

**Transformation Plan Initial Progress Report Template
Columbia Pacific CCO**

This form is a template for the Transformation Plan Milestone Report requirement. Use of this form is not required, but the elements outlined below do represent the required elements for reporting for each Transformation Area. You are welcome to use your Innovator Agent to assist you in the completion of this report. Your Innovator Agent can also supply you with a version of this template that includes your individual CCO’s Transformation Plan benchmarks and milestones copied within each corresponding section below.

Please send your completed Transformation Plan Milestone Report to the CCO Contract Administrator, David Fisher (DAVID.H.FISCHER@dhsosha.state.or.us) by no later than 5:00 pm on July 1, 2014.

Transformation Area 1: Integration of Care

Benchmark 1	
How Benchmark will be measured (Baseline to July 1, 2015)	<ol style="list-style-type: none"> 1) Utilization rate of alternative pain management interventions. 2) Appropriate opioid prescribing practices based on the model developed by the Clinical Advisory Panel. 3) Rates of prenatal screening for clinical depression and alcohol and drug addictions “Screening, Brief Intervention and Referral to Treatment (SBIRT)”,
Milestone(s) to be achieved as of July 1, 2014	<ol style="list-style-type: none"> 1) 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. 2) Contractor develops an alternative pain management model for piloting in at least one clinic in its Service Area. 3) Initiate partnerships with social services and school-based providers to provide addictions screening and intervention for adolescents.
Benchmark to be achieved as of July 1, 2015	Contractor attains a reduction in number of opioids prescribed for

	<p>Members using standardized benchmarks and improvement targets or, if unavailable, reduction specifications mutually agreed upon by the parties. Contractor attains improvement in Member depression and SBIRT screenings and referral for services reflected in the established CCO benchmarks and improvement targets..</p> <p>Contractor achieves increases in integrated care management services provided to the Members with SPMI as described in (1) above.</p>
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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.	<p>Form Clinical Advisory Panel to evaluate current and new integration models for spread to at least three clinics in the CCO in 2014.</p>	<p>CAP formed. Missouri bi-directional medical home model reviewed for adoption at one CMHP in the CCO service area.</p> <p>Behaviorist placed at Tillamook Family Health Center early in 2013 and patients/workflow completely integrated. Placed behaviorist at Dunes Family Medicine and Reedsport Medical Group in late November. Behavioral Health Specialist currently working in Vernonia will move into the new Vernonia Family Health Center when construction is complete this fall. Planning to create a fully integrated model has begun.</p> <p>Working on placement of behaviorist at Rinehart Clinic.</p> <p>Have started discussions about placing an Addictions</p>	<p>Joint meetings of the CAP and CCO Finance Committee are occurring on a regular basis to share learnings and potential strategies for adoption of new care models and alternative financing.</p> <p>Elimination of barriers to access, and opportunity for brief interventions vs. longer individual therapy visits. At co-location sites, the behaviorists are able to input their clinical information into a shared care plan on the clinic's EHR.</p> <p>Scappoose currently has a mental health provider and 2 psych residents; the addition of an addictions specialist</p>

		specialist at Scappoose Clinic and a Behavioral Health specialist at the Legacy Primary Care Clinic in St. Helens.	will improve access to screening and treatment of substance use disorders.
2.	Develop alternative pain management model	<p>The CCO CAP approved adopting a slightly modified and enhanced version of the Southern Oregon Opiate prescribing protocol and Multnomah County Health Department prescribing contraindications list for the pilot site.</p> <p>The contract between Clatsop Behavioral Health and Mid-Valley Behavioral Health was signed to replicate Salem’s successful pain clinic in Astoria. This pain clinic will support primary care providers across the county, including FQHC and system (Providence) as well as independent practitioners.</p> <p>The North Coast Pain Clinic opened for services in early June with 30 referrals in the first two weeks of operation. In addition, GOBHI has initiated pain patient management consulting for CCO clinics outside the Astoria area, to help bridge until those communities also have pain clinic resources similar to those currently in Astoria.</p>	The pain clinic will provide access for chronic pain management to all residents of Columbia and Tillamook counties, in addition to the Clatsop pilot location.
3.	Initiate partnerships with social services and school-based providers to focus on screening and intervention for adolescents. Screenings would be for both addictions and mental health services.	Provided technical, staffing and financial support for the county Public Health department to open a new SBHC in Columbia County, along with re-opening and integration with a primary care clinic in rural Vernonia. This provides new capacity in an isolated rural community with a resident catchment area of ~ 4,000 people. Both the school-based clinic and primary care	The grant funding for adolescent suicide prevention represents a new partnership between the CCO, the regional ESD and the community mental health provider in Columbia County.

		<p>site have addictions staff and mental health providers on site.</p> <p>SBHC and Primary Care Clinic (Vernonia Family Health Center) are open. Capital campaign for new health center facility successfully completed with CCO support. Construction expected to be completed Fall 2014.</p> <p>New clinics increased capacity for kids and adults (over 100 patients/week).</p> <p>The CCO provided grant support for ASIST and RESPONSE suicide prevention and intervention training for all elementary, middle and high schools in Columbia County.</p>	<p>SBHCs in Rainier and Vernonia have augmented capabilities to serve as medical homes, allowing the CCO to assign members to their PCPs. This will have long-term implications for improving access to primary care services in these communities.</p>
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2 a.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

Barriers include current provider shortages in both primary and behavioral care, causing restrictions in access to care for low-income adults and delays in placing behaviorists in primary care clinics. This barrier was exacerbated by the ~70% increase in OHP enrollment since January 1st as a result of ACA expansion. In addition, current OARs that govern documentation requirements for mental health and addictions services, as well as federal HIPAA and PHI restrictions, continue to be barriers to integrated care plans for members. The final barrier is the current limited state definition of SPMI; the ability to include functional impairment, and chronic depression, as accepted diagnoses in addition to diagnoses of bipolar disorder and schizophrenia, would allow a much larger population to qualify as SPMI for integrated care planning.

2 b.) 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.

Representatives from the CCO partner organization, Greater Oregon Behavioral Health Inc. (GOBHI), are participating in the state’s task force regarding changing the OAR documentation requirements. Both CCO partner organizations, CareOregon and GOBHI, are assisting with provider

recruitment and retention efforts, including offering financial incentives for new providers and seeking affiliations with provider training programs. CCO staff are also facilitating and providing consultation to both primary care and behavioral health leadership across the CCO service area to help bridge communication and practice differences. GOBHI staff are helping support behavioral health billing for appropriate services provided in a primary care setting. In addition, the CCO provided billing consultation to the Vernonia health center to support its entrance into FFS billing processes.

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

The CCO's four local Community Advisory Councils have not been directly involved in these integration efforts. Addictions and mental health services, including crisis and suicide prevention, are two of the three top priorities for community health improvements in all four of the CCO's counties. The CCO's grant program, called the Community Wellness Investment Fund, has also provided a focus for conversations at CAC levels regarding alternative models and sites of care for members.

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

Both CAP and Board members attend CAC meetings to assure alignment and cohesive efforts across the CCO. Joint meetings of the Regional CAC and Board of Directors (BOD) have occurred twice and are now scheduled for routing re-occurrence.

2e.) How was the CAP involved in the activities for this transformation area / how was the CAP informed of the outcomes for the activities in this transformation area?

The CCO's Clinical Advisory Panel has been involved in recommending strategies to better integrate care, as well as putting in place the CAP recommendations for systemic improvements in chronic pain and opiate prescribing. The CAP includes broad representation of provider types in the CCO, including behaviorists, physicians, nurses/nurse practitioner, a dentist, and pharmacists, thereby allowing disparate perspectives and new solution sets to emerge to better manage the care and outcomes for CCO members. While the CAP created the opportunity for these providers to come together, the relationships are now being managed independently of the CAP or the CCO.

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. 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 to be achieved as of July 1, 2015	Contractor ensures that 70% of Members are enrolled with PCPCH Tier 3 clinics.

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.

Action Taken or Being Taken to Achieve Milestones or Benchmarks		Outcome to Date	Process Improvements
1.	Launch Primary Care Medical Home collaborative (Patient and Population Centered Primary Care) with seven largest clinics in CCO.	Collaborative launched March 2013. Completed six learning sessions and between-meeting follow up with all clinics. Topics covered include: leadership, data for improvement, team based care, access, and population management. Participating clinics improved preventative measures, implemented proactive identification of patient needs (“scrubbing”), standardized rooming procedures, etc. The CCO has begun planning for a Year 2 collaborative.	Integrating coaching on specific incentive metrics education and best practice sharing with involved clinics. Planning for Year 2 will integrate the collaborative into the CAP and focus on operationalizing transformation activities.
2.	Train primary care improvement coach(s) to provide additional resource to support CCO clinics.	Completed training for coach (Practice Coaching for Primary Care Transformation by UCSF Center for Excellence in Primary Care and CareOregon), deployed	Tested using embedded practice coaches within a clinic to serve multiple sites, and learned that it was too

		with one CCO clinic as a pilot. Provided additional training to one embedded practice coach at a large CCO clinic.	challenging to carve out time. Current CCO infrastructure requires external resources for practice coaching and support for emergent leaders embedded within clinics.
3.	Meet with key PCPCH practices to review CCO definition(s) of “high risk”/”super user” members and identify drivers.	Meetings occurred with six of the CCO’s eight largest clinics to share data on each clinic’s high risk patients. See Element 7, item 1.	

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

Resourcing and building the practice coach capacity within the local community has been challenging. We identified key staff in partner clinics to take on the role of practice coach for other clinics in the collaborative but found that having them free up time to participate with other practices was challenging.

2 b.) 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.

Focusing on deploying CCO based resources across clinics and more robustly. Provide additional coaching for emergent leaders within each practice to support their work within their clinic.

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

N/A

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

N/A

2 e.) How was the CAP involved in the activities for this transformation area / how was the CAP informed of the outcomes for the activities in this transformation area?

Updates on the collaborative and a decision to continue the collaborative for an additional year have been brought to the CAP. In 2014, a clinical champion from the CAP will be identified to be a resource for CCO staff in the development of content and direction of the collaborative.

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	1) Contractor integrates capitation payments for mental health and addictions treatment with all relevant Providers. 2) Contractor selects at least one primary care clinic for an Alternative Payment Methodology.
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. 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.

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.

Action Taken or Being Taken to Achieve Milestones or Benchmarks		Outcome to Date	Process Improvements
1.	Integrate capitation payments for mental health and addictions treatment.	CareOregon and GOBHI completed the transition of capitation and management of A&D services to GOBHI effective July 2013. This allowed GOBHI to sub-capitate their CMHPs to provide both mental health and addictions services.	This transition coincided with CareOregon assuming responsibility for processing GOBHI claims from PHTech, which allows better integration and reporting of data for behavioral and medical services.
2.	a) Explore possibility of alternative payment methodology with the Oregon Primary Care Association (OPCA) with FQHCs in the service area.	Two FQHCs in the service area are selected for Phase 2 of the FQHC Alternative Payment Methodology. Both are scheduled for implementation of a new primary care capitation APM for CCO payments by late Fall, 2014.	Providing support to identified FQHCs on data and other prerequisites to implementing an APM model

	<p>b) Develop PCP incentive payment program and start implementation. Incentive program focuses on choosing key measures for the clinic, getting data out of the clinical record, and finding ways to improve on selected measures.</p>	<p>Model was introduced at the joint CAP/Finance committee meeting and approved by the CCO BOD in June. Incentive measures payment forthcoming from OHA will be allocated to all PCPCH-recognized clinics in the CCO starting Summer, 2014.</p>	<p>Continue to follow committee structure to refine model to be specific to priorities of the CCO. Refining the contracting and reporting structure connected to the incentive payment model.</p>
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2 a.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

Bridging the conversation between the CAP and the finance committee (model of care and payment) continues to be challenging. Both need to be able to weigh in on the direction and decisions but they had separate meetings and structure. With APMs for the OHP population only, there is insufficient scale to incent many clinics to adopt an alternative to fee-for-service payment, as it requires clinics to manage two payment, reconciliation and reporting systems simultaneously.

2 b.) 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.

Implemented joint Finance Committee and CAP meetings every four months to discuss relevant related topics.

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

N/A

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

N/A

2e.) How was the CAP involved in the activities for this transformation area / how was the CAP informed of the outcomes for the activities in this transformation area?

The CCO CAP is involved through the joint finance committee/CAP meetings that discuss issues related to payment and model(s) of care.

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 to be achieved as of July 1, 2015	Contractor engaged in the process of implementing CHIP priority strategies throughout its Service Area.

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.

Action Taken or Being Taken to Achieve Milestones or Benchmarks		Outcome to Date	Process Improvements
1.	Form local and regional CAC governance groups.	<p>Four Local-CACs and one Regional-CAC fully formed with agreed upon Charter and Governance policies.</p> <p>All five advisory councils completed identification of health priorities and potential community actions that the advisory councils will champion for each county (Reedsport only for Douglas County).</p> <p>Identified priority health recommendations were moved forward to the Regional Advisory Council at the end of January 2014.</p>	<p>Developed local council membership grid/matrix of roles to track accuracy of representation from the community including the geographic area the advisory council member represents.</p> <p>Developed partnership/collaborative relationships with local health departments, behavioral health providers and hospitals to assess CCO service area for health</p>

			needs.
2.	Draft meta-analysis of existing needs assessments	Information has been gathered on all existing Needs Assessments, Community Vitality reports, Community Benefit Reports from local hospitals, Local Behavioral Health Providers Biennial Implementation Plans (BIP), Parks and Recreation needs assessments and Public Health Departments CHA/CHIP for the CCO service areas.	Created matrices of health improvement background information by data source, health issue and a data table that shows the correlation between the CAP, Transformation Plan and State goals for identifying data that helped the CACs to make decisions regarding creating the CHIP.
3.	Schedule joint and public Board and CAC(s) meetings to prioritize gaps and opportunities identified in meta-analysis	All local CACs in the CCO service areas have held public events to present information regarding the community needs assessments and identified health priorities. Joint meetings of the R-CAC and BOD were held in February and June, 2014. The Regional CHIP was approved at the June Board meeting.	Developed contacts at the local level with community government, local community service providers and media. Developed process to advertise community events to get community input on health priorities.
4.	Prioritize community health needs with a health equity framework and identify at least three areas for strategy development.	Each local CAC has heard information about local health data compared to state and national health data. Each local CAC has identified three health priority areas they would like to champion in their county. CHA completed for each county/area and regional CHIP completed that identified three health priorities and goals, objectives and best practices to address the	Developed health data grids that identify health issue background information by health, data source and a data table that summarizes CCO health data. Utilized Rating Key Health Issue Using Criteria Worksheet for CAC

		priorities.	members to process and identify health priority issues. Local CHA and Regional CHIP outline and data collection defined.
5.	Convene focus groups, stakeholder meetings and other data-gathering and community conversations in order to finalize prioritized community health needs.	<p>Seven community meetings have been held where local community members were invited to hear information about the CCO needs assessment and potential health priority areas. Feedback was solicited and documented from community members regarding their opinions of the health and health care needs in their counties.</p> <p>A six question survey to gather information about the community's perception of health was given regionally.</p> <p>A survey using narrative methodology was conducted in Spring 2014.</p>	<p>Data analyst developed power point presentations of baseline health data for each of the local advisory councils.</p> <p>Data related to the OHA incentive metrics was gathered.</p> <p>1200 community members responded to paper and electronic surveys across the region.</p> <p>Created survey action plans that documented community resources for placement of surveys.</p> <p>Developed contacts in the communities (health care providers, probation and parole, Public Health departments, libraries, small businesses and schools) to promote the community survey.</p> <p>300 community members</p>

			responded to the narrative survey. This process oversampled the Hispanic community and will be used to begin the process of having a better understanding of the health care needs and perceptions of health of the Hispanic community.
6.	<p>Complete a comprehensive CCO-wide community health improvement plan.</p> <p>Create a plan for collecting primary data in 2014. This will be developed in close partnership with county Public Health, OEI, and/or other stakeholders already conducting required community assessments.</p>	<p>Public Health and epidemiological data was reviewed and gathered by a data analyst. This data was presented to all the local advisory councils. The public was invited to these presentations.</p> <p>Primary data was collected via survey in 2013. An additional plan to create primary narrative and other data was completed in May 2014.</p> <p>The Community Health Improvement Plan is completed and approved by the CPCCO Board of Directors. It was submitted to OHA on June 30th.</p>	Community development of the CHIP using specific group decision making processes were identified and implemented.

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

It continues to be difficult to bring local representatives to the advisory council table who meet the criteria for OHP (family member, self or have been on OHP in the recent past). In the more rural areas key players in community services are often already serving on multiple boards or community groups creating a challenge when recruiting new members to the CAC that are not already committed to other volunteer activities.

There continue to be challenges around getting information to CAC members who do not have social services or health care provider backgrounds that helps the CAC members make informed decisions regarding health priority recommendations. For now, the “lived experience” of health care takes a back seat to health data and community survey results. There is work to be done to bring OHP representatives to the table and to make sure they are empowered to feel comfortable with overseeing the needs assessment and health improvement plan process.

We had difficulty completing our goal of connecting with the Office of Equity and Inclusion to get data that identifies health disparities related to race and ethnicity by zip code in our service region.

The work of the CHA for four counties/areas and creating/writing a CHIP made it difficult to complete the goals of recruiting more OHP representatives at our local CAC's.

2 b.) 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 CCO's CAC Coordinator attended the state-sponsored CAC summit. CAC members who attended the summit felt that it was incredibly helpful and were better able to understand the importance of getting the perspective of CPCCO members when planning activities and making decisions about improving the health of the community.

Worked with and trained Promotoras to assist with survey collection of the Hispanic community.

Created a matrix of roles/grid that helps to identify where the local councils might recruit new members.

Membership status and goals are discussed as part of each advisory council's agenda.

Created survey improvement and planning document for 2014.

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

The Advisory Councils participated in the process of selecting the three regional health priorities, identifying high level goals and setting objectives/indicators for each that goal. The Advisory Councils identified potential community partners to complete goals of the health priorities.

The Advisory Councils have been included in all aspects of this work, including participating in the process of gathering data and community information regarding health issues and health care perceptions. Council members assisted with conducting the community survey. Council members assisted with attending community meetings. Council members were given information summaries regarding the health care issues in their county and, through a facilitated discussion, made recommendations regarding health priorities to address in their county.

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

The regional CAC attending the June board meeting where the CHIP was approved by the Board of Directors.

The local CAC(s) are given updates at their monthly meetings including opportunities to give feedback regarding the needs assessment and health improvement plan process.

2e.) How was the CAP involved in the activities for this transformation area / how was the CAP informed of the outcomes for the activities in this transformation area?

The incentive metrics that the CAP is working to improve/meet were reviewed by the CACs. The CAP incentive metric, SBIRT, was incorporated into the CHIP.

The CAC Coordinator attends the CAP meetings and gives information as requested to CAC members regarding the work of the CAP. A CAP representative attended CAC meetings in three of the counties to give information regarding what the CAP is working on and to ask advice regarding increasing community awareness of CAP incentive metrics.

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	<ol style="list-style-type: none"> 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. 2) Contractor defines Baseline percentage of primary care clinics sharing any portion of the medical record with other Providers
Benchmark to be achieved as of July 1, 2015	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. Contractor ensures that appropriate Contractor representatives participate in the OHA statewide HIE development process and help establish HIE Benchmarks.

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.

Action Taken or Being Taken to Achieve Milestones or Benchmarks		Outcome to Date	Process Improvements
1.	Survey key practices to identify current EHR and meaningful use stage.	Surveys sent and compiled for major primary care practices in the CPCCO. Over 60% of CPCCO members are assigned to a clinic with OCHIN EPIC EHR and an additional 19% are assigned to clinics with EPIC EHRs. OCHIN plans to be able to implement MU 2 standards in late 2014. CPCCO will work with OCHIN clinics to successfully move from MU 1 to MU 2 by the end of 2015. The CCO is also engaging with OHA to utilize their technical assistance offer to help specifically with MU adoption.	Over 75% of members are assigned to clinics at Meaningful Use 1.

2.	Survey clinics with EPIC EHRs (both OCHIN and non OCHIN clinics) to identify current use/adoption of Care Everywhere, and any additional HIE programs.	<p>Survey in progress. Based on the results of this survey CPCCO will implement appropriate interventions/ training opportunities to improve use of current HIE technology within CPCCO.</p> <p>OHA (HITAG) staff met with the CCO Clinical Advisory Panel in June to discuss survey results and discuss clinic priorities for advancing HIE using state-supported Technical Assistance staff.</p>	
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2 a.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

Integration of EHR data from CPCCO’s mental health practices will be a challenge as many are on different platforms. CPCCO is looking to the state HIE development process for strategies at the state level for HIE development.

Regional HIE development for clinics without access to CareEverywhere or CareElsewhere, specifically for smaller private practices with low CCO membership, poses challenges due to limited staff and financial resources.

2 b.) 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 looking to the state HIE TA process for strategies specific to use of direct secure messaging and electronic notifications. CPCCO staff will continue to seek the state’s leadership for integration of mental health and physical health clinical records. CPCCO currently has representation on the OHA 1.5 technical workgroup, HITAG.

CPCCO is engaging with OCHIN (as major provider of EMR in the network) to address:

- Claims (physical as well as mental health) and clinical data merging for reporting and analytics
- Use of OCHIN reporting for clinical CCO incentive metrics

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

N/A

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

N/A

2e.) How was the CAP involved in the activities for this transformation area / how was the CAP informed of the outcomes for the activities in this transformation area?

Discussions have occurred at the CAP for identification of current EHR systems in use within the CCO and the current barriers for information sharing.

Shared CPCCO's Year 1 Technology Plan with the CAP.

Participating in OHA technical assistance needs survey.

Discussed clinic priorities for health information sharing at June CAP meeting.

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	<ol style="list-style-type: none"> 1) Contractor develops a Community-specific definition of, and standards for, cultural competence. 2) Contractor creates a cultural competence policy and registry of vital documents for meeting cultural competence standards. 3) Contractor defines appropriate Benchmarks for Community-specific improvements throughout its Service Area.
Benchmark to be achieved as of July 1, 2015	<p>Contractor implements cultural competence policy and in process with Community-specific improvement Benchmarks.</p> <p>Contractor populates the Member materials registry and ensures that 80% of vital documents are translated into predominant languages or meet “Plain English” standards.</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.

Action Taken or Being Taken to Achieve Milestones or Benchmarks		Outcome to Date	Process Improvements
1.	Contractor develops a Community-specific definition of, and standards for, cultural competence.	<p>Care Oregon has sponsored a health needs/disparities project via a consulting vendor, Cognitive Edge, which is being piloted in CPCCO.</p> <p>CPCCO used a narrative methodology to identify the community definition of, and standards for, cultural competence. This process will be accomplished by using Cognitive Edge SenseMaker™ software.</p>	

		<p>The initial phase of narrative data collection has been completed with 300 unique responses from the CPCCO service area. The Latino/Hispanic community was successfully over-sampled (12.3% of stories vs. 6.4% of population).</p> <p>The results are being analyzed with special attention to responses from the Latino/Hispanic community to develop the community definitions of cultural competence.</p> <p>Community definitions of cultural competence will be included in CPCCO cultural competence policies.</p>	
2.	Contractor creates a cultural competence policy and registry of vital documents for meeting cultural competence standards	<p>Policies and procedures have been created and updated regarding cultural competence, language access, and translation services that are available to all CPCCO members.</p> <p>Vital member documents have been identified and are being translated, posted on the CCO website and assessed for other changes based on cultural competence determinations from the narrative process described in 3, below.</p>	<p>CPCCO member handbook meets Plain English criteria and is available in both Spanish and English (with translation to other languages available on request) in paper form and electronically on the CPCCO website.</p> <p>CPCCO website allows all web content to be translated via Google Translators.</p> <p>Columbia Pacific CCO providers and members are able to access Passport to Languages for telephonic interpretative services.</p>

3.	Contractor defines appropriate Benchmarks for community-specific improvements throughout its Service Area.	<p>CPCCO will use Cognitive Edge to identify benchmarks that will be used to measure community specific improvements.</p> <p>The final report from Cognitive Edge has been completed. CPCCO staff are currently reviewing the report to complete work on community-specific benchmarks. These will be shared with the CCO's four local CACs to determine final benchmarks and strategies for improvement as part of the CCO CHIP.</p> <p>The CCO is investigating forming a workgroup to guide on-going strategies for health disparities reduction.</p>	
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2 a.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

The majority ethnic group for the general population in the Columbia Pacific CCO service area is Caucasian with Hispanic a distant second. The primary challenge for the CPCCO service area is to educate the community regarding the importance of cultural competence and understanding diversity as it relates to health and the socio-economic indicators of health. The secondary challenge is in building authentic, trusting relationships with members of the Hispanic community, working with natural leaders to ensure that any policies developed reflect the needs and experiences of the community that the cultural competence policy would most directly aim to impact.

2 b.) 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.

CCO staff have met with OEI representatives to better understand and apply OHA approaches and resources to address cultural competence for members and providers.

CPCCO is exploring a future project with poverty expert Donna Beegle. The goal is for Donna to provide poverty training (including the relationship of race and culture regarding health and the socio-economic indicators of health). These trainings would be given to the advisory councils and communities that the CCO serves. One strategy is to use Beegle's Poverty Institute to provide a hands-on two-day training for

educators, health, justice, social service professionals, and community members who want to better understand poverty and to gain tools for bridging individuals out of poverty.

Through the narrative health needs/disparities project, CPCCO partnered with Catholic Charities' *Promotores de Salud* from the metro area to collect stories at events targeting the Hispanic community. CPCCO also developed relationships with local groups representing the Hispanic community, including the Lower Columbia Hispanic Council. CPCCO participated in the Council's Cinco de Mayo celebration.

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

Advisory Council members were invited to be part of the narrative collection process including being trained to use the Cognitive Edge survey collection tool.

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

The Community Advisory Council was informed of the CCO's intent to use Cognitive Edge methods and was given an opportunity to give feedback regarding the use of the narrative methodology to gather information. The results and report of the Cognitive Edge survey will be disseminated to the CACs for feedback, particularly in how the conclusions drawn from the narratives relate to or resonate with CAC member experiences as community representatives.

2e.) How was the CAP involved in the activities for this transformation area / how was the CAP informed of the outcomes for the activities in this transformation area?

The CAP was not involved in the activities for this transformation area.

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	<ol style="list-style-type: none"> 1) 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. 2) Contractor completes a written plan to improve delivery of culturally competent care by Participating Providers. 3) Contractor identifies clinic-specific opportunities and pilots using navigators, peer support, community care teams or other non-traditional health workers.
Benchmark to be achieved as of July 1, 2015	<p>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.</p> <p>Contractor Quality Improvement (QI) plan includes specific targets and strategies for cultural competence, diversity and health literacy trainings, clinical practices and workplace norms.</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.

Action Taken or Being Taken to Achieve Milestones or Benchmarks		Outcome to Date	Process Improvements
1.	Develop baseline data to identify super-users and other high risk populations who could benefit from more primary care intervention or other outreach strategies.	<p>The CCO CAP adopted the Health Commons Grant CMMI definition of high utilizer (also called super-users).</p> <p>High risk patients in five categories have been identified</p>	High utilizer subgroup of the CAP formed to determine recommendations for implementation and monitor results.

		<p>for six of the eight largest clinics in the CCO (65% of total members). These categories include: CMMI defined high utilizers, 10% of members with 50% of expenses, member with pharmacy risk score > 10, members with chronic opiate use, members with chronic mental illness. Data shared with clinicians and strategies being developed to address priority risk groups by clinic.</p>	<p>Comprehensive SAS Business Intelligence data base developed to produce detailed demographic and utilization production reports on super-users.</p>
<p>2.</p>	<p>Develop a written plan to improve cultural competence of participating providers.</p>	<p>A clinic-specific cultural competence assessment tool has been developed consistent with CLAS.</p> <p>A written plan to improve provider competence has been completed, with milestones and accountable parties identified. Contacts are being made at each major CCO participating provider clinic site to determine the optimal assessment tool respondent, and set up appointments for completing the assessments.</p> <p>CPCCO clinics are being invited to participate in a Health Equity Learning Series developed by GOBHI in collaboration with Office of Equity and Inclusion. The sessions will include Language Access and Interpreter Certification.</p>	<p>A physician leader had been assigned to develop the clinic assessment and participating provider training plan. This leader serves as a practice coach for other primary care medical home capability building. This physician leader also participates in the CAP, so outreach and non-traditional workers, or other strategies to address super-users, can be coordinated with CPCCO's cultural competence policy.</p> <p>Systems and processes have been developed to closely coordinate this work with the work to develop a member definition of cultural competence.</p> <p>Closer linkages with another CCO</p>

			(EOCCO) have been formed to address health equity strategies and learnings across similar rural geographies in Oregon.
3.	Identify clinic-specific opportunities and pilots to help better manage care and outcomes for high risk patients.	At the June CAP meeting, a decision was made to reconvene the work group on high risk patients to identify optimal pilot site(s) for location of traditional, health resilience or outreach workers.	

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

Leadership, staff and provider buy-in and time has been the biggest challenge. CPCCO clinics are already stretched to meet PCPCH, Meaningful Use, FQHC, RHC and CCO metrics. Building out the time for assessing clinic competence is difficult.

An additional challenge that has just surfaced is the transition of the CCO’s physician to an out of state work opportunity, requiring the identification of a replacement and ongoing clinical leader to assist with this body of work. The CCO’s Transformation Specialist, who has background and experience with clinical practices, will serve in an interim bridging role as a new leader is found.

2 b.) 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.

CCO staff have met with OEI representatives to better understand and apply OHA approaches and resources to address cultural competence for participating providers. CCO staff have attended OEI trainings and conferences devoted to health equity and are actively building ongoing relationships with OEI staff.

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

See Progress Report for Elements 4 and 6.

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

See Progress Report for Elements 4 and 6.

2 e.) How was the CAP involved in the activities for this transformation area/how was the CAP informed of the outcomes for the activities in this transformation area?

The CAP decided on the CMMI definition of high utilizer and four other high risk patient categories, and identified those CPCCO members meeting the definitions for each. CCO staff have met with individual clinics to share data, and identify aggregate interventions for the CAP to approve and implement, as well as clinic specific strategies for identified high risk populations.

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 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.

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.

Action Taken or Being Taken to Achieve Milestones or Benchmarks		Outcome to Date	Process Improvements
1.	Complete 2014 QI Plan.	2014 QI plan completed and submitted to OHA 1/31/2014. 2014 QI plan and transformation plan update pending OHA review and comments.	
2.	Develop and implement reporting capabilities.	CareOregon/CPCCO has developed internal reports using SAS Business Intelligence software which incorporates demographic and claims data to be utilized in the analysis of health disparities related to utilization and performance metrics.	Utilizing data for population based assessment to drive interventions. Increased sharing of meaningful data with our provider and

		<p>Assessment of the incentive metrics and health outcomes performance across different race/ethnic populations in CPCCO was reviewed.</p> <p>CareOregon/CPCCO has purchased HEDIS software that will provide additional data to be used in the identification of disparities based on race/ethnicity, language, age, and gender for preventative health screenings. Medicaid data is currently being uploaded into the database and health outcomes data by race and ethnicity will be reviewed quarterly to identify health outcomes disparities and any improvement from the 2013 baseline.</p>	community partners.
3.	Develop 2015 QI plan	<p>Evaluation of 2013 and 2014 data will inform the 2015 QI plan.</p> <p>The QI plan will include identified CCO targets and strategies for improvement based on the results of the CHIP and the identified CHIP outcomes measurements, as well as watch measures for any of the key performance metrics within CPCCO where disparities are identified.</p>	

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

Columbia Pacific is not able to develop internal reports to capture health disparities for many of the 17 incentive metrics as the data is held at the state level.

Baseline demographic data will be used to assess the new ACA member population as well as the results of the CHA; however data related to preventative care and health outcomes is lacking.

2 b.) 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 has requested member level data including race/ethnicity and language for incentive metrics from OHA.

CPCCO has engaged local community partners (e.g. DHS) in the sharing of information for the incentive metrics.

CPCCO staff members have regularly attended the state Quality & Health Outcomes Committee meeting and Learning Collaborative.

CPCCO has internally identified ways to capture ACA expansion members, which is being used to analyze utilization of primary care services, acute care service, and preventative care services, and identify any health disparities among this new member population.

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

In Q3 2014, data related to health outcomes rates for different race/ethnic population within CPCCO will be shared with the CAC and the CAP.

The CAC has been involved in gathering data and community information for the Community Health Assessment and in the identification of the key priority areas which are captured in the CHIP and will inform the key quality metrics for the 2015 QI plan.

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

In Q3 2014, an analysis of health disparities for selected CCO incentive metrics and CCO Core Performance Measures will be complete and the results will be shared with the CAC and CAP.

2 e.) How was the CAP involved in the activities for this transformation area/how was the CAP informed of the outcomes for the activities in this transformation area?

In Q3 2014, data related to health outcomes rates for different race/ethnic population within CPCCO will be shared with the CAC and the CAP.