

**Transformation Plan 2015-17
Yamhill Community Care Organization**

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Yamhill Community Care Organization
Your Local Health Partner

Historically, the geographical area served by the Yamhill Community Care Organization (Yamhill CCO) 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 Yamhill CCO 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 Yamhill CCO 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 anticipated that baseline measures for Yamhill could be significantly poorer than for the rest of the state, which gave us great opportunities for improvement. We see Yamhill CCO 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 dental care.

The Yamhill CCO is a large complex system involving a payer, multiple physical, behavioral and dental 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. 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 are incorporated into the transformation plan initiatives or benchmarks as relevant.

The Yamhill CCO contains four main workgroups. These groups were established to conform to the state legislation establishing the formation of CCOs. These groups include the Yamhill CCO Governing Board, the Clinical Advisory Council (CAP), the Community Advisory Council (CAC) and the Early Learning Council (ELC). Various subcommittees have been established within each workgroup, e.g. CAP ED Utilization subcommittee. Work on the 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 2015 Incentive Measure Benchmarks, some of the initiatives have set their own measures. Yamhill CCO subgroups will regularly review unique initiative measures and the OHA 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 Yamhill CCO transformation plan is the CCO's ability to produce the data it needs to support the desired changes.

The population served by the Yamhill CCO 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 were not extant baselines on any measures for this specific group. The Yamhill CCO staff and volunteers spent much of the first two years gathering and examining data from pre-existing MCOs, state and other community sources. The data is examined from the CCO perspective, looking for patterns of cost, care access, care quality and care disparity that stands to inform the specific steps needed for transformation. The Board anticipates that there will be changes to the transformation plan as the Yamhill CCO gains sophistication in producing and analyzing data.

To provide additional incentives for change, the Yamhill CCO governing board has developed an internal application process for funding transformational plans and projects. The transformation fund established by the Yamhill CCO will be the source of the funds. Deadlines will be set for future transformation fund applications to be submitted. The various work groups of the Yamhill CCO may submit applications for future funding transformation, as funds become available. Plans and projects will be data driven and will include metrics for implementing and monitoring plans and projects.

Work Groups

Transformational Plan Contact

Governing Board.....	Jim Carlough
Governing Board Alternative Pay	Jim Carlough / Jim Rickards
Governing Board Finance	Dennis Gray
CAC.....	Bonnie Corns

CAPJackie Erickson
CAP PCPCHJackie Erickson
CAP ED Utilization.....Charlene Gibbs
CAP Specialty Care.....Jim Rickards
CAP Transitions of Care.....Charlene Gibbs
CAP Behavioral Health.....Silas Halloran-Steiner

- 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 mental illness.

Owner: Mary Peterson

Point Person: Mary Petersen

Yamhill CCO Workgroups: CAP PCPCH, Behavioral & Transitions of Care Subcommittee

We have implemented Screening, Brief Intervention and Referral to Treatment (SBIRT) across the Yamhill CCO provider network. Both hospital EDs have begun using SBIRT and Yamhill CCO will provide technical assistance to develop referral pathways as requested by each department. Partnering with George Fox University's Doctor of Psychology Program, annual SBIRT training will be provided, as well as ad-hoc training sessions for new providers. We intend to include SBIRT in the PCPCH collaborative described in benchmark #2 for this area of transformation.

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 University's Doctor of Psychology Program because of its expertise in this model and Yamhill CCO has supported embedded behaviorists employed by Willamette Valley Clinics, Virginia Garcia Memorial Health Center, Physicians Medical Center, Providence Medical Group, Villa Med Center, and West Hill Med Center. 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 benchmark #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. Yamhill CCO will provide technical assistance to identify and/or develop referral pathways to treatment as requested. 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; Yamhill CCO will collaborate with Project ABLE to utilize 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 use the Coaching for Activation tool to assist in behavior change.

Yamhill County Health and Human Services (YCHHS) and Virginia Garcia Memorial Health Center (VGMHC/VG) have completed a bilateral integration project in which a PCP and a CMA from Virginia Garcia is 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.

Yamhill CCO launched the first cohort for the Persistent Pain Program (PPP) at the beginning of March 2015. This first member cohort began with an hour long orientation, an hour long individual intake and then began their 2 hour classes for eight weeks. The next cohort orientation is scheduled to begin on April 1, 2015 with the plan to continue to launch new cohorts at least monthly, more frequently based upon demand. The program consists of a pain management curriculum delivered by a licensed Behaviorist, and a movement pathway delivered by a physical therapist specializing in chronic pain and/or a chronic pain yogi instructor. The program is eight weeks in duration, with classes held once a week for two hours. The PPP includes the exploration of diet, exercise, and alternative therapies such as massage, chiropractic, and acupuncture/pressure. The program does not manage or prescribe medications and works as part of the patient care team with the patient and PCP. The Yamhill CCO was fortunate to be able to expand its current office space to build a Wellness Center, where the PPP takes place. This new space is designed for both class activities and movement therapy, with collapsible tables and stackable chairs. In addition to the Persistent Pain Program we will also be able to use the space for other health management group classes, such as Living Well with Chronic Diseases.

OHA Relevant Metrics

Core/Performance Metrics

1. All-cause readmissions
2. Physical, mental and dental assessments 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: Physical, mental and dental assessments for children in DHS 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	2015-17 Proposal
How Benchmark will be measured (Baseline July 1, 2015)	<ul style="list-style-type: none"> • % of individuals age 12+ screened each year, as shown in CPT codes (CCO Incentive Measure; Must Pass PCPCH Measure 3.C.0). 	Baseline July 1, 2015 Baseline: 4.8% (Based on Dec 2014 Performance Report)
Milestone(s) to be achieved as of July 1, 2016	<ul style="list-style-type: none"> • Training and incorporation into patient flow in all PCPCH settings. • Training and incorporation into patient flow in both emergency departments; determine if ED coding will be captured in the OHA measure; determine whether SBIRT in mental health can be captured in the OHA measure. • Use Non-Traditional Health Workers (NTHWs) and other outreach mechanisms to assist medical providers in successfully linking referred individuals with treatment. 	Milestone(s) July 1, 2016 <ul style="list-style-type: none"> • SBIRT training will be held in 2015 and 2016 for all who implement the SBIRT. • Yamhill CCO will provide technical assistance to hospital ED's in the development of referral pathways to treatment for positive screens.
Benchmark to be achieved as of July 1, 2017	<ul style="list-style-type: none"> • Achieve state performance target as defined by OHA financial incentive metric 	Benchmark July 1, 2017 Active use of SBIRT Tool and implementation of requisite or associated work flows.

AOT #1 Benchmark 2	Incorporate Behaviorists into PCPCH	2015-17 Proposal
How Benchmark will be measured (Baseline July 1, 2015)	<ul style="list-style-type: none"> • % of members enrolled in clinics with a behaviorist • 2015 PIP • 2015 Incentive Metric 	<p>Baseline July 1, 2015 Baseline: 78% of our 2013 membership is assigned to a PCPCH with behaviorist. (based on member months data Jan 2015)</p>
Milestone(s) to be achieved as of July 1, 2016	<ul style="list-style-type: none"> • Behaviorists funded, hired, trained and employed by Willamette Valley Clinics, Villa 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: <ul style="list-style-type: none"> » 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 	<p>Milestone(s) July 1, 2016 Clinics with a behaviorist will report quarterly on the following measures to build sustainability of the model:</p> <ol style="list-style-type: none"> 1. Proportion of encounters for mental health vs. health and behavior codes 2. Number of service units per patient per 3 months 3. Average length of sessions 4. Percentage of costs recouped through billings, all payers 5. PCP Satisfaction
Benchmark to be achieved as of July 1, 2017	<ul style="list-style-type: none"> • 3% increase in the number of Members served in PCPCH which include behaviorists 	<p>Benchmark July 1, 2017 3% increase in the number of Members served in PCPCH with embedded behaviorists.</p>

AOT #1 Benchmark 3	Depression Screening/Follow-up in PCPCH	2015-17 Proposal
How Benchmark will be measured (Baseline July 1, 2015)	<ul style="list-style-type: none"> • CCO incentive measure (encounter data + chart review); meets Must Pass PCPCH Measure 3.C.0. 	Baseline July 1, 2015 Baseline: 47.73% (Baseline determined by YCCO proof-of-concept data submitted 2014 to OHA)
Milestone(s) to be achieved as of July 1, 2016	<ul style="list-style-type: none"> • 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). 	Milestone(s) July 1, 2016 <ul style="list-style-type: none"> • PCPCH collaborative will offer technical support to clinics in order to establish workflows and referral pathways for Depression Screening & Follow-Up • Understanding the internal referrals to behaviorist as well as external referral pathways to follow up care throughout the system • Data tracking system will be established to monitor and report on this measure
Benchmark to be achieved as of July 1, 2017	<ul style="list-style-type: none"> • Meet state performance target. 	Benchmark July 1, 2017 Benchmark 100% as determined by OHA

AOT #1 Benchmark 4	Peer Wellness Specialists (PWS)	2015-17 Proposal
How Benchmark will be measured (Baseline July 1, 2015)	<ul style="list-style-type: none"> • Total FTE of Peer Wellness Specialists; • Improvement in Patient Activation Measure (PAM) scores for individuals served by PWS. 	Baseline July 1, 2015 Baseline: 2.5 FTE Peer Wellness Specialists (PWS) are on staff at Project ABLE to work with Yamhill CCO members as appropriate.

<p>Milestone(s) to be achieved as of July 1, 2016</p>	<ul style="list-style-type: none"> · 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. · 	<p>Milestone(s) July 2016</p> <ul style="list-style-type: none"> • PWS will work in collaboration with the Community Health Workers (CHW) and the Community Based EMS Program to provide support to members as appropriate. • PWS will be trained on the PAM tool and Coaching for Activation tool
<p>Benchmark to be achieved as of July 1, 2017</p>	<ul style="list-style-type: none"> • Meet target # of FTE for PWS as determined 7/1/2016 • 10 point gain in average PAM score for clients served by PWS • 	<p>Benchmark July 1, 2017</p> <ul style="list-style-type: none"> • PWS clients will demonstrate an PAM score improvement of 10 points by the end of service • PWS FTE will increase if deemed necessary by data and usage

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

Owner: Laura Byerly

Point Person: Jackie Erickson

Yamhill CCO Workgroups: CAP PCPCH subcommittee

1. PCPCH Initiative:

- Develop PCPCH Collaborative (aka PC3) to assist clinics in progressing along the tier status in the PCPCH spectrum to improve Yamhill CCO patient access, coordination and comprehensive integrated care, as well as provide technical assistance in working toward meeting the incentive metrics.

2. Integrative Behavioral Health Model – Integration of behavioral health into primary care is crucial to transformation. This is addressed in Area of Transformation 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 US Preventative Services Task Force (USPSTF) recommendations
 - Pediatric immunization schedule appropriately completed at 2 years of age (A typical schedule includes doctor's visits at age 2 months, 4 months, 6 months, 12 months, between 15 and 18 months and 24 months).
 - Adolescent well child visits for ages 12-21 years
 - Developmental screening by 36 months old
 - Appropriate management of ADHD medications
4. Establishing new Yamhill CCO 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.
 - 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
 - HbA1C is documented within last 6 months, for all diabetics
 - Referral for mammogram for appropriate patients based on US Preventative Services Task Force (USPSTF) recommendations

AOT #2 Benchmark 1	Establishing with PCPCH	2015-17 Proposed
How Benchmark will be measured (Baseline July 1, 2015)	<ul style="list-style-type: none"> Using claims and CCO data, what percentage of members are seen by their PCP within 90 days of assignment by Yamhill CCO to the PCP. 2015 PIP 2015 Incentive Metric 	July 1, 2015 Baseline Baseline: 45.61% (Baseline determined by CareOregon data January 2015)
Milestone to be achieved as of July 1, 2016	<ul style="list-style-type: none"> 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. 	Milestone(s) July 1, 2016 <ul style="list-style-type: none"> Improve data tracking system established to monitor and report on this measure monthly. Yamhill CCO will monitor monthly reports showing percentage of new enrollees that are established with their PCPCH within 90 days. This data will be shared with PCPCHs on the monthly <i>Clinical Quality Incentive Report</i>.
Benchmark to be achieved as of July 1, 2017	<ul style="list-style-type: none"> 3% improvement over baseline in percentage of patients seen within 90 days of being assigned to PCP 	Benchmark July 1, 2017 3% increase over baseline in percentage of new enrollees that are established with their PCPCH within 90 days of assignment.

AOT #2 Benchmark 2	Adolescent well child visits for ages 12-21 years	2015-17 Proposed
How Benchmark will be measured (Baseline July 1, 2015)	<ul style="list-style-type: none"> Percentage of Adolescent Well Child (AWC) visits 2015 PIP 2015 Incentive Metric 	July 1, 2015 Baseline Baseline: 31.3% (Based on CCO Performance Report Dec 2014)

Milestone to be achieved as of July 1, 2016	<ul style="list-style-type: none"> • Use an incentive-reward based reminder system to engage adolescents in completing their AWC visit 	Milestone(s) July 1, 2016 <ul style="list-style-type: none"> • Incentive-reward systems will be established with PCPCHs for adolescents completing an AWC visit • This data will be shared with PCPCHs on the monthly <i>Clinical Quality Incentive Report</i>.
Benchmark to be achieved as of July 1, 2017	<ul style="list-style-type: none"> • 3% improvement over baseline in percentage of patients seen within 90 days of being assigned to PCP 	Benchmark July 1, 2017 3% increase over baseline in percentage of AWC visits

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

Yamhill CCO Workgroups: Governing Board Alternative Payment Subcommittee and Financial Subcommittee

Alternative Payment Models (APMs) are being developed by Yamhill CCO 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 Yamhill CCO 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	2015-17 Proposal
How Benchmark will be measured (Baseline July 1, 2015)	<ul style="list-style-type: none"> • 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. • Adjust methodologies to meet desired targets and outcomes. • Develop accountability plan 	Baseline July 1, 2015 Number of providers enrolled in APM at the end of June 2015.
Milestone to be achieved as of July 1, 2016	<ul style="list-style-type: none"> • Study and refine targeted benchmarks. • Adjust methodologies to meet targets. 	Milestone(s) July 1, 2016 Accountability language added to LOAs with providers using APMs
Benchmark to be achieved as of July 1, 2017	<ul style="list-style-type: none"> • Implement one or two alternative methodologies that meet targeted health outcomes. 	Benchmark July 1, 2017 2% Increase number of providers enrolled in APM

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
Yamhill CCO Workgroup: CAC

- 1) The CAC used a modified MAPP process for performing the CHA and developing the CHIP.
 - a) The CAC formed workgroups to complete the various sections of the CHA and the CHIP, engaging community stakeholders and plan members as appropriate.
- 2) The CAC works closely with the Yamhill CCO Board, the CAP, and other community partners to ensure that there is no duplication of efforts in implementing the strategies within the CHIP.

- a) The CAC used 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 included, but were 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 was evaluated by the YCPH Accreditation Coordinator.
- 3) The CAC engaged the Yamhill CCO Board, the CAP, and other community partners to review Key Health Indicators and set priorities for the CHIP.
- 4) The CHIP was adopted by the Board on June 2, 2014 and was 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 OHA, members, partner agencies, providers and the general public in various written formats including newsletters, newspaper articles, and websites and will be available in English and Spanish by 2017.
- 6) The CAC will perform a CHA and CHIP formal process every five years.

AOT #4 Benchmark 1	CHA & CHIP	2015-17 Proposal
How Benchmark will be measured (Baseline July 1, 2015)	<ul style="list-style-type: none"> • The Yamhill CCO will issue an annual update by July 1, 2015 demonstrating the progress toward the goals set during the development of the CHIP. 	Baseline July 1, 2015 Annual update will be submitted to OHA by June 30, 2015
Milestone to be achieved as of July 1, 2016	<ul style="list-style-type: none"> • The CAC will utilize a modified MAPP process for the Community Health Assessment (CHA) and development of an annual Community Health Improvement Plan (CHIP). 	Milestone(s) July 1, 2016 <ul style="list-style-type: none"> • CAC members will track and monitor CHIP metrics and produce an Annual Update to be submitted to OHA as required each year • Annual Updates will be provided to consumer members, providers and the community.
Benchmark to be achieved as of July 1, 2017	<ol style="list-style-type: none"> 6. At the CHIP year end, (June 30th) 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. 7. The MAPP process will be followed so that a CHA is performed every five years by the CAC, with annually reported updates. 	Benchmark(s) July 1, 2017 <ul style="list-style-type: none"> • Annual update will be written in English & Spanish • Annual updates will be submitted to OHA as required each year

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

Owner: Jim Carlough, Jim Rickards, MD

Point Person: Seamus McCarthy

Yamhill CCO Workgroups: HIT Subcommittee

1. Crimson Tool has been placed into an evaluation period until March 2016 given technical challenges with implementation, limited provider adoption and limited ability to obtain actionable data from the tool. During the evaluation period the usefulness of the tool will be reassessed. Additionally, its relevance to the organization will be re-assessed given new state-wide OHA supported HIE tools such as the EDIE system and Pre-Manage system.

2. Recognizing the multiple EHR systems utilized by community partners and stakeholders, Yamhill CCO will continue to assess current technology and best practices to ensure reliability of data exchanges and develop a system to store data collected from those multiple systems.

AOT #5 Benchmark 1	Crimson Care Ambulatory Module	2015-17 Proposal
How Benchmark will be measured (Baseline July 1, 2015)	Number of Yamhill CCO Network Providers Participating in Clinical Data Exchange with the Crimson Population Risk Management (CPRM) Tool.	Baseline July 1, 2015 One provider clinic using the CPRM tool.
Milestone(s) to be achieved as of July 1, 2016	Engagement of at least 25% of Yamhill CCO Network Providers by the Advisory Board to begin Implementation of the Crimson Population Risk Management Tool.	Milestone(s) July 1, 2016 Crimson Tool has been placed into an evaluation period until March 2016 given technical challenges with implementation, limited provider adoption and limited ability to obtain actionable data from the tool. During the evaluation period the usefulness of the tool will be reassessed. Additionally, its relevance to the organization will be re-assessed given new state-wide OHA supported HIE tools such as the EDIE system and Pre-Manage system.

AOT #5 Benchmark 1	Crimson Care Ambulatory Module	2015-17 Proposal
Benchmark to be achieved as of July 1, 2017	50% of Yamhill CCO Network Providers Participating in Clinical Data Exchange with Crimson Population Risk Management Tool.	Benchmark July 1, 2017 At least 50% of providers have been engaged and informed of tool.

AOT #5 Benchmark 2	Interoperability Between Systems	2015-17 Proposal
How Benchmark will be measured (Baseline July 1, 2015)	<ul style="list-style-type: none"> • Percent of Yamhill CCO Network Providers currently using an Electronic Health Record. • 2015 Incentive Metric 	Baseline July 1, 2015 Baseline: 69.9% (based on OHA Dashboard Feb. 2015)
Milestone(s) to be achieved as of July 1, 2016	Assessment of communication platforms that will align multiple systems, including medical, behavioral, dental and early learning systems, which would allow for valid data exchanges and storage between systems.	Milestone(s) July 1, 2016 <ul style="list-style-type: none"> • System & software assessments completed; • Program licenses purchased; • Training plan developed and implemented for Yamhill CCO staff; • Training plan developed for partner organizations
Benchmark to be achieved as of July 1, 2017	Implementation of communication platforms that will align multiple systems, including medical, behavioral, dental and early learning systems, which would allow for valid data exchanges and storage between systems.	Benchmark July 1, 2017 <ul style="list-style-type: none"> • Program licenses for partners purchased; • Training plan developed; • Communication platforms implemented and in use

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
Yamhill CCO Workgroups: CAC

1. Yamhill CCO enrollment data will be 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.
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 Yamhill CCO 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	2015-17 Proposal
How Benchmark will be measured (Baseline to July1, 2015)	<ul style="list-style-type: none"> • Using current demographic data, cultural composition of our members and their associated language use will be assessed. 	Baseline July 1, 2015 Baseline will be based off of Quarter 1, 2015 demographic data
Milestone(s) to be achieved as of July 1, 2014	<ul style="list-style-type: none"> • Yamhill CCO enrollment data will be reviewed 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 Yamhill CCO Board and CAP. 	Milestone(s) July 1, 2016 <ul style="list-style-type: none"> • Yamhill CCO will develop a procedure for review of member materials including: <ul style="list-style-type: none"> • Multiple language options • Cultural appropriateness • Health Equity • Demographic data of Yamhill CCO members will be assessed for cultural composition. • Focus groups will be considered for disparate populations to determine needs regarding written materials, including Member Handbook, website and social media. • Health Literacy training for: <ul style="list-style-type: none"> ▪ Consumer members ▪ Providers & clinic staff ▪ Yamhill CCO staff

AOT #6 Benchmark 1	Addressing Members' Cultural, Health Literacy, and Linguistic Needs	2015-17 Proposal
Benchmark to be achieved as of July 1, 2015	<ul style="list-style-type: none"> Implementation of the review process for member materials will ensure they are culturally and linguistically appropriate for the member population of Yamhill CCO 	Benchmark July 1, 2017 <ul style="list-style-type: none"> Implement the review process for member materials

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
 Yamhill CCO Workgroups: CAC

- 1) Determine the baseline for current cultural composition of Yamhill CCO providers, Members, and any current positions that fulfill the role of NTHW.
 - a) Make a determination as to whether Yamhill CCO provider and Member cultural composition aligns with current standards.
- 2) Determine realistic targets for bringing new providers and NTHWs into the Yamhill CCO, 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	2015-17 Proposal
How Benchmark will be measured (Baseline July1, 2015)	<ul style="list-style-type: none"> 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. Perform survey of Yamhill CCO staff and NTHWs to determine if Percentages of providers and NTHW cultural composition will closely match the cultural composition of the Member population as is feasible for Yamhill County. 	Baseline July 1, 2015 Baseline: Quarter 1, 2015 cultural composition data of Yamhill CCO members, Yamhill CCO staff and NTHWs.
Milestone(s) to be achieved as of July 1, 2016	<ul style="list-style-type: none"> 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. 	Milestone(s) July 1, 2016 <ul style="list-style-type: none"> Demographic data of Yamhill CCO members is assessed for cultural composition. At least one Cultural Diversity, Health Equity training will be provided for network providers and Yamhill CCO staff.
Benchmark to be achieved as of July 1, 2017	<ul style="list-style-type: none"> 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. 	Benchmark July 1, 2017 <ul style="list-style-type: none"> Demographic data of Yamhill CCO members assessed for cultural composition and compared to baseline. 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):

Yamhill CCO 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 Yamhill CCO transformation plan. The Yamhill CCO 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. The first two years of the Yamhill CCO has 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 analyzing that data. 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. 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 CAP committees and used to formulate a customer service action plan. The CAC and CAP will consider a recommendation to the Board for Yamhill CCO to pay for a BRFFS over-sample in the next round of assessments.

AOT #8 Benchmark 1	Improve experience of care	2015-17 Proposal
How Benchmark will be measured (Baseline July 1, 2015)	2014 CAHPS data will be reviewed and analyzed annually in regard to patient satisfaction, access, and quality of care. This data will be presented to the CAC and CAP for actionable plans.	Baseline July 1, 2015 Initial review of the June 2014 CAHPS Survey results by the Yamhill CCO staff.
Milestone(s) to be achieved as of July 1, 2016	Results of 2014 CAHPS survey reviewed by Board and CAP, and CAC and improvement targets will be established.	Milestone(s) July 1, 2016 Improvement targets established by the CAC, CAP and Board.
Benchmark to be achieved as of July 1, 2017	Improvement of established targets on the CAHPS Survey.	Benchmark July 1, 2017 Improvements in specific targets identified will be demonstrated by the most current CAHPS Survey results.

AOT #8 Benchmark 2	Quality plan will address disparities in the health outcomes of the severe and persistently mentally ill	2015-17 Proposal
How Benchmark will be measured (Baseline July 1, 2015)	Establish feasibility of monitoring Specific Measures of quality of care, such as pap smears, colon cancer screening, and mammography, which will be reviewed as the whole group of severely mentally ill and then by subgroups within that population by race, ethnicity, language and location (rural vs. town). Results will then be compared to national rates. This data will be shared with PCPs in an actionable form.	Baseline July 1, 2015 Explore feasibility of data collection for these specific measures regarding the SMI population, and sub-populations. If available, this data will be baseline.
Milestone(s) to be achieved as of July 1, 2016	The Yamhill CCO baseline rate of these preventive measures for this group can be set this year.	Milestone(s) July 1, 2016 Systems will be in place to collect and report data on these specific measures for this specific population.
Benchmark to be achieved as of July 1, 2017	Rates for these measures of quality improve to the benchmark set after analysis of 2015 baseline data, if available.	Benchmark July 1, 2017 Number of preventative services provided for this group will have increased by 3% over baseline.