

# Columbia Pacific Coordinated Care Organization (CPCCO)

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## *Transformation Plan Summary*

### **Background**

Columbia Pacific CCO was formed via a partnership with CareOregon, Greater Oregon Behavioral Health (GOBHI) and community leaders in Columbia, Clatsop and Tillamook counties as well as 5 zip codes in the coastal communities of Douglas County. These CCO partners share the geography of the Columbia River and the Pacific Ocean, rural environments and demographic characteristics which have historically been linked to the resource-based economies of logging and fishing. For the majority of the population in the CCO, members must travel significant distances over 2 lane highways to major population centers. Columbia Pacific CCO has 4 hospitals, 24 primary care clinics, and 10 mental health/addictions sites within the service area. All 4 hospitals are small critical access hospitals with 25 or fewer beds and limited specialty providers except on a rotational basis. With approximately 14,000 covered members, the CCO has entered into a management services agreement with CareOregon to provide staffing support for finance, information services, customer service, governance and other CCO business functions. Each of the four identified counties have recruited their own Community Advisory Committee (CAC); a regional CAC is now being formed with representation from each of the local structures.

Considerable risk was assumed in the development of this particular CCO, with the assumption for care and costs for some 7,000 members (half of the CCO membership) who were Medicaid Fee for Service (FFS) or “Open Card” for their physical health care prior to that time. These members have little to no experience with managed care and have been known to seek their medical care on a random and uncoordinated basis and occasionally outside the geographic limits (sometime crossing into another state) of the now-defined CCO. These individuals represent an incomplete history of care utilization and a management challenge for effective care coordination systems and cost containment under a global budget.

### **Transformation Initiative Descriptions**

*(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.*

No baseline is available to Columbia Pacific CCO for the number of members with severe and persistent mental illness; the CCO will utilize the Clinical Advisory Panel (CAP) to provide guidance for integration work. Efforts of the CAP will include the development of data to establish baselines, the use of “hot spotting” processes between primary care and behavioral health providers in the CCO to identify consumers with high utilization of both services and use

of CAP members and their expertise to develop a work plan utilizing evidence-based models for integration which are applicable to the rural communities in CPCCO. Integration and co-location of behavioral health care workers (including Peer Support Specialists and other non traditional health care workers) within primary care settings will be a priority as models are selected and tested.

Current available data available indicates marked problems of chronic pain and drug dependence in the adult member population of CPCCO, with 6 of 7 prescriptions for adults being written for opioids/narcotics. Following drug dependence, the top diagnosis for adults within the CPCCO is diabetes.

Benchmarks for this element of the Transformation Plan include the selection of primary care and behavioral health integration models which will be implemented in at least 3 clinics of the CPCCO by December 2013, the development of an alternative pain management model for patients with complex co-morbid conditions including addictions by December 2013 and use of community-wide effective screening practices focusing on mental health and addictions.

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

There are currently two Tier 2 and four Tier 3 certified Patient Centered Primary Care Homes (PCPCH) within the Columbia Pacific CCO; these practices account for 58% of the empanelled members within the organization. The CCO has indicated a desire in their plan to leverage development of additional PCPCH practices with the integration efforts of Transformation Element #1 by formalizing a model for bi-directional development to assist existing community mental health providers to attain PCPCH certification.

Benchmarks include increasing the percentage of members receiving care via a PCPCH from the current level of 58% to 75-80% by December 2015. CPCCO intends to support this achievement by selection of 7-9 clinics within CPCCO by spring of 2013 to participate in a PCPCH Collaborative. This cohort would be supported during implementation by Practice Coaches specific to PCPCH; with planned implementation in December of 2013. The CAP will work to identify additional financial resources to support the spread of PCPCH as well as identify, guide outreach to and manage high-risk complex member cases.

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

Columbia Pacific CCO will integrate the separate funding streams for mental health and addictions treatment into one consolidated pool that has the ability to be sub-capitated for providers by July 2013. The CCO will charter the Finance Committee and the CAP to research existing payment methodologies that align payment with health outcomes and incent integration of mental health/behavioral health services (including addictions and treatment). The work of these committees will be informed by the Innovator Agent, CareOregon and GOBHI staff and other knowledgeable individuals or organizations. Such alternative models could include a “shared flex fund” for use by Community Care Teams (CCT) to facilitate coordination of care,

disposition, placement and support for those members crossing traditional lines of clinical responsibility.

Additional incentive payment models via pilots based on clinical-level quality improvements will be utilized to test the effectiveness of alternative payment methodologies.

The benchmark in this area requires demonstration of utilization of alternative payment methodology by July, 2014.

***(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.***

Columbia Pacific CCO has established 4 separate Community Advisory Councils (CACs) which are meeting on a monthly basis. The CCO has contracted for the services of a knowledgeable consultant to work with the CACs to fully understand and act upon the requirement to perform a Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). The Contractor will assist the CAC to gather all available assessment data and perform a meta-analysis of existing assessments; this analysis will help to identify gaps and develop priorities. CPCCO will work closely with the Office of Equity and Inclusion and the Innovator Agent to gather additional information and perform analysis with the CAC on areas of disparity across the CCO. The CAC will prioritize community health needs by convening focus groups and stakeholder meetings to inform the strategies that will be addressed in the CHIP.

Once the work of each of the 4 CACs is completed, a final CCO-wide CHA/CHIP will be completed that incorporates all the local findings, stories, priorities and strategies for addressing gaps that create health disparities and health inequity in the CCO's communities.

Benchmarks require that the CCO-wide CHIP be completed by July, 2014.

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

Columbia Pacific CCO does not yet have a baseline for the number of contracted providers currently using EMRs. Work on the concept of the Health Information Exchange in Oregon is taking place at the state level. Many of the larger practices serving the primary care needs of the CCO population (including the Federally Qualified Health Centers) are using OCHIN Epic as a common platform. There is no parallel clear consistency of EMR product use across behavioral health providers in the CPCCO.

Columbia Pacific CCO sees value in completing an inventory of provider capabilities to meet Stage 1 Meaningful Use criteria, to determine the existing ability to share medical information electronically and to assess opportunities for TA to implement and upgrade existing systems at the provider level; the assessment will be completed by June, 2013. These efforts are intrinsically linked to PCPCH criteria and increase in Tier Levels described in Transformation Element 2. Care Everywhere is proposed as the mechanism for organization-wide integration. Staff will be encouraged to seek TA and training from state agencies to deploy the Oregon

Health Authority's CareAccord platform across the provider network and with key specialty providers outside the CPCCO.

Community-wide event notification regarding members accessing primary care services through local EDs and urgent care settings represents an opportunity for exploration for CPCCO for greater care coordination and member engagement and education. The CAP will be chartered to review applicable models and make recommendations on this practice and available facilitative technology by December, 2013.

CPCCO will work collaboratively with Innovator agents, partner organizations and state agencies to develop state-led initiatives to allow more effective interface of physical and mental health EMRs and care plans. CPCCO has agreed to be a participant in the next phase of state-wide HIE development by designating appropriate executive and staff representatives to be available for an interview with an Oregon Health Authority (OHA) consultant and by participating in a series of stakeholder workgroup meetings. After the process concludes and the next phase of state-side HIE services are defined, CPCCO intends to update this HIE component of the Transformation Plan.

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

The majority ethnic group for the general population in CPCCO is Caucasian with Hispanic members a distant second. The percentage of Hispanic population varies from a low of less than 5% to a high of 17% dependent upon the city and county. No baseline is yet known for the race, ethnic or language needs of the CPCCO members by community. All materials are currently produced in English and Spanish. CCO providers and members are able to access Passport to Languages for telephonic interpretation. A CPCCO website was launched in January 2013 which contains the capacity for all web content to be translated via Google Translators to increase accessibility to Spanish-only members of the CCO.

A benchmark has been established that CPCCO will develop and communicate baseline information on race, ethnicity, and language needs of CCO members by community, including assessment of existing provider capabilities by September, 2013. Additional benchmarks which cross into the next Area of Transformation will be noted there.

***(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).***

A Cultural Competence Policy which includes standards and a repository of member documents that meet those standards will be developed by December, 2013. The CPCCO will create a standard process to collect and utilize member input on the issues of delivery of culturally competent care and services. In addition, the CCO will see advice from subject matter experts on the quality of written materials, outreach and other communications with members.

The CPCCO will develop a program including competencies and training curriculum which will be required for CCO providers to create an environment where reductions in health disparities

through the use of culturally competent practices and workers is a norm. This benchmark will be achieved by September, 2013. In addition, an ongoing workgroup (a subgroup of the CAC with community-based organization leadership and other interested individuals) will be convened to guide strategies for health disparities reduction.

The work of Transformation Elements 6 and 7 will be informed by the results of the CHA completed by the CAC, the prioritization that is driven by the CHA to create the CHIP as well as by claims, clinical data, client satisfaction data, and complaint processes or other proxies that indicate the quality and adequacy of access and care.

***(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.***

CPCCO will establish a Quality Improvement Plan that capitalizes on the existing data sources available to evaluate the clinical outcomes and patient experience. The Quality Improvement Plan will, to the extent possible, include measure to assess and incorporate metrics for health improvement based on social determinants and health disparities. The plan will utilize quality standards and metrics developed by OHA specifically for CCOs.

As part of Transformation Element 8, the CPCCO will develop and implement outreach, training and tools to assist primary care providers improve in the 3 areas selected for Performance Improvement Projects (PIPS); these areas are best practices in the treatment of chronic pain with opioids, consistent screening during prenatal and maternity care for behavioral health and addictions issues and developmental screening for children under 36 months. The PIPs are required to be designed, implemented and evaluated by December 2013.

Columbia Pacific CCO has indicated an interest in sponsoring a clinic/provider learning collaborative regarding outcomes measurement. Efforts in this area will incorporate best practices that will support improvement with practice-specific performance improvement projects as well as overall CCO metrics and performance targets.