

## CCO 2015 – 2017 Transformation Plan Contract Amendment Definitions

- (1) “**Baseline**” means the Contractor’s status in effect on the effective date of its Previous Contract, 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 (or a later date set by amendment to its Transformation Plan and Areas of Transformation).
- (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 31, 2017 (or a later date set by amendment to its Transformation Plan and Areas of Transformation).
- (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 31, 2016 (or a later date set by amendment to its Transformation Plan and Areas of Transformation).

## CCO 2015 – 2017 Transformation Plan Contract Amendment Benchmarks

- (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 plan must specifically address the needs of individuals with severe and persistent mental illness.

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| Benchmark 1  | Identify the number of Members in the service area who have a diagnosis of Severe and Persistent Mental Illness (SPMI) conditions and a diagnosis of diabetes who have not had HgbA1C and LDL laboratory test.   |
| How Benchmark will be measured (Baseline to July 31, 2017) | Utilizing data obtained from community mental health partners in service area, identify the number of members with a diagnoses of schizophrenia and/or bipolar disorder designated as SPMI and utilize CCO claims to identify those members with SPMI and diabetes who have claims/encounters processed (appropriate CPT codes) for a HgBA1C and LDL laboratory tests in 2015. |
| Milestone(s) to be achieved as of July 31, 2016            | 80% of all members in service area with SPMI and Diabetes will receive both HgBA1c and LDL laboratory tests.   |
| Benchmark to be achieved as of July 31, 2017               | 80% of all members in service area with SPMI and Diabetes will receive both HgBA1c and LDL laboratory tests and maintain continued compliance with routine laboratory testing.   |

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

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| Benchmark 2  | Increase the number of members assigned to certified PCPCH clinics   |
| How Benchmark will be measured (Baseline to July 31, 2017) | <ul style="list-style-type: none"> <li>Contractor will measure the number of Members assigned to a certified/recognized PCPCH at each tier level</li> <li>Implement strategies to develop recognized/certified PCPCH member engagement programs for certified PCPCHs.</li> </ul> |
| Milestone(s) to be achieved as of July 31, 2016            | At least 80% of members will be assigned to a certified PCPCH clinic at any tier level.  |
| Benchmark to be achieved as of July 31, 2017               | 100% of contracted primary care clinics will be certified PCPCH clinics (any tier). 100% of all members will be assigned to a certified PCPCH clinic.  |

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

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| Benchmark 3  | Reward successful PCPCH clinics via an incentive program, measured by PCPCH Certification (any tier) and continued improvement in State Metrics program from 2011 baseline for assigned members in PCPCH clinics. Baseline of certified PCPCHs (any tier) is 4.   |
| How Benchmark will be measured (Baseline to July 31, 2017) | Maintain and continue to update tracking system used to calculate improvement bonuses, based on state specifications.<br><br>Adapt the 2013 performance improvement bonus allocation algorithm to further weight incentivization based on PCPCH certification.  |
| Milestone(s) to be achieved as of July 31, 2016            | Board has established negotiating committee who will review payments and payment methods to continue to develop payment methodologies, based on Provider Performance of State Metrics and PCPCH Certification Status.<br><br>Pay 2015 PCPCH metric incentive funds only to certified PCPCHs. Increase certified PCPCH clinics to 5. |
| Benchmark to be achieved as of July 31, 2017               | Consistent method of payment developed and maintained that fairly aligns payments with health outcomes in addition to incentivizing PCPCH certification.  |

- (4) **Area of Transformation:** Preparing a strategy for developing Contractor's Community Health Assessment and adopting an annual Community Health Improvement Plan consistent with ORS 414.627.

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| Benchmark 4  | Continue to identify areas of health improvement in the Community Health Assessment, implement strategies and goals identified in the completed CHIP, and provide yearly updates to OHA on CHIP progress in accordance with the CCO Contract.   |
| How Benchmark will be measured (Baseline to July 31, 2017) | Timely submission of CHIP yearly updates (due 06/30/2016 and 06/30/2017) that clearly address the CCO contractual requirements.<br><br>The responsibility for monitoring progress of the CHIP will be the responsibility of the QI director and the transformation coordinator, working through the CAC. Coordination of the CHIP with other projects seeking to improve the health of the community (example, Blue Zone Project) will also be implemented by the transformation coordinator and the QI director, but working in coordination with the CAC and supporting the goals of CAC. |
| Milestone(s) to be achieved as of July 31, 2016            | Semi –annual review of the CHIP by the CAC to assess the effectiveness of goals, strategies, and objectives and determine if they continue to meet the health needs of the community.<br><br>Submission of the CHIP update prior to June 30, 2016 which clearly addresses the contract requirements and addresses the   |

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|  | health needs of the community.  |
| Benchmark to be achieved as of July 31, 2017 | Semi-annual review of the CHIP by the CAC to assess the effectiveness of goals, strategies, and objectives and determine if they continue to meet the health needs of the community.<br><br>Submission of the CHIP update prior to June 30, 2017 which clearly addresses the contract requirements and addresses the health needs of the community. |

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

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| Benchmark 5  | Support Jefferson Health Information Exchange in coordinating data and care  |
| How Benchmark will be measured (Baseline to July 31, 2017) | JHIE utilization by both providers and CHA for care coordination, redundancy reduction, and efficient care measurement.  |
| Milestone(s) to be achieved as of July 31, 2016            | Yes/No measure – JHIE activates customized aggregate data reporting for CHA use.<br><br>Additional measure – at least 80% of CHA case managers logging in to JHIE Community Health Record on a daily basis.                    |
| Benchmark to be achieved as of July 31, 2017               | Yes/No measure – CHA is able to log in to JHIE and report state required clinical metrics at least monthly.<br><br>Additional measure – More than 40% of CHA enrollees to be assigned to a JHIE connected clinic as their PCP. |

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

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| Benchmark 6  | CHA will have all member materials available in Spanish for delivery to non-English speaking members   |
| How Benchmark will be measured (Baseline to July 31, 2017) | CHA will track the percentage of Spanish non-English speaking members that receive member materials in their primary language                              |
| Milestone(s) to be achieved as of July 31, 2016            | CHA confirms that all member materials are available in Spanish and 50% will be disseminated to Spanish non-English speaking members in our CCO population |
| Benchmark to be achieved as of July 31, 2017               | CHA confirms 85% will be disseminated to Spanish non-English speaking members in our CCO population.   |

- (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).

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| 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 31, 2017) | Perform a baseline survey (by 7.1.2015) and subsequent surveys 1/31/16, 7/1/16 to measure training program participation.   |
| Milestone(s) to be achieved as of July 31, 2016            | CHA attains improvement of 30% over the baseline percentage rate of cultural diversity program completion by PCPs, PCPCHs or Specialists.   |
| Benchmark to be achieved as of July 31, 2017               | CHA attains improvement of 50% over the baseline percentage rate of cultural diversity program completion by PCPs, PCPCHs, Specialists, mental health and substance use disorder providers. |

**(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.

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| Benchmark 8  | Reduction of identified disparities in Affordable Care Act (ACA) conditions specifically comprehensive DM care (LDL-C screening and HbA1c in the SPMI population and timeliness of prenatal care for high risk pregnant members). |
| How Benchmark will be measured (Baseline to July 31, 2017) | CHA will sustain a 20% increase from baseline of comprehensive DM care for SPMI and Spanish members in prenatal care.   |
| Milestone(s) to be achieved as of July 31, 2016            | Complete analysis and identification of disparities related to comprehensive DM care (ACA condition) and prenatal care and development of priority improvement plans.   |
| Benchmark to be achieved as of July 31, 2017               | Sustained increase in care of 20% of disparities (DM Care and Prenatal Care) identified for improvement.  |