnosis and diabetes that receive HbA1c and LDL testing from the December 2012 baseline: HbA1c = 72.73% LDL-C= 72.73%.

b. Members referred for ICM services will have an integrated treatment plan for coordinated care. CHA will have a 80% increase in integrated treatment plans.

c. SBIRT screenings increase to 25% as identified by procedure codes as listed on the SBIRT metric specifications.

d. Mobile crisis team that is operationally available to the community, PCPCH/PCP clinics and ED facilities. CHA will increase response from this team from 25% to 50% of services provided outside of the ED setting.

Deliverables

a) Quarterly reports to OHA on PIP PDSA activities, barriers and changes in implementation strategies.

b) Tracking of SBIRT screening (both brief and long forms) using running charts to show an increase in our overall membership being screened. Focus will be on the PCPCHs, and other facilities as may be appropriate in the future. Review and documentation of all PCP and other activity will be used to report members who had both positive short screens and resultant full SBIRT interventions. Facilitate the correct billing and diagnostic coding for these activities per the OHA Incentive Metric specifications.

c) Reporting of crisis service delivered by using place of service codes on the claim. CHA will decrease the number of services provided at place of service codes other than 23.

PCPCH clinic development.

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

1. Continue to educate contracted network facilities and providers as to the fundamentals of the PCPCH model and how it is applicable to our unique area:
    - Provision of comprehensive services with a team-based model
    - Patient –centered care involving family and the patient's own self-management skills
    - Coordination of care (transitions of care, teams with CHWs, case managers in-house, etc.)
    - Accessibility (after hours, E-mailing, E-prescribing, EHR meaningful use
    - Quality (patient satisfaction surveys, Improvement plans, Evidence-based care)

    Such education will include training in the needs of enrollees with ACA-qualified diagnoses as well as the integration of PCPCH activities and the "Pay-For-Performance" initiative of the Incentive Metrics Pool. The degree to which CHA can offer to coordinate case management activities with those of the PCPCH will also be explained and negotiated.

2. Facilitate and encourage the completion of a Tier 1, 2 or 3 PCPCH system which includes all of the area's in-network PCPs. With the removal of State funding (historically passed thru to the area's existing PCPCHs by the local CCO/FCHP) for PCPCH status, further alternative funding models will be developed in order to foster this system completion. This replacement funding will require development and negotiation of PCPCH incentives based on the pay-for-performance Incentive Metrics Pool (see section on Alternative Payment Methodologies") and its deliverable, patient-centered outcomes.

3. Facilitate the collaboration among community partners to further develop the Community Assessment and Health Plan. Such partners will include the CCO Community Advisory Committee and the existing "Healthy Klamath" program's website and its ongoing local newspaper's site.

4. Develop a reporting system to assist in identifying enrollees with ACA qualifying diagnoses, such as:
    - SPMI
    - Two or more Chronic Health conditions, etc.

Enrollees with an ACA-qualifying diagnoses set will be educated as to the benefits of selecting/being assigned to a Tier 1, 2 or 3 PCPCH. As the PCPCH system completes (see Benchmarks and Milestones), this activity will shift to simply facilitating the timely assignment of these enrollees to a PCP, all of whom will be part of a PCPCH by definition.

CHA will work to assist the new CMHP in Klamath County to more fully integrate with the Behavioral Health and Dental Health resources both in the PCPCHs and in the community at large. Tracking the services provided to the ACA-qualifying enrollee population will allow CHA to measure the effectiveness of the PCPCH model in coordinating these services and to increase the penetration rate of these services to this population.

5. Conduct ongoing community education processes for both CCO enrollees and the community at large. Partner and coordinate with local PCPCHs in these processes, with the aim of clarifying the availability of community resources, ancillary agencies/treatment providers and other services, both public and private. These will include:
    - face to face presentations at local community center
    - public service announcements
    - Integration with the "Healthy Klamath" website.

6. Support adherence to CHA contracts, policies and procedures, including data reporting requirements, EHR utilization at the "meaningful use" level, and health information exchange participation.

7. Address issues with health literacy and health disparities among local sub-populations with the use of functional technologies such as website design modification, etc.

8. Encourage the use of Traditional Healthcare Workers and Case Managers by both the PCPCHs and CHA to help guide enrollees to existing community resources. With the creation of a new CMHP in Klamath County, and the changing face of its institutions and systems, this facet of the combined efforts of all partners cannot be overstated.

Timeline:

June 2013:

a. Disseminate all 2011-2012 Baseline date regarding PCPCH participation to all stakeholders, including CHA Board and Committees as well as existing/future PCPCHs.

June 2014:

a. Alternative payment methodologies developed and agreed upon, which will foster the PCPCH system.

Calendar year 2014-2015:

a. Completion of the PCPCH system.

Benchmarks:

a. Increase the percentage of CHA enrollees assigned to a PCP in a PCPCH.
    - Starting at Baseline year 2011, measure the total percentage of enrollees that are assigned to a PCPCH at yearly intervals.

b. Increase the percentage of reimbursement available through the Alternative Payment Methodology (per the Transformation Plan) to facilitate completion and maintenance of the PCPCH system.

Milestones:

December 2013

a. 50+% of enrollees will be assigned to a PCPCH.

Calendar year 2014

a. 75% of enrollees will be assigned to a PCPCH.

Calendar year 2015

a. 100% of enrollees will be assigned to a PCPCH.
b. CHA will meet the requirements of each year of the PCPCH-related Incentive Metric, rounds 1 and 2.
c. 100% of contracted PCPCH facilities in CHA's area will be reimbursed at least for their PCPCH status per the Alternative Payment Methodology.

Deliverables:

a. Periodic reporting on Percentages of enrollees assigned to a PCPCH.
b. Reporting on number of clinics in area that are PCPCH vs not.
c. Provision of CHA contractual language consistent with the expectation of PCPCH eligibility and payment methodologies that reflect this aim.

Cascade Health Alliance, LLC

Transformation Plan

Alternative Payment Methodologies

(3) Implementing consistent alternative payment methodologies (APMs) that align payment with health outcomes. (Incentives)

Cascade Health Alliance (CHA), a CCO in Klamath County, supports PCPCH healthcare delivery systems and the Pay For Performance (P4P) methodology. CHA is also invested in the reduction of healthcare costs while promoting evidence based quality of care. The basis of this quality of care, and for the P4P process will be the OHA's 33 identified, measurable and evidence based and patient centered quality outcomes (Metrics). CHA is working with its contracted providers to bring its payment system in line with the aims of the of the OHA Incentive Metric Pool initiative.

CHA will use 2011 Baseline data initially, as the basis to measure PCPCH improvements.

The APM will slowly increase the percentage of payment to providers that is based on quality, cost efficient and evidence based care to its enrollees in line with the overall evolution of the OHAs incentive Metrics initiative. As time passes, a higher percentage of all providers (PCPs and PCPCH based providers first) will have an increasing portion of their reimbursement determined by the quality and efficiency of their care, and not its volume.

The CCO Incentive Measure Pool will be used as a model.

Timeline:

March 2014

a. APM policies reviewed and approved by CHA Committees, Board and the OHA

June 2014

a. Methodology for allocating reimbursement from the Incentive Metrics Pool reviewed and approved as above. Initially, the funds will be limited to those earned by the CCO for its adherence to the required Metrics.

July 2014

a. Incentive Metric Pool allocated per the above Methodology. Initially, funds are projected to be allocated based on participation in "meeting" the Incentive Metrics.

Benchmarks:

January - March 2014

a. Determine degree of CCO compliance ("meeting at least 12.6 Metrics including EHR), and correcting any anomalous data affecting this compliance rate.

April - June 2014

a. Develop reporting system to allocate the percentage of compliance with each Incentive Metric on a PCPCH or facility basis.

July 2014

a. Disburse Metric Pool funds based on the developed APM, tracking for future comparison the relative contribution of the various PCPCHs/facilities to the overall success of the Metric program

Milestones:

a. CHA will develop policies that are approved by Committees and Directing Boards on Alternative Payment Methodologies to be piloted with Providers and recognized PCPCH clinics by July 1, 2014.

b. Contractor will begin piloting Alternative Payment Methodologies via contract amendments, in compliance with OHA reimbursement requirements by July 1, 2014.

Deliverables:

a. Utilize the available Metric Pool funding to incentivize the increase in the percentage of PCPCH based PCPs in the contracted. Aim for 100% PCPCH enrollment by calendar year 2015.

b. Replace the funding for PCPCH that has been lost at the State level, to allow continuation of existing PCPCH system. Attempt to replicate that level of funding.

c. Improvement from "meeting" the number of Metrics that ensure full Pool participation toward satisfying all measurable Incentive and Quality Metrics as a matter of best practice, and good care for the community, across all payers.

d. Utilize the Metrics as the pilot program to realize the P4P APM for all providers, across all payers, in our community

Cascade Health Alliance, LLC

Transformation Plan

Community Health assessment

(4) Preparing a strategy for developing Contractor's Community Health Assessment and adopting an annual Community Health Improvement Plan consistent with Senate Bill 1580 (2012), Section 13.

Cascade Health Alliance (CHA) has participated in initial, early work to collaborate with community partners in a Community Health Needs Assessment (CHNA) since August of 2012. The participants included were Sky Lakes Medical Center, Klamath Open Door Family Practice (FQHC), Klamath County Public Health, OHSU School of Nursing (OIT Branch), OHSU Department of Family Medicine (Cascades East Branch), the Healthy Klamath Initiative and Cascade Health Alliance, (formerly Cascade Comprehensive Care). The CHNA has thus far been as global as was possible, and has concentrated on population-level needs as well as the unique challenges inherent with the health needs of certain high-risk sub-groups of the CHA/Klamath County area (the poor, the SPMI population, the obese and persons with multiple chronic diseases, for example).

However, the bulk of these efforts have been conducted prior to CHA receiving its Notice to Proceed. Thus, there was no Mental Health or Dental Health collaboration in this process (none was allowed due to the incomplete CCO formation). The CHNA thus far cannot be said to have been complete or completed. Since NTP to CHA was granted by the OHA on 9/1/2013, this process has continued with the addition of the newly formed Klamath County CMHP (with all other local Behavioral Health providers represented), the soon to be contracted Dental Health providers, as well as CHA's newly formed Community Advisory Committee (only recently activated).

Most recently, a new resource has appeared on the local scene: the Sky Lakes Wellness Center. This foundation is headed by 2 MPH graduates (1 is a returning, recent MD graduate of the local OHSU Cascades East Family Medicine). Supported in part by CHA, this foundation is committed to addressing healthcare disparities in Klamath County. It plans to GIS-map the social demographics of the area, and to help design interventions to remedy same. They have already received a Cambria Foundation Grant, are supported by our Medical Center and are awaiting IRB approval for their studies. CHA is currently negotiating data-sharing initiatives with SLWC, consistent with HIPPA guidelines.

Plan:

The Community Health Needs Assessment (CHNA) is the first of its kind in Klamath County formally assessing and documenting the health of our community utilizing a coordinated and collaborative process.

1. The primary goal of our CHNA is to better understand the health of our community, its underlying determinants, and develop local strategies to address our community's specific needs and identified priority issues. The CHNA will help identify community health priorities, establish benchmarks, monitor trends in the health status of Klamath County residents, and develop a platform for collaboration to improve health status. The end-point of this process will be the creation of the Community Health Improvement Plan, CHIP.

2. Data Collection: The Healthy Klamath partners have collected data through community health surveys, focus groups, stakeholder interviews, and secondary data sources. The secondary data was collected through the Healthy Communities Institute and can be viewed at www.HealthyKiamath.org. These data come from a variety of sources and have been thoroughly vetted. This effort will entail the HIPPA-compliant sharing of information that has thus far been unprecedented in our area.

3. An interim Community Advisory Council (CAC) has been formed and its members named, including the chairperson that will be representative of this committee on the CCO Board of Directors. CHA will have the CAC review, comment, approve the CHNA, and begin working on the Community Health Improvement Plan CHIP to serve as a strategic population health and health care service plan for the community served by the CCO.

Community Health Improvement Plan

1. Next steps

    a. Together, we must decide which areas of concern to focus on. We must identify specific, measurable, and action oriented objectives to improve these areas of concern and ultimately improve the health of our community.

    b. The Community Health Improvement Assessment is the first step in the development of a community plan. The community health assessment is to be used as platform for discussion. The multi-faceted data collection and analysis allows for identification of local health issues, the community's perception of those health issues, and local organizations ability to react to those issues.

This document is intended to be a living document, calling each of us to further investigate local health issues and better understand our local needs. OHSU School of Nursing students will continue to conduct focus groups and listening sessions to ensure the voices of every community are heard and represented.

Together, we must identify the top priority issues to change for Klamath County. Upon identifying these top priority issues, we will add a supplement document known as the Community Health Improvement Plan. This improvement plan will serve as our strategic plan and guiding document for improving the health of the community.

c. To see a completed preliminary, pre-CCO Community Health Assessment, visit: www.HealthyKlamath.org.

d. A committee of community partners are meeting quarterly to assist in the development of the community health plan.

Community Advisory Council (CAC)

1. The CAC membership is being selected by a committee composed equally of representatives from Klamath County that are served by the CCO.

2. CAC Will include:

    a. Representatives of the community with consumer representing the majority.

    b. Representatives from County government will be requested to serve on the CAC.

3. CAC Duties:

    a. Ensure that the healthcare needs of the consumer and the community are being addressed as identified in the community health assessment and plan.

    b. Meetings will be held at least once quarterly.

    c. Assist in identifying and advocating for preventive care practices that will be utilized by CHA to serve the members of Klamath County.

    d. Review the community health assessment and assist in the development of a prevention plan to serve the strategic population health care and the services provided to the community by CHA.

e. The community health improvement plan will describe the scope of activities and services for CHA is responsible to provide to the members of service.

f. Coordinate with CHA to develop community practice standards.

Timeline:

a. CAC will be in operation within 5 months following the start of the CCO NTP.

b. CAC will review, approve or complete modifications to the Community Health Needs Assessment by Sept. 1, 2014.

c. Community Health Improvement Plan (CHIP) will be complete within 1 year of the Community Health Needs Assessment (CHNA).

Benchmarks:

a. Launch of "Healthy Klamath" website, completed in early 2013.

b. The CAC is being reconvened and members are being selected. First meeting will occur by Feb., 2014.

c. Quarterly meetings with all partners and stakeholders in developing the Community Health Improvement Plan.

d. CHIP completed and approved by CAC September 1, 2015.

Milestones:

a. Selection of CAC member's by Jan. 31, 2014.

b. First CAC meeting by Feb. 2014.

c. Sept.1, 2015, the Community Health Improvement Plan will be developed and approved by CAC.

Deliverables:

a. New CAC committee developed by Feb. 2014.

b. Community Health Needs Assessment completed, Accepted by CAC and submitted to OHA by Sept. 1, 2014.

c. CAC- approved Community Health Improvement Plan completed and submitted to OHP by Sept. 1, 2015.

Cascade Health Alliance, LLC

Transformation Plan

Electronic Health Record Development

(5) Developing a plan for encouraging electronic health records; health information exchange; and meaningful use.

Background:

Over 90% of all providers (Specialists and PCPs) in CHAs geographical area and network possess and utilize an Electronic Health Record (EHR), whether or not they have applied for or received incentive payments for same from any source. The issues that affect the meaningful use of these EHRs are ones in common with all other communities nation-wide: The adaptation of EHRs occurred before the technology was mature enough to allow for data exchange, sharing of clinical information and coordination of care across all portions of the healthcare delivery system.

Cascade Health Alliance (CHA) will address this in two ways. (1) Partnering with providers and other CCOs to develop a health information exchange (Jefferson Health Information Exchange or JHIE) and (2) purchasing a care coordination program for CHA that will allow development of care plans and assist in high member utilization. Following are the particulars for each project.

I-Executive Summary/Abstract (Health Information, provided by JHIE)

Jefferson Health Information Exchange (JHIE) is an organization that utilizes a multi-stakeholder approach to addressing the triple aim.

Summary of benefits of JHIE

1. Provide immediate, real-time notification of member presentment at an emergency room and discharge from the hospital that will improve care coordination, identify high utilizers and reduce readmissions

2. Gain the benefit of community participation –

    a. Providing greater clinical data availability to improve care quality and outcomes, improve efficiency and reduce costs

    b. Leveraging resources (human and financial) across the community to benefit from more services and functions at a lower cost

c. Providing community-wide population health and data analytics to allow for more robust information with which to make business decisions

d. Providing efficiency through accessing electronic information for HEDIS and other reporting requirements

Goals

a. Improve the care provided by Southern Oregon's health care providers and to reduce medical errors associated with the inaccurate and incomplete information available to providers of medical care

b. Improve communication among healthcare providers and their patients to provide the right care at the right time based on the best available information

c. Reduce the number of duplicative tests and automate the referral process, ensuring a patient's doctors have all the information needed to treat them

d. Improve care coordination for behavioral health patients and bridge the information divide between primary care and behavioral health care

e. Reduce the time and financial costs of connecting clinics, hospitals, pharmacies, labs, etc. to support meaningful use of health information technology, by reducing complexity and creating efficiencies

Project Description

An important strategy in our care coordination and cost containment plan is connectivity to the regional HIE, the Jefferson Health Information Exchange. This connectivity requires us to send JHIE a file of our members each month so they can determine for whom to send us an alert when our member presents in the emergency department, hospital or urgent care center. Furthermore, we will receive a discharge summary upon the patient's discharge from one of these points of care, as well as a notice when our member is transferred from one location to another within a facility (e.g., emergency department to hospital admission). The benefits we receive from this connectivity toward reaching our transformation plan goals include:

a. Gaining access to clinical data from contributors to the HIE (lab, radiology, transcriptions, cardiology studies, etc.)

b. Improving our ability to manage care quality and cost and to create efficiencies by enhancing communication channels across the care team, reducing duplicated tests and directing patients toward more appropriate care settings and services

c. Improving the patient experience by ensuring they are seen by the right provider at the right time, to keep them healthy and manage their chronic health conditions.

d. Managing hospital readmissions by addressing the major risk factors* affecting 30-day readmission:

- Hospital admission through the emergency department (85% greater risk)
- Co-morbidities of congestive heart failure, renal disease, cancer, weight loss, and iron deficiency anemia
- Discharge with high risk medications (50% greater risk with steroid, narcotic, antibiotic, and cardiovascular medications)
- Socio-economic factors

*Reference: http://malnutrition.andjrnl.org/Content/articles/Redefining-Readmission.pdf

Project Timeline

a. Kick-Off – January 2014 (25% of payment)

b. Testing Completed – March 2014 (50% of payment)

c. Go-Live – June 2014 (25% of payment)

Each phase of JHIE implementation gives added value for all participants. For example, Phase I offers a closed loop referral system with secure messaging which, when fully enacted, will increase coordination of care within the medical community and give the behavioral health community unparalleled connection and access to data for true care coordination and integration. Phase II data collection from participating members will allow for decreased costs and improved care by reducing duplicative tests especially in hospital emergency departments, where many times a patient's records are not available. Phase III brings in data analytics and population health management. JHIE also supports providers in achieving meaningful use by providing them with functionality that helps them to satisfy Stage 2 (and proposed Stage 3) requirements.

Project Objectives and Metrics

a. Reduction of the rate of hospital admissions for those at greatest risk (defined above)
b. Reduction in the rate of duplicate testing
c. Member satisfaction

Phase I

a. Receipt of emergency admission and hospital discharge information in real-time to support care management
b. Provider-to-provider communication to support information exchange, promoting care coordination across communities
c. Become part of policy decision-making process to define data access requirements

Phase II

a. Care team access to real-time clinical history via patient search
b. Access to member records to support efficient data collection for quality reporting
c. Cost avoidance of duplicate tests, re-admissions, duplicative drug therapy, due to better data at time of care

Phase III

a. Population health management
b. Identification of high utilizers
c. Cost avoidance due to faster outbreak detection
d. Monitoring for at-risk populations

Spread of Innovation

As a member of JHIE, we are proving out new and innovative technologies for payer interaction with health information exchange. The community alerting and ability to access a community health record of clinical information about our members will prove out the ROI and value of HIE in a transformational health care system. This work will be available to other CCOs and payer organizations following our "pioneering" implementation. JHIE is scalable and is open to including other health care and payer participants beyond the Southern Oregon region.

II-Executive Summary/Abstract (Care Coordination Program Introduction)

Our Care Coordination Program for the managed care members will facilitate the delivery of sophisticated, high-quality medical care, which has come to require teams of health care providers—primary care physicians, specialists, nurses, technicians, and other clinicians.

Each member of the team tends to have specific, limited interactions with the member and, depending on the team member's area of expertise, a somewhat different view of the member.

In effect, the health care team's view of the member can become fragmented into disconnected facts and clusters of symptoms. Health care providers need less fragmented views of members.
Leveraging an EHR across the continuum of care allows for:

- PCPCH coordination with the health plan to assist in delivery of services
- Better integration among providers by improved information sharing
- Viewable and up-to-date medication and allergy lists
- Order entry at point of care or off-site
- Standardization of data, order sets, and care plans, helping to implement common treatment of members using evidence-based medicine.
- Access to experts for rural health care providers by sharing best practices and allowing for specialized care through telemedicine
- Population management, trended data, and treatment and outcome studies
- More convenient, faster, and simpler disease management.

Project Description

Electronic health record (EHR) systems can decrease the fragmentation of care and improve care coordination. EHRs have the potential to integrate and organize member health information and facilitate its instant distribution among all authorized providers involved in a member's care. For example, EHR alerts can be used to notify providers when a member has been in the hospital, allowing them to proactively follow up with the member.

With EHRs, the PCPCH and every provider can have the same accurate and up-to-date information about a member. This is especially important with members who are:

- Seeing multiple specialists
- Making transitions between care settings
- Receiving treatment in emergency settings

Other benefits include:

- Better availability of member information, which can reduce medical errors and unnecessary tests

- Better availability of information, which can also reduce the chance that one specialist will not know about an unrelated (but relevant) condition being managed by another specialist

- Better care coordination, which can lead to better quality of care and improved member outcomes

Project Timeline

- Review products to evaluate which ones meet the requirements for connectivity to JHIE and local clinicians, with plans to purchase within the next eight months

- Review the products to evaluate each one's effectiveness at producing desired outcomes

- Purchase a program by June of 2014

Measurable Project Objectives and Metrics

Care coordination is fundamental to ensuring positive health outcomes for members. The care coordinators act on behalf of linked providers to ensure that members receive well-coordinated care within and across all healthcare organizations, settings, and levels of care by:

- Identifying at-risk members for the purpose of reducing preventable emergency department visits, thereby reducing hospital re-admission rates

- Achieving improved individual health outcomes through:

    - Connecting members with the health care network and supporting them as they navigate through it

    - Coordinating services for health plan members to achieve positive individual-level health outcomes

- Assuring collaborative planning and improvement of our health care system

- Reducing the risks of injury and harm by striving to ensure a culture of prevention and safety

- Soliciting and carefully considering feedback from all members (and their families when appropriate) regarding their health care experiences

Care coordination ensures that all of the member's needs are coordinated with the assistance of a primary point of contact. The point of contact provides information to the member and the member's caregivers and works with the member to make sure that he or

she gets the most appropriate treatment, while ensuring that health care is not accidentally duplicated. This process improves the quality of care as well as member satisfaction.

For care coordination to be successful in the Health Plan, the following criteria must be met:

The Care Coordination program must assist the team in:

- Member assessments
- Service planning
- Member coordination and referral
- Follow-up/monitoring
- Member education/counseling

Spread of Innovation

Prior to the development of CCOs, there were very limited options for coordination of care among members' health care providers.

Below are some examples of teamwork among the member's health care providers concerning coordination of:

- Follow-up on missed appointments
- Management of referrals and interventions as needed
- Counseling, including referral, discharge information and home follow-up with members.
- Systems must be put in place and utilized with the intention of preventing acute health crises while protecting the member's health. For example: It has been strongly recommended that tracking systems be established where the Care Coordinator/PCPCH is notified of any problems at the time of occurrence. For example, if a member does not keep her prenatal appointment, the Care Coordinator/PCPCH should be notified the day of the scheduled appointment so that the necessary tracking can be accomplished. Likewise, if the attending physician or nurse determines a need for a member to be referred to a specialist, the Care Coordinator should be notified at the time of the appointment so that the referral appointment can be made and the recipient notified before leaving the clinic or office.

This was not an option for coordinating care prior to the development of CCO's.

CHA looks forward to being able to share any improvements to processes that come from the implementation of these 2 projects, as well as collaboration with other CCOs on

problems that arise, as more and more CCOs use Health Information clouds and meaningful use projects and care coordination systems. For example, CHA will be initially joining several other CCOs in funding and participating with JHIE in its initial start-up.

Timeline (Combined HIE and Care Coordination Program)

January - June 2014

a. Investment in and testing of JHIE, prior to release.

Present - May 31, 2014

a. Evaluation of Care Coordination Programs (including data compatibility with JHIE)

June 2014

a. Purchase, implement Care Coordination Program

July 2014

a. JHIE "goes live" with its participating CCOs

2015 and beyond

a. On-going JHIE progress toward State 3 meaningful use throughout CHA network

Benchmarks:

a. Increase the number of contracted providers enrolled and active with JHIE by 10% as compared to "go live" date, within 1 year.

b. Increase the number of contracted providers enrolled and active with JHIE by 20% as compared to "go live" date, within 2 years.

c. 100% of contracted providers (enrolled and active with JHIE) who are connected with the Care Coordination program and at Stage 3 meaningful use, as JHIE progresses to this level.

Measurables:

a. 10% reduction in hospital readmissions from2013 baseline for 2015 as measured by administrative data(part of OHA quality Metric Program)

b. 10% Reduction of duplicative testing using administrative data on CCO Ancillary Utilization data as a surrogate marker.

c. Improving enrollee satisfaction using CAHPS data as surrogate marker

Deliverables:

a. JHIE "go-live" date of June, 2014.

b. CHA, through JHIE, will have 60% of its local, contracted providers sharing data through the HIE.

c. Care Coordination program purchased and implemented by July 2014
   - Care plans for multi-morbidity members that will be available to all providers working with an individual member.
   - Reporting on member assessments, service planning, member coordination and referral, follow-up/monitoring and member education counseling.

Cascade Health Alliance, LLC

Transformation Plan

Member Engagement Cultural Health Literacy Linguistic Needs

(6) Assuring communications, outreach, Member engagement, and services are tailored to cultural, health literacy, and linguistic needs. How do we engage the Hispanic population?

Plan:
Cascade Health Alliance will encourage, explore and adopt policies and procedures that assist providers in communication, outreach, member engagement and those services are tailored to the cultural and linguistic needs of members with diverse backgrounds and values supporting the dignity of all members. Klamath County is dependent on cultural diversity in order for its agricultural-based economy to survive. OHP membership assigned to CHA is made up of 92.87% Caucasian (preferred language English), 6.64% Hispanic (preferred language Spanish), 0.02% are Central American Indian, 0.03% members are Russian, 0.03% use sign language, 0.32% are undetermined, 0.09 are Chinese/Asian and 1 Vietnamese. The prevalent language spoken in Klamath County is English with 7% of members reporting that Spanish is their preferred language.

In addition to more traditional cultural and linguistic issues, Klamath has challenges that are related to a culture of poverty and lack of education. Klamath County (CHA's geographical area) has one of the State's highest illiteracy rates at 12%. It is tied for 5th amongst Oregon's Counties in unemployment and Childhood poverty. These issues can potentially cause greater barriers to care than the more traditional cultural or linguistic disparities.

Cascade Health Alliance will address these issues by gaining knowledge of the current provider panel's awareness of cultural, health literacy, and linguistic needs of members by using the American Speech-Language-Hearing Association (ASLHA) checklists. Develop policies and training activities to assist providers in delivering services that are tailored to cultural, health literacy, and linguistic needs of our community members. CHA will implement the National eHealth Collaborative's Patient Engagement Framework on its website in order to better engage members of the community. Lastly, CHA will collaborate with the Sky Lakes Wellness Center in its GIS-mapping of Health Care Disparities and Barriers as part of its IRB-approved study and intervention initiative to address chronic diseases in Klamath County. This collaboration will initially involve assisting the disparity arm of the study with demographic data.

- Work with public health departments, CAC and providers to generate quality standards that include cultural competence and incentives for providers to meet standards for outreach, Member engagement, and services that are tailored to cultural, health literacy, and linguistic needs.
- Survey CHA's provider network using ASLHA tools for areas of need regarding cultural competence issues.

- Build into CHA's website the Patient Engagement Framework.
- Recruiting of traditional health workers with Spanish language expertise and have them available to our Primary Care Homes.
- Engage the Office of Equity and Inclusion's policy on collecting race, ethnicity and language data and disseminate that to all committees and clinics via electronic means.
- Data sharing and partnering with SLWC as above

Timeline:

1. Identification of culturally diverse populations and develop reports that assist in identifying these members in our provider network by December 2014.

2. Data sharing with SLWC as above Present through Fall, 2014.

3. Disseminate surveys to clinics in first quarter of 2014. Calculate results and report to CAC, and internal committee's to assist in developing policies & training activities by July 2014.

4. Phase one of the National eHealth Collaborative's Patient Engagement Framework complete in the CHA website by July 2014 as follows.

5. Recruitment of Spanish-speaking CHWs by July-Sept, 2014

(Information and Way-Finding) maps, directions and service directories.

(e-Tools) Wellness guides and prevention activities

(Forms: Printable) Adavance directives, Mental Health directives, etc.

(Patient-Specific Education) care plans, tests, OHP insurance information.

Benchmarks:

1. Surveys sent, reviewed and reported to the CAC and internal committee's/Board of findings July 2014.
2. Member materials available on website in Spanish and by audio.
3. Cultural competency policies and training materials available on CHA website and disseminated to all providers by December of 2014.
4. Development of a community wide intervention set as part of the SLWC program to address obesity, diabetes and other chronic health issues by overcoming barriers in culture, language and economic disparity by July, 2014.
5. At least 1-2 Spanish-speaking CHWs hired and in service by Fall, 2014.

Milestones:

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1. Surveys sent and returned from provider offices, needs of providers and staffs documented.

2. Cultural Competency training program developed and available on CHA website by December 2014.

3. Training on cultural competence policies completed by July 2015.

4. Presentation and commentary on the SLWC GIS-mapping and healthcare disparities study and the recommended intervention set by the CHA community Advisory Committee by Fall, 2014.

5. CHWs, as above.

Deliverables:

1. Ongoing Community assessment and CHIP with updates to the Healthy Klamath Website to assist members with health disparities navigate the system.

2. Promote access of CCO members to appropriate linguistic support in the PCPCH facilities. At this time, several of the facilities have access to translators for Spanish in the clinics and through the local hospital, with which they are affiliated.

3. Maintain the language line, use Google translate and other sources to develop and review member materials.

4. An intervention set approved and facilitated by the CHA Community Advisory Comittee regarding the initiatives put forth by the SLWC by Jan. 2015.

5. CHWs, as above.

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Cascade Health Alliance, LLC

Transformation Plan

Assuring Culturally Diverse Needs Met

(7) Assuring that the culturally diverse needs of Members are met (cultural competence training, provider composition reflects Member diversity, traditional health care workers composition reflects Member diversity).

Plan:

The two primary populations in Klamath County are English & Spanish. CHA's plan is to address all OHP enrollees regardless of race, ethnic cultures, disability, religious preferences or sexual preference. The plan also applies to training of CHA staffs, our provider network and their staffs, and community supports that interact with our Medicaid beneficiaries through their association with CHA.

CHA plan is to transition to a more diverse workforce that reflects the racial, ethnic, cultural, and diversity within the community we serve**.** CHA will collaborate and support the development of strategies to recruit and retain a diverse workforce using recommendations of the CAC, the community health assessment partners, community supports, Hispanic Advisory board, and the Office of Equity & Inclusion (OE&I).

Assist the local educational institutions in developing health care programs that educate and assist in attaining health equity, diversity and cultural competency in the community-based organizations.

CHA will also explore incentive/payment methodologies to increase participation of provider staff in metrics, training and events/information relating to meeting cultural needs of Klamath County. CHA will work with providers to create and disseminate functional tools, guidance, trainings and clinical guidelines that can be practical in use in the clinics that assist in educating current staff, and for recruiting a more culturally diverse staff.

Implementation and adherence to non-discrimination policies and procedures for all contracted providers.

Timeline:

Year 1:

1. Develop policies and procedures that enforce diversity in clinics through contracts.

2. Acquire and develop a DMAP/OE&I approved training curriculum using the webinars available through OE&I.

3. Supply materials to all PCPCH staffs and providers to do trainings.

Year 2:

1. Community training through the Healthy Klamath partners efforts supported by CHA to providers and the community.

2. Employment of Health Navigators with knowledge of Spanish culture into the PCPCH clinics/or provider agency that all contracted providers can access.

3. Specifically for Hispanic enrollees develop programs designed to increase Spanish speaking traditional healthcare workers to help guide and inform members of the available resources in Klamath County.

4. Develop a process of collecting information on the health care needs, sensitivities, and preferences among our Hispanic members through providers, committees and data collection.

5. CHA will develop community resources to assist providers with culturally and linguistically competent care coordination, focused on Hispanic members.

6. CHA will instill discussion/reporting of cultural diversity and cultural competencies at trainings, committees, and community meetings.

Benchmarks:

1. Collect a baseline survey in 2014 to measure training program participation.

2. Training program developed and training begins July 2014.

3. December 30, 2015: 80% of Providers have received training on cultural competence from CHA policy and the OE&I webinars that correlate with policies for cultural diversity.

Milestones:

1. Cultural competence training policies developed and training documents that address cultural competence by the CCO completed by July 2014.

2. Contracted providers engage in training related to cultural competencies and 50% complete the training by December 2014.

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3. Achieve by December 31, 2015 improvement of 80% clinics/staff that have completed training related to cultural competencies.

Deliverables:

1. July 2014 policies, procedures and training program approved by CHA committees and dissemination to all contracted providers for implementation and training.

2. Discussions and education through electronic communications/Care Connect quarterly CCO newsletter, and CHA sponsored trainings to our contracted providers with articles from OE&I Diversity training and discussions around the importance of diversity and its impact on health outcomes, quality of care, quality of life, and member satisfaction.

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Cascade Health Alliance, LLC

Transformation Plan

Quality Improvement Plan to Eliminate Disparities

(8) Developing a quality improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes. (Spanish population)

Plan:

CHA's QIP will include milestones and benchmarks from all of the areas of transformation. Claims data and hybrid reporting methods will be developed and addressed in policy & procedures to allow measurement of CHAs progress.

- Incorporate a team of Traditional Healthcare Workers to help reduce disparities by (for example) helping members navigate the health system, meet transportation needs, and receive assistance with scheduling appointments. This will promote utilization of CHAs PCP network and result in diversion of members from high cost, short term ED care. THWs will receive all needed education regarding language, social and linguistic issues in our area.

- Use of a measurement in the metrics of race and ethnicity:
    - Collection of race, ethnicity and language data from PCPCH and OE&I. Collaborate with the Sky Lakes Wellness Center in its GIS-population and disparities mapping study currently just getting underway. See prior Transformation Plan sections.
    - Certification of medical interpreters within the Traditional Healthcare Worker cadre.
    - Advancing effective communication, cultural competence and patient-centered care in various health care settings through testing or certification.
        - Collect and analyze member-focused data
        - Educate, activate and empower Community Advisory Council members
        - Develop and provide health education classes, resources
        - Engage and mobilize Traditional Health Workers
        - Improve HEDIS scores for Spanish health measures
        - Provide organizational leadership and coordinate program activities.
- Integrate measure 6 (Member Engagement Cultural Health Literacy Linguistic Needs) into the QA plan to meet the deliverables.
- Focus on the Hispanic population while observing all other populations through reports on diversity of the population utilization PCP's.

- Count the number of members of ethnic type 2013 and all consecutive years to identify penetration rates.
- Development of policy & procedures that focus on Cultural and linguistic competency. Policies will be tailored to community needs through collection of data to identify service needs, interpreter service needs, and increase the number of minority health providers.
- CHA with assistance of OHA reports will collect, analyze, and use of the data for the identification and improvement for identified ethnic groups. CHA will use the accepted national standard for data collection for race and ethnicity categories in the Office of Management and Budget's Directive 15.
- CHA will help minority elderly by promoting broader availability of home- and community-based services by educating staffs on income eligible seniors that qualify for full Medicaid or Medicaid-financed coverage of Medicare cost sharing.
- PCPCH clinics: CHA and community partners can expand the number and capacity of community health centers (PCPCH), reduce financial barriers to obtaining primary care, and increase research efforts to address disparities in primary care for minority populations.
- Workforce development. CHA will foster a more diverse health workforce by diversifying applicant pools, developing incentive programs, ensuring adequate data collection, and Educational Institutes to incorporate Cultural competency training to health related fields.

Timeline:

Year 2014:

1. Work plan that identifies areas of focus for the CCO.

2. Reports to PCPCH clinics, committees, Healthy Klamath partners, Sky Lakes Wellness Center and the CAC on collected metrics data, identified at-risk sub-populations and discovered disparities.

Benchmarks:

1. Policies & procedures that address Traditional Healthcare Workers and their role in the CCO to address health disparities. CHA will have up to five Traditional Healthcare Workers by July 2015 who have met OHA requirements.

2. Through the above P&P, develop interventions that address the disparities identified.

3. Reduce the number of ED visits by members of the identified at-risk sub-populations by 20% by December 31, 2015.

4. Increase the number of PCP and early prenatal visits by 20% in the at-risk sub-populations by 20% by December31, 2015.

Milestones:

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1. Evaluation of the pilot program through the Transformation funds project grant of combining THW and NEMT to identify:
    a. Member populations served in each QTR 2014.
    b. Reduction in ED utilization of members identified as high utilizers and served by THW.
2. Educate all providers on the diversity of the population they serve.
3. Methods that clearly define the diverse populations that will be the focus of improvement and measurable outcomes (e.g. Spanish, pregnant members, members who do not engage with PCP's at least annually).

Deliverables:

1. THW fully incorporated into the CCO and available to members who need assistance in navigating the health care system.
2. Reporting capabilities to identify race, ethnicity and language barriers of the members enrolled in the providers care.

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Exhibit K - Attachment 1 - Transformation Deliverables and Benchmarks

A. Definitions for Exhibit K

For purposes of this Exhibit K, these terms have the following meanings:

(1) "**Baseline**" means the Contractor's status in effect on the Contract Effective Date, primarily in light of any policies, procedures, operational or contractual arrangements or Provider arrangements, including but not limited to materials submitted during RFA 3402 as well as information submitted to OHA during the readiness review process.

(2) **"Benchmark"** means an objectively identifiable and measurable standard that the Contractor will report on to measure its progress in executing its Transformation Plan and that is the Contractor's target for the transformation area to be achieved by July 1, 2015.

(3) **"Milestone"** means an identified incremental outcome that is both a short-term target and a logical step that moves the Contractor toward achieving its Benchmark. A Milestone may represent a stage or phase that is met on the way to achieving the Benchmark. A Milestone should be achievable on or before July 1, 2014.

B. Transformation Plan Deliverables

Contractor shall provide the following deliverables for every transformation area on the schedule described below. Contractor shall combine the reports for all transformation areas and Benchmarks into a single report.

CHA is requesting a year or at least a 6-month extension to the deliverable dates below. CHA has not been able to begin coordination of care to influence change in healthcare delivery in Klamath Falls area prior to September. The CAC committee is now being formed and meeting to assist in this process.

Deliverable		Deliverable Date
(1)	Initial progress report	~~January 1, 2014~~ July 1, 2014
(2)	Milestone report	~~July 1, 2014~~ December 31, 2014
(3)	Second progress report	~~January 1, 2015~~ July 1, 2015
(4)	Benchmark report	December 1, 2015

Progress, Milestone and Benchmark reports must address each transformation area, including actions taken or being taken to achieve the Milestone and Benchmark, outcome of these activities, and process improvements. Contractor shall also describe how its Community Advisory Council (CAC) was involved in the process and informed of the outcomes in each transformation area.

Progress and Milestone reports must also identify any areas where the Contractor has encountered barriers to achieving a Milestone or Benchmark, and describe its efforts to work with OHA through the Innovator Agent and Learning Collaborative to develop alternative strategies to reach the Benchmark.

C. Benchmarks for 2013 – 2015 Transformation Plan Amendment

This section addresses eight transformation areas, corresponding to the eight areas required to be included in Contractor's Transformation Plan. Within each of the eight areas of transformation, this section establishes one or more Benchmarks. Progress will be measured from a Baseline that begins with

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Contractor shall provide the following deliverables for every transformation area on the schedule described below. Contractor shall combine the reports for all transformation areas and Benchmarks into a single report.

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(4)	Benchmark report	December 1, 2015

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Progress and Milestone reports must also identify any areas where the Contractor has encountered barriers to achieving a Milestone or Benchmark, and describe its efforts to work with OHA through the Innovator Agent and Learning Collaborative to develop alternative strategies to reach the Benchmark.

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the Contract Effective Date. This section describes how Contractor will measure progress toward achieving each Benchmark, including one or more Milestones. A Benchmark and at least one Milestone required for each transformation area. Contractor will report on progress, Milestones and Benchmarks using the schedule described in Section B.

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

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 December 1, 2014)	CHA will have a 15% increase in the number of members with SPMI diagnosis and diabetes that receive HbA1c and LDL testing from the December 2012 baseline: HbA1c = 72.73% LDL-C= 72.73%.
Milestone(s) to be achieved as of July 31, 2014	Contractor attains 10% improvement over Baseline measurement.
Benchmark to be achieved as of December 1, 2015	Contractor attains 20% improvement over Baseline measurement.

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

Benchmark 2	
	Increase the # of Members assigned to a recognized PCPCH clinics.
How Benchmark will be measured (Baseline to July 1, 2015)	• Contractor will measure the number of Members assigned to a recognized PCPCH at each tier level • Contractor will measure percentage of PCPs in contracted network reimbursed for PCPCH status per APM.
Milestone to be achieved as of December, 2013	December 2013 50+% of enrollees will be assigned to a PCPCH. Calendar year 2014 75% of enrollees will be assigned to a PCPCH. Calendar year 2015 100% of enrollees will be assigned to a PCPCH. CHA will meet the requirements of each year of the PCPCH-related Incentive Metric, rounds 1 and 2. 100% of contracted PCPCH facilities in CHA's area will be reimbursed at least for their PCPCH status per the Alternative Payment Methodology.
Benchmark to be achieved as of December 1, 2015	• 100 % of Members will be assigned to a certified PCPCH at any tier level. • CONTRACTOR will have all PCPCH certified

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	Providers contracted using consistent Alternative Payment Methodologies.

(3) **Area of Transformation:** Implementing consistent alternative payment methodologies that align payment with health outcomes.

Benchmark 3	
	Reward successful Primary Care Providers (PCPs, PCPCH clinics) via a shared savings program, as measured by metrics improvement from 2011 benchmarks for assigned Members in the PCP/PCPCH clinics care.
How Benchmark will be measured (Baseline to July 1, 2014)	January - March 2014 Determine degree of CCO compliance ("meeting at least 12.6 Metrics including EHR), and correcting any anomalous data affecting this compliance rate. April - June 2014 Develop reporting system to allocate the percentage of compliance with each Incentive Metric on a PCPCH or facility basis. July 2014 Disburse Metric Pool funds based on the developed APM, tracking for future comparison the relative contribution of the various PCPCHs/facilities to the overall success of the Metric program
Milestone to be achieved as of July 1, 2014	CHA will develop policies that are approved by Committees and Directing Boards on Alternative Payment Methodologies to be piloted with Providers and recognized PCPCH clinics by July 1, 2014.
Benchmark to be achieved as of July 1, 2015	100 % of contracted providers will be a tier 1, 2 or 3 PCPCH clinics.

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

Benchmark 4	
	Continuing efforts to identify areas of health improvement in the Community Health Assessment and completion of a Community Health Improvement Plan (CHIP) for Klamath Falls and surrounding areas.
How Benchmark will be measured	Timely submission of the Community Health Needs Assessment

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(Baseline to July 1, 2015)	and the Community Health Improvement Plan.
Milestone to be achieved as of July 1, 2014	1. Selection of CAC member's by Jan. 31, 2014. 2. First CAC meeting by Feb. 2014. 3. Sept.1, 2015, the Community Health Improvement Plan will be developed and approved by CAC.
Benchmark to be achieved as of September 1, 2015	1. Launch of "Healthy Klamath" website, completed in early 2013. 2. The CAC is being reconvened and members are being selected. First meeting will occur by Feb., 2014. 3. Quarterly meetings with all partners and stakeholders in developing the Community Health Improvement Plan. 4. CHIP completed and approved by CAC September 1, 2015.

(5) Area of Transformation: Developing a plan for encouraging electronic health records; health information exchange; and meaningful use.

Benchmark 5	
	Percentage of Participating Providers in Contractor's network that participate in the Jefferson Health Information Exchange (JHIE) for information sharing across care Contractor's provider settings.
How Benchmark will be measured (Baseline to July 1, 2015)	Measure the number of local contracted providers enrolled in JHIE from 01/01/2013 baseline.
Milestone to be achieved as of December 31, 2014	Contractor attains a 10% increase JHIE users sharing data across provider care settings as measured by the number of enrolled local providers.
Benchmark to be achieved as of July 1, 2015	Contractor attains a 20% increase over the Baseline of eligible JHIE users sharing data across care settings as measured by the number of enrolled local providers.

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

Benchmark 6	
	Cascade Health Alliance will encourage, explore and adopt policies and procedures that assist providers in communication, outreach, member engagement and those services are tailored to the cultural and linguistic needs of members with diverse backgrounds and values supporting the dignity of all members.
How Benchmark will be measured (Baseline to July 1, 2015)	• Contractor will track activities of SLWC (and report to the CHA CAC), the dissemination and processing of surveys to provider facilities per transformation plan,and the hiring progress of THWs
Milestone to be achieved as of December 31, 2014	• Surveys sent and returned from provider offices, needs of providers and staffs documented. • Cultural Competency training program developed and available on CHA website by December 2014. • Training on cultural competence policies completed by

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	July 2015. • Presentation and commentary on the SLWC GIS-mapping and healthcare disparities study and the recommended intervention set by the CHA community Advisory Committee by Fall, 2014. • THWs, as above.
Benchmark to be achieved as of July 1, 2015	• Surveys sent, reviewed and reported to the CAC and internal committee's/Board of findings July 2014. • Member materials available on website in Spanish and by audio. • Cultural competency policies and training materials available on CHA website and disseminated to all providers by December of 2014. • Development of a community wide intervention set as part of the SLWC program to address obesity, diabetes and other chronic health issues by overcoming barriers in culture, language and economic disparity by July, 2014. • At least 1-2 Spanish-speaking CHWs hired and in service by Fall, 2014.

(7) **Area of Transformation:** Assuring that the culturally diverse needs of Members are met (Cultural Competence training, provider composition reflects Member diversity, Certified Traditional Health Workers and Traditional Health Workers composition reflects Member diversity).

Benchmark 7	
	Increase the number of PCP, PCPCH or specialist practice sites completing cultural diversity training programs.
How Benchmark will be measured (Baseline to July 1, 2015)	Cultural Diversity training completed by CHA's contracted providers.
Milestone to be achieved as of December 31, 2014	Contracted providers engage in training related to cultural competencies and 50% complete the training by December 2014.
Benchmark to be achieved as of December 30, 2015	December 30, 2015: 80% of Providers have received training on cultural competence from CHA policy and the OE&I webinars that correlate with policies for cultural diversity.

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

Benchmark 8	
	Data acquisition to allow mapping of sub-populations that are experiencing barriers to care on the basis of race, language or culture (including the "culture of poverty", likely to be Klamath

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	County's largest at-risk cultural entity). Develop processes that will address the issues in the relevant groups, including the education of providers in the area, and the CHW cadre to break down the barriers to care that are identified.
How Benchmark will be measured (Baseline to July 1, 2015)	Collection of race, ethnicity and language data from PCPCH and OE&I. Collaborate with the Sky Lakes Wellness Center in its GIS-population and disparities study currently just getting underway. See prior Transformation Plan sections. Count the number of members of ethnic type 2013 and all consecutive years to identify penetration rates for PCP utilization, ED utilization.
Milestone to be achieved as of December 31, 2015	Contractor will have a THW cadre fully incorporated into the provider panel of the CCO and available to members who need assistance in navigating the health care system, by December 31, 2015.
Benchmark to be achieved as of December 31, 2015	Reduce the number of ED visits by members of the identified at-risk sub-populations by 20% by December 31, 2015. Increase the number of PCP and early prenatal visits by 20% in the at-risk sub-populations by 20% by December 31, 2015.

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	Providers contracted using consistent Alternative Payment Methodologies.

(3) **Area of Transformation:** Implementing consistent alternative payment methodologies that align payment with health outcomes.

Benchmark 3	
	Reward successful Primary Care Providers (PCPs, PCPCH clinics) via a shared savings program, as measured by metrics improvement from 2011 benchmarks for assigned Members in the PCP/PCPCH clinics care.
How Benchmark will be measured (Baseline to July 1, 2014)	January - March 2014 Determine degree of CCO compliance ("meeting at least 12.6 Metrics including EHR), and correcting any anomalous data affecting this compliance rate. April - June 2014 Develop reporting system to allocate the percentage of compliance with each Incentive Metric on a PCPCH or facility basis. July 2014 Disburse Metric Pool funds based on the developed APM, tracking for future comparison the relative contribution of the various PCPCHs/facilities to the overall success of the Metric program
Milestone to be achieved as of July 1, 2014	CHA will develop policies that are approved by Committees and Directing Boards on Alternative Payment Methodologies to be piloted with Providers and recognized PCPCH clinics by July 1, 2014.
Benchmark to be achieved as of July 1, 2015	100 % of contracted providers will be a tier 1, 2 or 3 PCPCH clinics.

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

Benchmark 4	
	Continuing efforts to identify areas of health improvement in the Community Health Assessment and completion of a Community Health Improvement Plan (CHIP) for Klamath Falls and surrounding areas.
How Benchmark will be measured	Timely submission of the Community Health Needs Assessment

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(Baseline to July 1, 2015)	and the Community Health Improvement Plan.
Milestone to be achieved as of July 1, 2014	1. Selection of CAC member's by Jan. 31, 2014. 2. First CAC meeting by Feb. 2014. 3. Sept.1, 2015, the Community Health Improvement Plan will be developed and approved by CAC.
Benchmark to be achieved as of September 1, 2015	1. Launch of "Healthy Klamath" website, completed in early 2013. 2. The CAC is being reconvened and members are being selected. First meeting will occur by Feb., 2014. 3. Quarterly meetings with all partners and stakeholders in developing the Community Health Improvement Plan. 4. CHIP completed and approved by CAC September 1, 2015.

(5) Area of Transformation: Developing a plan for encouraging electronic health records; health information exchange; and meaningful use.

Benchmark 5	
	Percentage of Participating Providers in Contractor's network that participate in the Jefferson Health Information Exchange (JHIE) for information sharing across care Contractor's provider settings.
How Benchmark will be measured (Baseline to July 1, 2015)	Measure the number of local contracted providers enrolled in JHIE from 01/01/2013 baseline.
Milestone to be achieved as of December 31, 2014	Contractor attains a 10% increase JHIE users sharing data across provider care settings as measured by the number of enrolled local providers.
Benchmark to be achieved as of July 1, 2015	Contractor attains a 20% increase over the Baseline of eligible JHIE users sharing data across care settings as measured by the number of enrolled local providers.

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

Benchmark 6	
	Cascade Health Alliance will encourage, explore and adopt policies and procedures that assist providers in communication, outreach, member engagement and those services are tailored to the cultural and linguistic needs of members with diverse backgrounds and values supporting the dignity of all members.
How Benchmark will be measured (Baseline to July 1, 2015)	• Contractor will track activities of SLWC (and report to the CHA CAC), the dissemination and processing of surveys to provider facilities per transformation plan,and the hiring progress of THWs
Milestone to be achieved as of December 31, 2014	• Surveys sent and returned from provider offices, needs of providers and staffs documented. • Cultural Competency training program developed and available on CHA website by December 2014. • Training on cultural competence policies completed by

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	July 2015. • Presentation and commentary on the SLWC GIS-mapping and healthcare disparities study and the recommended intervention set by the CHA community Advisory Committee by Fall, 2014. • THWs, as above.
Benchmark to be achieved as of July 1, 2015	• Surveys sent, reviewed and reported to the CAC and internal committee's/Board of findings July 2014. • Member materials available on website in Spanish and by audio. • Cultural competency policies and training materials available on CHA website and disseminated to all providers by December of 2014. • Development of a community wide intervention set as part of the SLWC program to address obesity, diabetes and other chronic health issues by overcoming barriers in culture, language and economic disparity by July, 2014. • At least 1-2 Spanish-speaking CHWs hired and in service by Fall, 2014.

(7) **Area of Transformation:** Assuring that the culturally diverse needs of Members are met (Cultural Competence training, provider composition reflects Member diversity, Certified Traditional Health Workers and Traditional Health Workers composition reflects Member diversity).

Benchmark 7	
	Increase the number of PCP, PCPCH or specialist practice sites completing cultural diversity training programs.
How Benchmark will be measured (Baseline to July 1, 2015)	Cultural Diversity training completed by CHA's contracted providers.
Milestone to be achieved as of December 31, 2014	Contracted providers engage in training related to cultural competencies and 50% complete the training by December 2014.
Benchmark to be achieved as of December 30, 2015	December 30, 2015: 80% of Providers have received training on cultural competence from CHA policy and the OE&I webinars that correlate with policies for cultural diversity.

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

Benchmark 8	
	Data acquisition to allow mapping of sub-populations that are experiencing barriers to care on the basis of race, language or culture (including the "culture of poverty", likely to be Klamath

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	County's largest at-risk cultural entity). Develop processes that will address the issues in the relevant groups, including the education of providers in the area, and the CHW cadre to break down the barriers to care that are identified.
How Benchmark will be measured (Baseline to July 1, 2015)	Collection of race, ethnicity and language data from PCPCH and OE&I. Collaborate with the Sky Lakes Wellness Center in its GIS-population and disparities study currently just getting underway. See prior Transformation Plan sections. Count the number of members of ethnic type 2013 and all consecutive years to identify penetration rates for PCP utilization, ED utilization.
Milestone to be achieved as of December 31, 2015	Contractor will have a THW cadre fully incorporated into the provider panel of the CCO and available to members who need assistance in navigating the health care system, by December 31, 2015.
Benchmark to be achieved as of December 31, 2015	Reduce the number of ED visits by members of the identified at-risk sub-populations by 20% by December 31, 2015. Increase the number of PCP and early prenatal visits by 20% in the at-risk sub-populations by 20% by December 31, 2015.

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