

## Transformation Plan Final Progress Report Columbia Pacific CCO

**Please review prior Transformation Plan Progress Reports for additional information about activities in support of this plan. This document will not repeat prior submissions.**

### Transformation Area 1: Integration of Care

Benchmark 1	
How Benchmark will be measured (Baseline to July 1, 2015)	<ol style="list-style-type: none"> <li>1) Utilization rate of alternative pain management interventions.</li> <li>2) Appropriate opioid prescribing practices based on the model developed by the Clinical Advisory Panel.</li> <li>3) Rates of prenatal screening for clinical depression and alcohol and drug addictions “Screening, Brief Intervention and Referral to Treatment (SBIRT)”,</li> </ol>
Milestone(s) to be achieved as of July 1, 2014	<p>Contractor co-locates behaviorists working with addictions treatment and Primary Care Providers (PCP) in at least three major clinics in its Service Area with a focus on the Members with Severe and Persistent Mental Illness (SPMI) having one or more co-morbid conditions in addition to a mental health diagnosis. Benchmark met: YES.</p> <p>Contractor develops an alternative pain management model for piloting in at least one clinic in its Service Area. Benchmark met: YES.</p> <p>Initiate partnerships with social services and school-based providers to provide addictions screening and intervention for adolescents. Benchmark met: YES.</p>
Benchmark to be achieved as of July 1, 2015	<p>Contractor attains a reduction in number of opioids prescribed for Members using standardized benchmarks and improvement targets or, if unavailable, reduction specifications mutually agreed upon by the parties. Benchmark met: YES.</p> <p>Contractor attains improvement in Member depression and SBIRT screenings and referral for services reflected in the established CCO benchmarks and improvement targets. Benchmark met: YES.</p> <p>Contractor achieves increases in integrated care management services provided to the Members with SPMI as described in (1) above. Benchmark met: NO</p>

**1. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.**

Activity <i>(Action taken or being taken to achieve milestones or benchmarks)</i>		Outcome to Date	Process Improvements
1.	Reduction in opiates prescribed.	<p>As a percent of chronic opiate users over MED 120mg, CPCCO is on par with other CCOs at 16.4% and slightly above Multnomah County Health Department Clinics which are 14.1%.</p> <p>Of those individuals that have graduated from the pain clinic program (see below) and have prescription drug coverage through CPCCO, the average pre MED was 83mg and the average post MED was 43mg.</p>	CPCCO will continue to track overall opiate prescribing rates and will continue efforts to effect a decrease in overall prescriptions and rate of prescriptions exceeding 120 MED.
2.	Improve depression and SPIRT screening rates.	<p>As of the final OHA CCO Metrics Report provided in April 2015, CPCCO had improved SBIRT screening from the final rate of 2.8% in 2013 to a final rate of 10.9% in 2014.</p> <p>As of the same report, CPCCO had achieved a depression screening rate of 45% in 2014. This was the 5<sup>th</sup> highest rate of all the CCOs and well above the 25% benchmark.</p>	
3.	Develop alternative pain management model.	<p>The North Coast Pain Clinic (NCPC) has successfully continued operations. As of June, 2015, the clinic had received 431 referrals from across the CPCCO service area, oriented 242 patients, done individual intakes on 131 patients, and had 58 patients graduate from the program.</p> <p>There has been an average of positive movement in all</p>	CPCCO has moved forward with partnering with community organizations to open two more pain clinics in addition to the North Coast Pain Clinic. The two additional pain clinics will open towards the end of August 2015 and will be located in Scappoose, OR and Tillamook, OR.

		clinical outcomes measures including: <ul style="list-style-type: none"> <li>• Fear of Movement – average decrease of 3.6 points;</li> <li>• PHQ-9 – average decrease of 5.6 points;</li> <li>• Pain Self Efficacy Questionnaire – average increase of 12 points;</li> <li>• Oswestry Disability Index – average decrease of 9.4%.</li> </ul>	CPCCO will continue to track overall opiate prescribing rates and will continue efforts to effect a decrease in overall prescriptions and rate of prescriptions exceeding 120 MED.
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1. b) Please note whether benchmark(s) were met with a “yes” or “no” for each benchmark.

See above.

1. c) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

While the CCO has improved access to behavioral health interventions to members in primary care clinics, the achievement of bi-directional medical homes for members with SPMI was not met. Progress was made to develop shared data on SPMI members, as identified by the CCO’s behavioral health partner, GOBHI, and provided to primary care clinics. In addition, work is underway to co-locate primary care services in the CCO’s largest behavioral health system, Columbia County Mental Health. This work is underway. Additional clinic-specific data on high risk populations, including SPMI members, has been aggregated and continues to be updated to share with the CCO clinics at least annually.

1. d) Describe any strategies you have developed to overcome these barriers and identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

The largest barrier to overcome was developing a shared definition and reporting capability for SPMI members. Several strategies to overcome this barrier were deployed, including integrating behavioral health claims into the primary care claims system, developing clinic specific reports of members, creating clinic-level understanding of high risk populations, including SPMI and those with chronic opiate addictions, and beginning to implement community health workers in selected clinics with high numbers of high risk, high-utilizing members.

Work with OHA has primarily focused on assessing and beginning the process to implement Pre-Manage in CPCCO primary care and behavioral health clinics.

1. e) How was the Community Advisory Council involved in the activities for this transformation area?

The CACs were not involved in the activities for this transformation area.

1. f) How was the CAC informed of the outcomes for activities in this transformation area?

The CACs have been kept informed of the progress on implementing the North Coast Pain Clinic as well as the roll-out of additional pain clinics in the CPCCO service area. The CACs have also been kept informed of the process of integrating behavioral health providers into primary care settings.

## Transformation Area 2: PCPCH

Benchmark 2	
How Benchmark will be measured (Baseline to July 1, 2015)	Number of Members enrolled with Tier 1-3 PCPCHs.
Milestone to be achieved as of July 1, 2014	1) Contractor ensures that PCPCH Learning Collaborative is formed, training is completed and practice coaches deployed. Benchmark met: YES. 2) Contractor develops and deploys standardized utilization and medical cost reports to at least four PCPCH clinics for identification and intervention with high-risk patients. Benchmark met: YES.
Benchmark to be achieved as of July 1, 2015	Contractor ensures that 70% of Members are enrolled with PCPCH Tier 3 clinics. Benchmark met: YES.

**2. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.**

Action Taken or Being Taken to Achieve Milestones or Benchmarks		Outcome to Date	Process Improvements
1.	Achievement of member enrollment target into PCPCH Tier 3 recognized clinics	As of July 2015, CPCCO had 73.6% of members assigned to Tier 3 PCPCH Clinics.	See activities, following. The CCO continues to assist clinics in achieving PCPCH recognition in addition to increasing current capacity to achieve the Triple Aim goals.
2.	Implement intensive technical assistance project for key clinics.	The first pilot clinic for intensive technical assistance is proving to be successful. The template developed for this level of technical assistance program to key clinics in the CPCCO region continues to be a focus. The model currently is allowing a practice coach to spend 1-2 days a week in a clinic for an extended period of time (6-8 months). Key barriers to success are	Effectiveness of program has been realized and CPCCO is making staffing additions to allow for the intensive coaching program in addition to the PC3 model to continue successfully.  CPCCO continues to assess the technical assistance needs of the clinics and

		<p>identified collaboratively and worked together. During this process a key operational person is identified and trained up by the coach to continue the work after the practice coach exits each clinic. Technical assistance in the pilot clinic has transitioned to less intense (monthly assistance on phone and/or in person) from coach. Evaluation of the pilot clinic project continues.</p> <p>The intensive program has begun with a second clinic for this model and will continue to be assessed.</p>	<p>provide appropriate skills through diversity in the coaches' skill sets.</p>
<b>3.</b>	<p>Move Primary Care Collaborative (PC3) to an operational steering committee linked to the CAP.</p>	<p>This new model has proven to be successful. Clinics from across the care delivery region continue to be engaged. Clinics continue to have time and space for learning from each other as well as outside sources regarding leadership, using data, empanelment, etc.</p> <p>Communication between the CAP and PC3 continues to improve. The CAP designated a representative to participate in PC3 and a PC3 representative participates in the CAP meetings as well. The PC3 clinics have been able to provide feedback to the CAP regarding operationalizing a clinical initiative (opiate prescribing/pain clinic project) as well as implementation of the clinical metrics pay for performance pilot.</p>	<p>Formalized communication links between the CAP, CPCCO Finance Committee, and PC3.</p> <p>Increased collaboration between the CAP and PC3 on more strategic and operational clinical goals to achieve the Triple Aim.</p>

2. b) Please note whether benchmark(s) were met with a "yes" or "no" for each benchmark.

See above.

2. c) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

A barrier that CPCCO continues to face is the ability of the clinics to build internal capacity to carry out and sustain improvement work. The CCO continues to find a gap in leadership and operational skills among the clinics. Lack of Medical Director leadership at major clinics also continues to be a barrier as clinical champions are key to the success of primary care transformation.

2. d) Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

CPCCO is working to address the gaps in leadership and sustainability through the PC3 steering committee meetings and the CAP. PC3 meetings are addressing care transformation topics and incorporating leadership skills into those sessions. Through the intensive technical assistance model there is a focus on working with managers and leadership to grow skill sets as well as connect with other resources (leadership trainings, motivational interviewing, etc.)

2. e) How was the Community Advisory Council involved in the activities for this transformation area?

N/A

2. f) How was the CAC informed of the outcomes for activities in this transformation area?

The CACs receive regular updates of clinical initiatives for CPCCO.

### Transformation Area 3: Alternative Payment Methodologies

Benchmark 3	
How Benchmark will be measured (Baseline to July 1, 2015)	Number of clinics with Alternative Payment Methodologies, including mental health, addictions treatment and primary care clinics.
Milestone to be achieved as of July 1, 2014	Contractor integrates capitation payments for mental health and addictions treatment with all relevant Providers. Benchmark met: YES. Contractor selects at least one primary care clinic for an Alternative Payment Methodology. Benchmark met: YES.
Benchmark to be achieved as of July 1, 2015	Contractor ensures that 80% of Members receive care from Providers with integrated capitation for mental health and addictions services. Benchmark met: YES. Contractor ensures that at least one primary care clinic receives alternative incentive payments from Contractor, with an additional 3 primary care clinics engaged in the process of establishing integrated capitation methods for mental health and addiction services. Benchmark met: YES.

**3. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.**

Action Taken or Being Taken to Achieve Milestones or Benchmarks		Outcome to Date	Process Improvements
1.	Develop alternative payment models to support integration of mental health and addictions services in primary care.	A new blended funding pool was created within CPCCO wherein 1% is taken out of the global budget, prior to dispersal of funds to CareOregon and GOBHI, and placed in a separate funding pool.  The blended funding pool, to support co-location and integration of behavioral health consultants in primary care clinics, has been accessed by 3 primary care clinics, and they are in process of signing contracts with CPCOO and/or hiring behaviorists. An additional three clinics are	This blended funding pool has greatly facilitated clinic understanding of the value of brief behavioral health consultation as part of the primary care team.  The funding stream was designed in partnership with CareOregon and GOBHI; previously CPCCO members could only obtain reimbursable behavioral healthcare through GOBHI employed

		engaged in the process of seeking contracts to co-locate behaviorists in their primary care settings.	providers. This has eliminated barriers to access by locating behavioral health in the primary care setting.
2.	Create alternative incentive payments for primary care.	<p>Alternative payment models have been created and distributed to all PCPCHs in CPCCO, to incent achievement of metrics for SBIRT, adolescent well visit, colorectal cancer screening, developmental screening, diabetes control, hypertension control and depression screening. All 7 of CPCCO's PCPCH clinics have signed up for the alternative payments.</p> <p>Alternative payment models have been created and distributed to all clinics with over 500 members in CPCCO, to incent alternative visits types and other strategies to increase access to care (e.g. RN visits, telephonic visits, extended hours). Four of the 8 eligible clinics have received alternative funds to achieve access targets, with an additional 3 clinics in process of submitting proposals.</p>	This work has allowed the clinics to invest in infrastructure to support build out of capabilities for population health programs and management, otherwise unavailable in a straight fee-for-service payment model.

3. b) Please note whether benchmark(s) were met with a “yes” or “no” for each benchmark.

See above.

3. c) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

There have been no barriers to achieving these milestones.

3. d) Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

N/A

3. e) How was the Community Advisory Council involved in the activities for this transformation area?

N/A

3. f) How was the CAC informed of the outcomes for activities in this transformation area?

The CACs receive regular updates of clinical initiatives for CPCCO.

**Transformation Area 4: Community Health Assessment and Community Health Improvement Plan**

Benchmark 4	
How Benchmark will be measured (Baseline to July 1, 2015)	Community Health Improvement Plan (CHIP) completed on time and including recommendations from the Community Advisory Council (CAC), Community Advisory Panel (CAP) and from Community-identified priorities for population health improvements.
Milestone to be achieved as of July 1, 2014	Contractor completes comprehensive CHIP for its Service Area, including identified strategies to reduce health disparities based on Community-identified priorities. Benchmark met: YES.
Benchmark to be achieved as of July 1, 2015	Contractor engaged in the process of implementing CHIP priority strategies throughout its Service Area. Benchmark met: YES.

**4. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.**

Action Taken or Being Taken to Achieve Milestones or Benchmarks		Outcome to Date	Process Improvements
1.	2015 Community Wellness Investment Funds Grants	<p>CPCCO created opportunities for community health partnerships through the use of our CCO-designated Community Wellness Investment funds (CWIF). While some of the funds were granted to single agencies working towards goals that supported the CHIP, several projects are collaborations among multiple community stakeholders.</p> <p>These grants were initiated in early 2015 to specifically address identified goals and strategies in the Community Health Improvement Plan.</p> <p>Nine community proposals were funded throughout the three counties of CPCCO.</p>	Community Advisory Council members screened and rated all the grant proposals. Funded projects will report outcomes to their local community advisory council.

2.	Community Education Series on Brain Health	<p>In partnership with many community organizations, the Tillamook Community Advisory Council has developed and is sponsoring a series of community education events called The Amazing Brain. This project supports the CHIP goal of increasing the public’s awareness of the risk of substance abuse, the long term health effects of the abuse of alcohol, drugs, tobacco, and to better educate the community about the resources for behavioral health services. The focus is to better support healthy brains and minds, and to provide a community forum to identify projects the Community Advisory Council could support during the Tillamook County 2016 Year of Wellness.</p> <p>Four public education sessions were held for the Amazing Brain. There are current plans underway to replicate this series in Columbia County.</p>	<p>The local Community Advisory Council created and advised on the learning series outline and guest speakers.</p>
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4. b) Please note whether benchmark(s) were met with a “yes” or “no” for each benchmark.

See above.

4. c) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

More dedicated staffing and funding supports are needed to accomplish the goals outlined in the CHIP. In addition, the evaluation methodology and ways to objectively measure impact on improving health outcomes, as outlined in the CHIP, is difficult to obtain.

4. d) Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

One strategy for addressing the second barrier is to use County Health Rankings data to track health outcomes for each county in the CPCCO service area over time. Another strategy is to use evaluations to rate the usefulness of the education sessions by attendees at The Amazing Brain series and to track the number of attendees at each event.

OHA Technical Assistance funds helped pay for a facilitator to staff the development and implementation of the community education series. This will be scaled to other counties.

4. e) How was the Community Advisory Council involved in the activities for this transformation area?

All of the CPCCO Community Advisory Councils participated in reviewing, rating and recommending the CWIF grant proposals. The Tillamook CAC provided specific advice on the process and content of the education series, and will continue to do so for the subsequent programs. The other CACs have discussed the opportunities to replicate the series in other counties. The CACs also provided updates and input into progress on achieving progress for CHIP-identified improvements.

Finally, nine CAC members attended the CAC Summit in Bend, to improve their understanding of, and engagement in the local advisory council work and CHIP opportunities.

4. f) How was the CAC informed of the outcomes for activities in this transformation area?

See above. In addition, Community Wellness Investment Fund grantees will report to the CACs on the outcomes of their projects.

**Transformation Area 5: EHR, HIE and meaningful use**

Benchmark 5	
How Benchmark will be measured (Baseline to July 1, 2015)	Percent of Participating Providers achieving some level of meaningful use standards for Health Information Exchange (HIE).
Milestone to be achieved as of July 1, 2014	<p>1) Contractor completes inventory of Participating Provider capabilities related to meaningful use, adoption of CareAccord, Care Everywhere or other HIE technology between physical and mental health Providers. Benchmark met: YES.</p> <p>2) Contractor defines Baseline percentage of primary care clinics sharing any portion of the medical record with other Providers. Benchmark met: YES.</p>
Benchmark to be achieved as of July 1, 2015	<p>Contractor supports at least two clinics in its Service Area with attaining Stage 1 HIE meaningful use standards, or moving from Stage 1 to Stage 2 HIE meaningful use standards. Benchmark met: YES.</p> <p>Contractor ensures that appropriate Contractor representatives participate in the OHA statewide HIE development process and help establish HIE Benchmarks. Benchmark met: YES.</p>

**5. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.**

Action Taken or Being Taken to Achieve Milestones or Benchmarks		Outcome to Date	Process Improvements
1.	Meaningful use status	<p>Five clinics that are part of hospital systems within the CPCCO service area have achieved Stage 1 meaningful use, and CCO clinical staff are currently in process of assessing and assisting with quality improvements in an additional clinic to advance meaningful use status.</p> <p>CPCCO clinical staff have initiated work with a consultant to optimize the EHR, including</p>	

		advancing meaningful use status for all OCHIN affiliated clinics in the CCO's service area.	
2.	Participation in HIE	<p>CPCCO has dedicated a medical director and a QI staff person to attend the OHA HITAG group.</p> <p>CPCCO's HIE profile has been completed and includes areas for future focus for HIE.</p>	Through participation in these groups, and through knowledge of HIE from CareOregon affiliated CCOs, CPCCO has a better analysis of gaps and opportunities for HIE improvements than existed before.

5. b) Please note whether benchmark(s) were met with a "yes" or "no" for each benchmark.

See above.

5. c) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

The biggest barrier continue to be interoperability and shared share planning between the medical, behavioral, and now dental and APD records.

5. d) Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

CPCCO will be purchasing Pre-Manage and is implementing it for all primary and behavioral health clinics with over 500 assigned members. CPCCO is also currently investigating including APD case management staff in Pre-Manage for shared care planning of complex patients who span both systems.

CPCCO clinical leadership continues to work with the state in obtaining technical consultation and support to optimize the use of electronic health records for integrated care management.

5. e) How was the Community Advisory Council involved in the activities for this transformation area?

N/A

5. f) How was the CAC informed of the outcomes for activities in this transformation area? N/A

**Transformation Area 6: Communications, Outreach and Member Engagement**

Benchmark 6	
How Benchmark will be measured (Baseline to July 1, 2015)	Number and quality of Member communications and services that meet documented standards for translation, interpretation and health literacy.
Milestone to be achieved as of July 1, 2014	Contractor develops a Community-specific definition of, and standards for, cultural competence. Benchmark met: YES. Contractor creates a cultural competence policy and registry of vital documents for meeting cultural competence standards. Benchmark met: YES. Contractor defines appropriate Benchmarks for Community-specific improvements throughout its Service Area. Benchmark met: YES.
Benchmark to be achieved as of July 1, 2015	Contractor implements cultural competence policy and in process with Community-specific improvement Benchmarks. Benchmark met: YES. Contractor populates the Member materials registry and ensures that 80% of vital documents are translated into predominant languages or meet “Plain English” standards. Benchmark met: YES.

**6. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.**

Action Taken or Being Taken to Achieve Milestones or Benchmarks		Outcome to Date	Process Improvements
1.	Cultural competence policy and community-specific improvement benchmarks.	The CPCCO Cultural Competence policy has been in place since June 2014. The policy is in the implementation process across the departments of CPCCO plan operations.  Community representatives of Native American and Hispanic communities have been engaged in the process of assessing the need for improving access, and interpretation/translation services for	The Clatsop Nehalem Confederated Tribes, the Lower Columbia Hispanic Council and Northwest Regional Education Service District (and other community safety net providers) have been approached by CPCCO staff and will continue to be consulted to assess the ways that CPCCO service providers could improve access and culturally responsive

		<p>CPCCO members.</p> <p>Technical supports will be provided to CPCCO contracted providers, as appropriate, to assist with improvement and to sustain processes that improve access, interpretation and translation for CPCCO members which are culturally responsive and support the communities definition of, and standards for, cultural competence. Finally, the CCO communities and Community Advisory Councils will identify projects to financially sponsor and/or implement that support the improvement of health outcomes for CPCCO members.</p>	<p>health services to people who self-identify as Hispanic.</p>
2.	Member materials registry and Plain English documents.	The vital documents and member handbook currently meet Plain Language standards.	As vital documents are reviewed by Plan Operations, they are being posted to the CPCCO website to increase access to members.

6. b) Please note whether benchmark(s) were met with a “yes” or “no” for each benchmark.

See above.

6. c) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

Columbia Pacific CCO operates in a rural region with relatively small and insular minority communities. As such, it can be difficult to successfully engage the Hispanic community. There is a high level of relationship-building which must take place before going forward with any community activities. Because the Hispanic community is small, it is also challenging to ensure participation from a wide range of voices instead of letting the most accessible and integrated members speak for the community as a whole.

6. d) Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

Relationships have been developed with community representatives of the local Native American and Hispanic communities (see above). These representatives have been involved in the process of assessing the need for improving access, and interpretation/translation services for CPCCO members. These organizations will continue to be consulted to assess the ways that CPCCO service providers could improve access and culturally responsive health services to people who self-identify as Native American and Hispanic.

6. e) How was the Community Advisory Council involved in the activities for this transformation area?

CPCCO Community Advisory Councils reviewed and advised on how current CPCCO cultural competence policies and procedures could better support communication, outreach and member engagement. Community Advisory Councils also sponsored educational opportunities for each CCO community to learn about improving health and changing behaviors.

6. f) How was the CAC informed of the outcomes for activities in this transformation area?

The policies were presented to the CAC for feedback and improvement. The CACs also identify projects to financially sponsor and/or implement that support the improvement of health outcomes for CPCCO members.

**Transformation Area 7: Meeting the culturally diverse needs of Members**

Benchmark 7	
How Benchmark will be measured (Baseline to July 1, 2015)	Reduction in cost of care for Members served by non-traditional health workers.
Milestone to be achieved as of July 1, 2014	Contractor identifies group of high frequency users of the ED, acute and other high cost services that could be diverted to PCPs through non-traditional workers or other outreach strategies. Benchmark met: YES. Contractor completes a written plan to improve delivery of culturally competent care by Participating Providers. Benchmark met: NO. Contractor identifies clinic-specific opportunities and pilots using navigators, peer support, community care teams or other non-traditional health workers. Benchmark met: YES.
Benchmark to be achieved as of July 1, 2015	Contractor attains a 5% reduction in the per member per month cost of care for identified high-cost, high-utilizer Members compared to the Baseline for identified high-cost, high-utilizer Members who were not assisted by non-traditional health workers. Baseline and method of calculation to be mutually agreed by the parties. Benchmark met: Unknown.  Contractor Quality Improvement (QI) plan includes specific targets and strategies for cultural competence, diversity and health literacy trainings, clinical practices and workplace norms. Benchmark met: NO.

**7. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.**

Action Taken or Being Taken to Achieve Milestones or Benchmarks		Outcome to Date	Process Improvements
1.	Integrate Health Resilience Specialists (aka community health workers) into primary	Hired staff for the two largest primary care clinics in Columbia County. Each is expected to carry a caseload of 25 members at any given time, with a	Meeting with clinic partners to optimize case-finding and working with CPCCO Medical Director to manage barriers.

	care clinics.	total of approximately 60 reached in any year. Currently, one specialist has 18 unique clients engaged and 13 clients in outreach or referred status. The other has 5 clients engaged and 20 in outreach or referred status.	Building community partnerships.
2.	Build cultural competence infrastructure with a specific focus on health literacy.	All new health resilience staff attend trainings on health literacy. Trainings taken include: diabetes education, motivational interviewing, seeking safety, respiratory therapy.	Additional trainings in hypertension, addiction treatment in primary care, working with refugee populations, advanced motivational interviewing, and vicarious trauma are scheduled.
3.	Develop clinic-specific data on high risk patients.	In process is the development of data sets on high risk members, including related to high utilization, chronic opiate use, and chronic mental illness to allow each clinic to know who their most vulnerable patients are and develop specific interventions to meet their needs.	Scrubbing and aggregating data at the clinic level using various filters of medical risk.

7. b) Please note whether benchmark(s) were met with a “yes” or “no” for each benchmark.

See above. The program to deploy community health workers, called Health Resilience Specialists (HRS), has been hiring FTE and beginning the process of building caseloads to make impact. Due to the relatively recent hiring of the staff, it is unclear if the benchmark has been met. The cohort is too small at this point to demonstrate reduction in utilization.

7. c) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

Barriers have existed with regard to the deployment of the health resilience program included integrating them into clinical teams and workflows. A best practice for an HRS is to meet with clinic leadership once a week to discuss progress, make appropriate adjustments and build momentum of the program; this has been difficult for CPCCO clinics. Additional barriers included direct access to the community mental health clinics.

For health literacy and cultural competence work, the biggest barriers have been getting the attention of clinic leadership, given major competing priorities of meeting PCPCH certification, meaningful use, FQHC/RHC and CCO metrics, as well as surviving an 80% increase in membership as a result of the ACA expansion. Simply providing adequate access to timely appointments in primary care has been a significant

challenge. The clinics have demonstrated a high level of basic infrastructure support needs which impeded the processes needed to reduce per member per month costs and increase population health.

In Fall of 2015, the need for and importance of cultural competence and health literacy trainings will be reviewed at both the CAP and the CACs in order to inform the best way to incorporate this into patient care and the workplace.

7. d) Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

The Health Resilience Program Supervisor has offered flexibility and additional CPCCO medical leadership to bridge the current clinic leadership and staffing challenges. The current plan is to look for additional leadership within the clinic to meet the long term program needs.

The introduction of the health resilience program and clinic-specific member data will help bring focus on the high risk patient populations. The CPCCO Innovator Agent has also been involved, to help communicate the history of the area and how best to navigate with multiple players.

7. e) How was the Community Advisory Council involved in the activities for this transformation area?

HRS leaders met with the manager of the CPCCO CACs who provided many contacts for community involvement, to build relationships and referral streams. These included SAFE, Public Health, Columbia Community Mental Health, and the Community Action Team.

7. f) How was the CAC informed of the outcomes for activities in this transformation area?

The CAC Manager has continued to be informed as outreach was taking place and partnerships being built. CACs have been informed of the work related to community health workers and have been asked to provide insights into community specific barriers to care that can result in outcomes disparities.

**Transformation Area 8: Eliminating racial, ethnic and linguistic disparities**

Benchmark 8	
How Benchmark will be measured (Baseline to July 1, 2015)	Comprehensive QI plan developed with specific thresholds for reductions in disparities for: access to preventive care and screenings, childhood immunization rates, overweight and obesity, tobacco use, preventable hospital admissions or re- admissions, and mental health and addictions screenings and treatment.
Milestone to be achieved as of July 1, 2014	Contractor completes a written QI plan by May 30, 2014. Benchmark met: YES.
Benchmark to be achieved as of July 1, 2015	Contractor develops QI plan, collects data and implements strategies to address two priority areas of improvement for disparities reductions throughout its service area. Benchmark met: NO.

**8. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.**

Action Taken or Being Taken to Achieve Milestones or Benchmarks		Outcome to Date	Process Improvements
1.	Develop QI Plan	2014 and 2015 QI plans have been developed. The focus of the prior QI plans has largely been on care management, utilization management, appeals and grievances, and QI committee structure.  CPCCO achieved 105% and 104% performance payment dollars in 2014 and 215, respectively, based on achievement of over 13 of the 17 annual incentive measures.	The largely health plan focus of the QI Plans was determined inadequate to meet the major infrastructure challenges in CPCCO’s primary care clinics. This resulted in a major restructure of CareOregon and CPCCO staff to allow more dedicated technical assistance, medical direction, operational supports and practice coaching for the clinics.
2.	Evaluate data through a health equity lens.	Data elements are being determined.	

8. b) Please note whether benchmark(s) were met with a “yes” or “no” for each benchmark.

See above. See also responses to Area 7, related to health literacy as a major factor in health disparities reduction.

8. c) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

The biggest barrier in this area has been the need to shift from a health plan-driven QI focus to a clinic-driven QI focus. Working with clinics on achievement of access and incentive measures showed the inadequacy of the milestones set up for this original Transformation Plan. The 2016 and 2017 QI Plans will reflect the necessary focus on reducing health disparities and improving health literacy for the most at-risk members of CPCCO.

Another significant barrier has been the ability to obtain race and ethnicity data from the state at a more detailed level than county-wide reports. The ability to obtain such data from the state at a zip code level will allow more targeted strategies, in particular focused on prenatal timeliness and colorectal cancer screening for Hispanic populations. The Innovator Agent tried repeatedly but unsuccessfully to assist CPCCO in obtaining such data.

8. d) Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

CPCCO did not have a dedicated medical director until April 2015; this resulted in less of an integrated and clinic-facing QI program and interventions until very late in this Transformation Plan. With the full-time medical director, the subsequent QI Plans and strategies will be much more relevant to the specific patient populations in CPCCO. The other major strategies deployed to date have been to place health resilience workers in two pilot clinics to develop on-the-ground programs focused on health equity, and to develop clinic-specific lists of at-risk populations. CPCCO staff also oversampled the Hispanic population in the community needs assessment process, to assure that specific concerns would be included in the Community Health Improvement Plan.

8. e) How was the Community Advisory Council involved in the activities for this transformation area?

The CACs were not involved in these activities.

8. f) How was the CAC informed of the outcomes for activities in this transformation area?

The CACs have been kept informed of clinical initiatives and pilot projects.