Transformation Plan
Yamhill Community Care Organization

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Historically, the geographical area served by the Yamhill Community Care Organization (YCCO) has had the largest percentage of non-managed open-card Oregon Health Plan (OHP) members in the state – as much as 60 percent of the Medicaid population. Although three FCHPS have managed small proportions of those who are now YCCO members, overall both the OHP Membership and the medical provider systems have not been well engaged in previous OHP systems development and care improvement efforts.

The assignment of almost all of the YCCO members to a PCP in itself has been a challenging initial task that required mobilization of the primary care community. In the absence of previous management of care, we anticipate that baseline measures for Yamhill could be significantly poorer than for the rest of the state, which gives us great opportunities for improvement. We see YCCO as fulfilling the CCO vision in that it has already been the vehicle to bring together the entire medical community to focus on transformation of care. The spirit of partnership and commitment to innovation is exciting and perhaps unique within Oregon.

The overriding goal of the Yamhill Community Care Organization transformation plan is to develop a blueprint to achieve the Triple Aim of improving health, improving care, and decreasing the cost of physical, behavioral and, eventually, dental care.

The YCCO is a large complex system involving a payer, multiple physical and behavioral health providers, two hospital systems and other stakeholders. This can be described as a complex adaptive system. One way for complex adaptive systems to thrive and be successful is to be guided by simple rules. These rules should serve as a basis for the construction and operation of the system. The rules should help to provide a framework for innovative, adaptive and unique, locally relevant solutions. But the rules should not constrain the growth, plasticity or evolution of the system.

A set of simple rules will guide plans and projects developed within the transformation plan. The goal of these rules is to direct progress of the plan toward the Triple Aim and successful transformation in the delivery, payment and outcomes of behavioral, physical and dental health.

Simple Rules

1. Community spirit should guide transformation.
2. Plans and projects should be data-driven and monitored.
3. Process and outcome goals should work toward the Triple Aim.
4. Payments should be based on measurable production of value.

5. Transformational plans and projects should follow the general stepwise format of:
    - Smart standardization adoption
    - Meaningful metric adoption
    - Respectful reporting of metrics
    - Reimbursement development based on reported data
6. Care transformation should focus on care coordination, cost control and patient choice.

Additionally, improvements to the six elements of health care quality should be addressed. The goal of any aspect of the transformation plan should function to increase one or all of the six elements of health care quality: Effective, Equitable, Efficient, Timely, Patient-Centered and Cost-Effective.

Transformation Plan Template Organization

The plan is organized on the basis of the 8 key areas laid out in Exhibit K from the Oregon Health Authority. The YCCO has two additional areas of focus: ED Utilization and Specialty Care. Additionally, the OHA has developed three sets of potentially overlapping measures. These include Core/Performance Metrics, Bonus Pool/Incentive Metrics and Access Metrics. These metrics will eventually be incorporated into the transformation plan initiatives as relevant.

The YCCO contains three main workgroups. These groups were established to conform to the state legislation establishing the formation of CCOs. These groups include the YCCO Governing Board, the Clinical Advisory Council (CAP) and the Community Advisory Council (CAC). Various subcommittees have been established within each workgroup, e.g. CAP ED Utilization subcommittee. Work on the 10 initiatives of the transformation plan will be guided by these subgroups. Their goal is to develop and implement the projects to meet each initiative. An optimal timeline will be developed as part of the plans and projects to set development guidelines.

Although there is significant overlap with the OHA measure sets, many of the initiatives have set their own measures. YYCO subgroups will regularly review unique initiative measures and the OHS core incentive and access measures at the point where a project has an impact on a measure. An important factor to consider for the success of the YCCO transformation plan is the CCO's ability to produce the data it needs to support the desired changes.

The population served by the YCCO had not been identified as a unique population prior to the formation of the CCO. This will have an impact on the work of the CCO in important ways. The primary impact is that there are not extant baselines on any measures for this specific group. The YCCO staff and volunteers will spend much of the first year gathering and examining data from pre-existing MCOs, state and other community sources. The data will be examined from the CCO perspective, looking for patterns of cost, care access, care quality and care disparity that will inform the specific steps needed for transformation. The Board anticipates that there will be significant changes to the transformation plan as the YCCO gains sophistication in producing and analyzing data.

To provide additional incentives for change, the YCCO governing board has developed an internal application process for funding transformational plans and projects. The transformation fund established by the YCCO will be the source of the funds. Deadlines have been set for transformation fund applications to be submitted. The various work groups of the YCCO will submit applications for funding transformation plans and projects. Plans and projects will be data driven. Additionally, metrics will be included in the implementing and monitoring plans and projects.

Work Groups	Transformational Plan Contact
Governing Board	Jim Rickards
Governing Board Alternative Pay	Jim Carlough / Jim Rickards
Governing Board Finance	Paul Kushner
CAC	Bonnie Corns
CAP	Laura Byerly
CAP PCPCH	Jackie Erickson
CAP ED Utilization	Marie McDaniel-Bellisario
CAP Specialty Care	Jim Rickards
CAP Transitions of Care	Charlene Gibbs CAP
Behavioral Health	Kathy Savicki

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.

   Owner: Kathy Savicki
   Point Person: Mary Petersen
   YCCO Workgroups: CAP PCPCH, Behavioral & Transitions of Care Subcommittee

   We have already implemented Screening, Brief Intervention and Referral to Treatment (SBIRT) at Yamhill County Health and Human Services and are planning for SBIRT training and implementation in both Emergency Departments. We intend to include SBIRT in the PCPCH collaborative described in Initiative 2.

   The literature shows that the most transformative method of integrating behavioral health into primary care is the inclusion of behaviorists within the primary care team. We are partnering with George Fox because of its expertise in this model, and we're planning to incorporate these staff within each PCPCH as each organization is ready. We have identified measures to ensure fidelity to the team-based behavioral model.

   Depression screening and follow-up in primary care provides significant opportunities to improve both health outcomes and costs. We will work with the PCPCH Collaborative (see Initiative 2) to provide technical assistance to clinics in screening and follow-up. We are particularly concerned that expanding screening does not lead to inappropriate initial prescribing of anti-depressants rather than evidence-based interventions. The presence of behaviorists in clinics will make other interventions easily available.

   People with lived experience of mental health and addiction challenges are highly successful in engaging their peers in pursuing recovery; MVBCN will include YCCO in a pilot of Peer Wellness Specialists to bring additional health-related support to individuals with these challenges. We will use the Patient Activation Measure as a pre-post measure, and also as a guide to individualized health coaching.

   Yamhill County Mental Health and Virginia Garcia Memorial Health Center (VG) are planning a bilateral integration project in which a PCP and a CMA from Virginia Garcia will be stationed at Yamhill County's Mental Health program to provide PCPCH services. The goal is to improve physical health status of adults with Serious Mental Illness (SMI) who have or are at risk of chronic disease, and improve engagement with primary care for this high-risk population.

   YCCO CAP is scheduled for a February 2013 discussion on clinical approaches to treating chronic pain patients. We will amend this plan to include this initiative as soon as the CAP is ready.

OHA Relevant Metrics

Core/Performance Metrics

1. All-cause readmissions
2. Mental health assessment for children in DHS custody
3. Follow-up after hospitalization for mental illness

Bonus Incentive Pool/Incentive Metrics

1. Follow-up care for children prescribed ADHD medication
2. Composite Measure: mental health and physical health assessment for children in DHS (state) custody
3. Screening for clinical depression and follow-up plan
4. Alcohol and drug misuse, screening, brief intervention and referral for treatment (SBIRT)
5. Follow-up after hospitalization for mental illness

Access Metrics

1. Reducing preventable re-hospitalizations.
2. Integrating primary care and behavioral health.
3. Ensuring appropriate care is delivered in appropriate settings

AOT #1 Benchmark 1	SBIRT
How Benchmark will be measured (Baseline to July 1, 2015)	• % of individuals age 18+ screened each year, as shown in CPT codes (CCO Incentive Measure; Must Pass PCPCH Measure 3.C.0).
Milestone(s) to be achieved as of July 1, 2014	• Training and incorporation into patient flow in all PCPCH settings. • Training and incorporation into patient flow in both emergency departments; determine how ED coding will be captured in the OHA measure; determine whether SBIRT in mental health can be captured in the OHA measure. • Assess adequacy of A&D treatment capacity to allow rapid access to treatment; expand capacity if needed. • Use Non-Traditional Health Workers (NTHWs) and other outreach mechanisms to assist medical providers in successfully linking referred individuals with treatment.
Benchmark to be achieved as of July 1, 2015	• Achieve state performance target as defined by OHA financial incentive metric

AOT #1 Benchmark 2	Incorporate Behaviorists into PCPCH
How Benchmark will be measured (Baseline to July 1, 2015)	• % of members enrolled in clinics with a behaviorist
Milestone(s) to be achieved as of July 1, 2014	• Behaviorists funded, hired, trained and employed by Willamette Valley Clinics, Chehalem Medical Clinic, Virginia Garcia and Physicians Medical Center, Providence Medical Group. • Number of PCPCH qualifying at Tier 3.C.3 (PCPCH Measure) for behaviorists included in their team; • Reporting of fidelity measures: » proportion of encounters for mental health vs. health and behavior codes » # of service units per patient per 3 months » average length of sessions » % of costs recouped through billings, all payers » PCP satisfaction
Benchmark to be achieved as of July 1, 2015	• 50% of Members served in PCPCH which include behaviorists

AOT #1 Benchmark 3	Depression Screening/Follow-up in PCPCH
How Benchmark will be measured (Baseline to July 1, 2015)	• CCO incentive measure (encounter data + chart review); meets Must Pass PCPCH Measure 3.C.0.
Milestone(s) to be achieved as of July 1, 2014	• Include options for depression screening and follow-up in PCPCH collaborative; ensure availability of evidence-based treatment (medications as first-line intervention only for serious depression in adults).
Benchmark to be achieved as of July 1, 2015	• Meet state performance target.

AOT #1 Benchmark 4	Peer Wellness Specialists (PWS)
How Benchmark will be measured (Baseline to July 1, 2015)	• Total FTE of Peer Wellness Specialists; • Improvement in Patient Activation Measure (PAM) scores for individuals served by PWS.
Milestone(s) to be achieved as of July 1, 2014	• Peer Wellness Specialists hired and deployed to support wellness in individuals with mental health and addiction challenges • PAM training completed and coaching underway • Evaluate project and determine target # of PWS needed, funding mechanism, and # of members to be served.
Benchmark to be achieved as of July 1, 2015	• Meet target # of FTE for PWS as determined 7/1/2014 • 10 point gain in average PAM score for clients served by PWS .

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

   Owner: Laura Byerly
   Point Person: Jackie Erickson
   YCCO Workgroups: CAP PCPCH subcommittee

   1. PCPCH Initiative:
      - Implement PCPCH 101 work groups to help educate PCP's on PCPCH and implement PCPCH standards in their clinics so more YCCO members will be served by a certified PCPCH.
      - Develop PCPCH Collaborative to assist clinics in progressing along the tier status in the PCPCH spectrum to improve YCCO patient access, coordination and comprehensive integrated care.
      - Education to patients about PCPCH.
   2. Integrative Behavioral Health Model – Integration of behavioral health into primary care is crucial to transformation. This is addressed in Key Area 1.
   3. Establish Primary Care Metrics and Targets
      - Utilize goals of Oregon Health Authority Measures/Metrics to establish clinic baselines and benchmarks and other selected targets
        - Optimal diabetes care and blood pressure control
        - Colorectal cancer screening, cervical cancer screening and breast cancer screening based on USPSTF guidelines
        - Pediatric immunization schedule appropriately completed at 2 years of age
        - Adolescent well child visits for ages 12-21 years
        - Developmental screening by 36 months old
        - Appropriate management of ADHD medications
   4. Establishing new YCCO patients within 90 days of assignment
      - Goal to get patients established in PCP clinic within 90 days of assignment to clinic to improve access at appropriate level of care and avoid unnecessary ED visits.
      - Alternative payment methodology will be explored to reimburse PCP clinics for this unique visit.
        - Standard reimbursement for all YCCO providers through July 1, 2014, for Establish Care Visit
        - After July 1, 2014, reimbursement rate will be based on PCPCH tier status, i.e. Tier 3 status reimbursement higher.
      - Requirements specific for visit
        - Screen for tobacco use
        - SBIRT for patients > 12 years
        - Update required immunizations
        - Medication reconciliation
        - Update problem list
        - Check BP and BMI
        - Depression screen > 12 years
        - Referral for colon cancer screening for appropriate patients
        - HbA1cin documented within last 6 months, for all diabetics
        - Referral for mammogram for appropriate patients based on USPSTF

5. See Transformation Area 10 for information on Maternal Medical Home.

AOT #2 Benchmark 1	Establishing with PCPCH
How Benchmark will be measured (Baseline to July 1, 2015)	• Having a relationship with a PCP is important to good care, good health, and a good experience with the health care system. Being assigned to a PCP is not enough. We will evaluate, using claims and CCO data, what percentage of members are seen by their PCP within 90 days of assignment by YCCO to the PCP.
Milestone to be achieved as of July 1, 2014	• Establish baseline for each PCP practice of what percentage of their newly assigned patients they see within 90 days. • Reports of patients assigned, but without a visit, sent to practices monthly.
Benchmark to be achieved as of July 1, 2015	• 3% improvement over baseline in percentage of patients seen within 90 days of being assigned to PCP

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

   Owner: Jim Carlough, Jim Rickards, MD
   Point Person: CAP, Board APM subcommittee members
   YCCO Workgroups: Governing Board Alternative Payment Subcommittee and Financial Subcommittee

Alternative Payment Models (APMs) are being developed by YCCO for two main reasons;

1. Move reimbursement from Volume to Value based **—** The goal of this effort is to reimburse providers for coordinating care, implementing best practices and achieving desirable health and cost outcomes. Yamhill CCO anticipates that payment reform will help drive positive transformation of the delivery system. The benefits derived from delivery system transformation should lead to decreased cost as better health outcomes are achieved. This effort should aid transformation by providing incentives for improvements, as metrics such as key quality outcomes, access to services, utilization metrics and others are rewarded through APMs.

2. Fiscally manage the global budget **—** The current global budget allocated to Yamhill CCO is not monetarily sustainable based solely on Fee For Service (FFS) reimbursement. An alternative method of payment must be developed to manage the global budget and to control spending. Continuing the current FFS system may be necessary for some provider specialties and services; however, it will not continue as a standard or preferred payment model.

Because YCCO is a newly formed organization, historical claims data is limited. Prior to fully developing and implementing Alternative Payment Models (APMs), some baseline utilization and spend data must be obtained. A medical cost operating budget will be refined based on this data.

In this exercise, we plan to study and establish population health and utilization baselines and desired outcomes, then develop criteria for methodologies and incentive metrics through collaboration with stakeholders; risk corridors, delivery system readiness, system capabilities. It will be necessary to pilot payment models with higher volume providers and study changes to the outcomes baseline for assigned populations, with an opportunity to adjust methodologies to meet desired targets and outcomes. An example may include identification of several major medical expense pools, including inpatient and outpatient services, pharmacy, diagnostics and behavioral health services, and after amounts are allocated to these pools, alternative payment models will be developed for each pool and/or the different services within each pool in which a portion will be tied to outcome metrics. Development and implementation of APMs will be an iterative process. As longitudinal claims data is acquired, the APMs will be refined and finalized.

A Board subcommittee, the Alternative Payment Model (APM) subcommittee, is primarily working on the development of this data and models. The APM subcommittee is working closely with CareOregon in the development and adoption of APMs to ensure claim system compatibility and avoid disruption to provider cash flow. It is likely APMs currently used by CareOregon for other CCOs will be explored and considered for adoption.

Additionally, Yamhill CCO plans to utilize the soon-to-be assigned Innovator Agent to access additional state resources for potential alignment with other CCO payment models being developed. This may provide a benefit to those providers in contiguous ZIP codes or to Yamhill CCO's service area where multiple CCOs exist and to help reduce providers' unnecessary administrative work in managing different metrics and outcomes.

Alternative Payment Models could include:

1. Developing risk-based capitation models with outcome incentives.
2. Creating funding pools from reduced reimbursement and/or system transformation savings to permit upside risk incentives aligned with outcomes.
3. Sharing flexible funding pools for use by Community Health Workers (CHW) or Care Coordination Teams (CCT) for coordination of care, disposition, alternative placement and/or support services or items for those members whose needs cut across tradition lines of clinical responsibility.
4. Integrating the separate funding streams for co-located services.

AOT #3 Benchmark 1	Alternative Payment Methodologies
How Benchmark will be measured (Baseline to July 1, 2015)	• Study and establish population health and utilization baselines and desired outcomes. • Develop criteria for methodologies and incentive metrics through collaboration with stakeholders; risk corridors, delivery system readiness. • Pilot payment models with higher volume providers and study changes to the outcomes baseline for assigned population. • Adjust methodologies to meet desired targets and outcomes.
Milestone to be achieved as of July 1, 2014	• Pilot one to two methodologies with high volume providers that are related to defined outcomes. • Study and refine targeted benchmarks. • Adjust methodologies to meet targets.
Benchmark to be achieved as of July 1, 2015	• Implement one or two alternative methodologies that meet targeted health outcomes.

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.

   Owner: Bonnie Corns
   Point Person: Bonnie Corns
   YCCO Workgroup: CAC

   1) The CAC will use a modified MAPP process for performing the CHA and developing the CHIP.
      a) The CAC will form workgroups to complete the various sections of the CHA and the CHIP, engaging community stakeholders and plan members as appropriate.
   2) The CAC will work closely with the YCCO Board, the CAP, and other community partners to ensure that there is no duplication of efforts in performing the CHA.
      a) The CAC will utilize data from partner agencies to ensure consistency of data as well as limiting the duplication of processes, focus groups, and surveys during the CHA MAPP process.
      b) Partners will include, but are not limited to, Head Start of Yamhill County, Providence Medical Center – Newberg, Yamhill County Public Health, YCAP, and Yamhill County Health & Human Services Alcohol & Drug Prevention.
      c) The data used from other sources will be evaluated by the YCPH Accreditation Coordinator.
   3) The CAC will engage the YCCO Board, the CAP, and other community partners to review Key Health Indicators and set priorities for the CHIP.
   4) The CHIP will be adopted by the Board by July 1, 2014 and will be reported to Members, partner agencies, providers, and the general public in various written formats including newsletters, newspaper articles, and websites.
   5) The CAC will monitor the progress of the identified performance measures of the CHIP and issue annual progress reports to Members, partner agencies, providers and the general public in various written formats including newsletters, newspaper articles, and websites.
   6) The CAC will perform a CHA and CHIP formal process every five years.

AOT #4 Benchmark 1	CHA & CHIP
How Benchmark will be measured (Baseline to July 1, 2015)	• The Yamhill CCO will issue a Yamhill CCO Key Health Indicator Report by July 1, 2015 demonstrating the progress toward the goals set during the development of the CHIP.
Milestone to be achieved as of July 1, 2014	• The CAC will utilize a modified MAPP process for the Community Health Assessment (CHA) and development of an annual Community Health Improvement Plan (CHIP). • The CHIP will be reviewed and adopted by the Yamhill CCO Board by July 1, 2014.

Benchmark to be achieved as of July 1, 2015	• At the completion of the first year of the CHIP the CAC will compile a report for the Yamhill CCO regarding the progress of the specific measures that were to be addressed as a result of the CHA/CHIP process. • The MAPP process will be followed so that a CHA is performed every five years by the CAC, with annually reported updates.

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

Yamhill CCO agrees to participate in OHA's upcoming process to assess the next phase in statewide HIE development (including assessing the scope, financing, and governance of statewide HIE services). In particular, YCCO will make appropriate executive and staff resources available for an interview with an OHA consultant, and will participate in a brief series of stakeholder workgroup meetings if requested by OHA. After the OHA process concludes and the next phase of statewide HIE services are identified, Yamhill CCO will update this HIE component of our transformation plan at the next update cycle.

Only a single Benchmark/Milestone will be used initially - more will be implemented as information related to statewide HIE development unfolds.

AOT #5 Benchmark 1	Crimson Care Ambulatory Module
How Benchmark will be measured (Baseline to July 1, 2015)	• Percentage of YCCO Network Providers Participating in Clinical Data Exchange with the Crimson Population Risk Management Tool.
Milestone(s) to be achieved as of July 1, 2013	• Initial engagement of at least 50% of YCCO Network Providers by the Advisory Board to begin Implementation of the Crimson Population Risk Management Tool.
Benchmark to be achieved as of July 1, 2015	• 50% of YCCO Network Providers Participating in Clinical Data Exchange with Crimson Population Risk Management Tool.

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

Owner: Jim Carlough
Point Person: Bonnie Corns
YCCO Workgroups: CAC

1. Yamhill CCO enrollment data will be collected and assessed to determine the cultural composition of our members as well as literacy levels as a baseline measurement.
2. The CAC will review enrollment data and assess the preferred spoken and written languages of Yamhill CCO members, persons eligible for Medicaid, or underserved populations
3. The CAC will research best practices when determining a method to use for assessing the literacy levels of our members with the possibility of engaging members in a focus-group or in-person interviews.
4. Recommendations from that assessment will be sent to the YCCO Board and CAP.
5. Using the same assessment methodology data will show that communication tools are culturally and linguistically appropriate for the member population of Yamhill CCO.

AOT #6 Benchmark 1	**Addressing Members' Cultural, Health Literacy, and Linguistic Needs**
How Benchmark will be measured (Baseline to July 1, 2015)	• The CAC will produce a report to the Board and CAP stating that communication materials have been reviewed and meet current acceptable standards of communications to members. This includes outreach efforts tailored to local cultural composition.
Milestone(s) to be achieved as of July 1, 2014	• Yamhill CCO enrollment data will be collected and assessed to determine the cultural composition of our members as well as literacy levels as a baseline measurement. • The CAC will review enrollment data and assess the preferred spoken and written languages of Yamhill CCO members, persons eligible for Medicaid, or underserved populations. • The CAC will research best practices when determining a method to use for assessing the literacy levels of our members with the possibility of engaging members in a focus-group or in-person interviews. • Recommendations from that assessment will be sent to the YCCO Board and CAP.

AOT #6 Benchmark 1	**Addressing Members' Cultural, Health Literacy, and Linguistic Needs**
Benchmark to be achieved as of July 1, 2015	• Assessment performed with the same methodology as the baseline determination will show that communication tools are culturally and linguistically appropriate for the member population of Yamhill CCO

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

Owner: Jim Carlough
Point Person: Bonnie Corns
YCCO Workgroups: CAC

1) Determine the baseline for current cultural composition of YCCO providers, Members, and any current positions that fulfill the role of NTHW.
   a) Make a determination as to whether YCCO provider and Member cultural composition aligns with current standards.
2) Determine realistic targets for bringing new providers and NTHWs into the YCCO, keeping in mind that it is difficult to recruit providers for rural areas,
   a) The shortage of culturally diverse healthcare students, including NTHWs, physicians and nurses, make it more difficult to maintain a specific ratio between providers to Members.
3) 100% of staff will have participated in at least one formal cultural competency training.
4) 50% of contracted providers will have participated in at least one formal cultural competency training.
5) Percentages of providers and NTHW cultural composition will closely match the cultural composition of the Member population as is feasible for Yamhill County.

AOT #7 Benchmark 1	**Provider Network and Staff Ability to Meet Culturally Diverse Community Needs**
How Benchmark will be measured (Baseline to July 1, 2015)	• Member data will be assessed to determine any shifts in cultural makeup of the member population. • Yamhill CCO staff and providers will have engaged in formal cultural competency training. • Percentages of providers and NTHW cultural composition will closely match the cultural composition of the Member population as is feasible for Yamhill County.
Milestone(s) to be achieved as of July 1, 2014	• By following the MAPP process for Community Health Assessment (CHA), baseline population data will be provided to the CAP and Yamhill CCO in order to determine the culturally diverse needs of the Members. • Cultural diversity training will be provided to Yamhill CCO staff and contracted providers on an annual basis. • Document attempts to attract providers and NTHW whose cultural composition reflects Member diversity.

AOT #7 Benchmark 1	Provider Network and Staff Ability to Meet Culturally Diverse Community Needs
Benchmark to be achieved as of July 1, 2015	• Member data will be assessed to determine any shifts in cultural makeup of the member population. • 100% of staff will have participated in at least one formal cultural competency training. • 50% of contracted providers will have participated in at least one formal cultural competency training. • Percentages of providers and NTHW cultural composition will closely match the cultural composition of the Member population as is feasible for Yamhill County.

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.

Owner: Laura Byerly
Point person(s): Kathy Savicki, Ann Blume
YCCO Workgroups: Clinical Advisory Panel full committee

The Yamhill Coordinated Care Organization will create a quality improvement plan that addresses disparities in access, quality of care, experience of care and health outcomes that are identified in the population served, as well as incorporates the four Medicaid-required Performance Improvement Projects, and the YCCO transformation plan. The YCCO would like to assure that disparities faced by the severely mentally ill are also addressed. The voice of the customer is crucial in formulating responses to disparities in experience of care. Input from the Community Advisory Council will be obtained at the creation, and any revision, of the QI plan. As discussed in the opening paragraphs, the population served by the YCCO is not yet well-understood. The first year of the YCCO will provide data specific to the membership, allowing identification of where the population faces disparities. The CCO will be able to set benchmarks and create action plans after the first year of YCCO data becomes available. It is anticipated that the severely mentally ill will need special attention. The cultural/linguistic subgroups will be clarified, and cultural competency trainings identified if needed. Access to primary care homes and some specialty care is also thought to be an issue at the outset, awaiting confirmation from data and the sharing of experiences from CAC members.

The Community Advisory Council (CAC) is particularly well-suited to provide information that will be crucial in identifying disparities important to our particular community. Input from this body will also ensure the appropriately prioritized allocation of limited resources to address disparities. Assessing members' experience will be essential in understanding the total member picture. CAHPS will be conducted annually and results shared with the CAC and used to formulate a customer service action plan.

AOT #8 **Benchmark 1**	**Improve experience of care**
How Benchmark will be measured (Baseline to July 1, 2015)	• CAHPS surveys will be administered to the YCCO population. There is no historic CAHPS survey available for this unique population. Therefore, a baseline will be established by the first survey done by the YCCO. Benchmarks will be set once baseline is understood.
Milestone(s) to be achieved as of July 1, 2014	• Results of first CAHPS survey reviewed by Board and CAP, individual practices given their results, focus areas identified and the 2015 Benchmark improvement goals set for those areas. The 2014 survey will form the YCCO baseline.
Benchmark to be achieved as of July 1, 2015	• On this year's CAHPS we will see the improvement in scores of focus areas as defined during analysis of previous year's survey.

AOT #8 Benchmark 2	Quality plan will address disparities in access
How Benchmark will be measured (Baseline to July 1, 2015)	• Much of satisfaction with access is subjective and relies on CAHPS data. A measure of access that is more objective is whether or not preventive care visits occur. We will look at day zero data from previous open card and MCO claims to determine a rate of preventive visits by age, sex, race, ethnicity, language and location (rural vs large town). Data will be compared with statewide data to determine statistically significant disparities. Data will be shared with PCPs in an actionable form.
Milestone(s) to be achieved as of July 1, 2014	• The YCCO baseline rate of preventive care visits in groups with identified disparities can be set this year. Comparison of this year's data with available historic data will inform setting of benchmark for 2015.
Benchmark to be achieved as of July 1, 2015	• Rate of preventive care visits in groups with identified disparities increased by the goal determined after analysis of 2014 data

AOT #8 Benchmark 3	**Quality plan will address disparities in the health outcomes of the severe and persistently mentally ill**
How Benchmark will be measured (Baseline to July 1, 2015)	• Specific measures of quality of care, such as pap smears, colon cancer screening, and mammography, will be reviewed as the whole group of severely and persistently mentally ill and then by subgroups within that population by race, ethnicity, language and location (rural vs. town). Data will be gathered from a mix of open card and MCO claims at day zero and then YCCO specific claims, and sorted by the criteria described. Results will then be compared to national rates. This data will be shared with PCPs in an actionable form.
Milestone(s) to be achieved as of July 1, 2014	• The YCCO baseline rate of these preventive measures for this group can be set this year. Comparison of this year's data with available historic data will inform setting of benchmark for 2015.
Benchmark to be achieved as of July 1, 2015	• Rates for these measures of quality improve to the benchmark set after analysis of 2014 baseline data.

AOT #8 Benchmark 4	Quality plan will address disparities in adult outcomes
How Benchmark will be measured (Baseline to July 1, 2015)	• Specific measures of adult quality of care, such as the diabetes care elements of HgbA1c and LDL cholesterol, will be reviewed by subgroups of race, ethnicity, language and location (rural vs. town). Data will be gathered from a mix of open card and MCO claims at day zero and then YCCO specific claims, and sorted by the criteria described. Results will then be compared to national testing rates. This data will be shared with PCPs in an actionable form.
Milestone(s) to be achieved as of July 1, 2014	• Using YCCO specific data, the baseline rate of these measures can be set this year, and disparities identified. Comparison of this year's data with available historic data will inform setting of benchmark for 2015.
Benchmark to be achieved as of July 1, 2015	• Performance on the identified measures will improve to the benchmarks set after analysis of 2014 data.

Key Area 8 Benchmark 5	Quality plan will address disparities in pediatric outcomes
How Benchmark will be measured (Baseline to July 1, 2015)	• Specific measures of pediatric quality of care, such as developmental screening, will be reviewed by subgroups of race, ethnicity, language and location (rural vs. town). Data will be gathered from a mix of open card and MCO claims at day zero and then YCCO specific claims, and sorted by the criteria described. Results will then be compared to Oregon statewide screening rates. This data will be shared with PCPs in an actionable form.
Milestone(s) to be achieved as of July 1, 2014	• Using YCCO specific data, the baseline rate of this measure can be set this year, and disparities identified. Comparison of this year's data with available historic data will inform setting of benchmark for 2015.
Benchmark to be achieved as of July 1, 2015	• Performance on the identified measure will improve to the benchmark set after analysis of 2014 data.