

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

This form is a pre-populated template for Columbia Pacific CCO's Transformation Plan Initial Progress Report requirement. (Be aware that OHA has moved the due date of this report from the first of the year to January 31, 2014.) 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.

Please send your completed Transformation Plan Initial Progress Report to the CCO Contract Administrator, David Fisher (DAVID.H.FISCHER@dhsosha.state.or.us) by no later than 5:00 pm on Friday, January 31, 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 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

	<p>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. Just placed behaviorist at Dunes Family Medicine and Reedsport Medical Group in late November. Working on imminent placement of behaviorist at Rinehart Clinic.</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 will improve access to screening and treatment of substance use disorders.</p>

<p>2.</p>	<p>Develop alternative pain management model</p>	<p>CAP approval to adopt Southern Oregon Opiate prescribing protocol and Multnomah County Health Department prescribing contraindications list for the pilot site.</p> <p>Agreement in principle and contract being developed between Clatsop Behavioral Health and Mid-Valley Behavioral Health to replicate Salem’s successful pain clinic in Astoria ; pain clinic site located. This pain clinic will support primary care providers across the county, including FQHC and system (Providence) as well as independent practitioners.</p>	<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.</p>
<p>3.</p>	<p>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.</p>	<p>Provided technical, staffing and financial supported 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 site have addictions staff and mental health providers on site.</p> <p>Clinics opened increased capacity for kids and adults (over 100 pts/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>The grant funding represents a new partnership between the CCO, the regional ESD and the community mental health provider in Columbia County.</p>

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 will be exacerbated by the additional OHP enrollment 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. Finally, GOBHI staff are helping support behavioral health billing for appropriate services provided in a primary care setting.

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

The CCO's 4 local Community Advisory Councils have not been directly involved in these integration efforts. However, addictions and mental health services, including crisis and suicide prevention, are surfacing as 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 are planned throughout the upcoming year, as well.

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?

Rather than the CACs, 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 7 largest clinics in CCO.	Collaborative launched March 2013. Completed 4 learning sessions and between meetings 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.	Integrating coaching on specific incentive metrics education and best practice sharing with involved clinics.
2.	Train primary care improvement coach 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 with 1 clinic as pilot.	Tested using embedded practice coaches within member clinics, learned that it was too challenging to carve out time.

			Testing using CCO-specific resource for practice coaching.
3.	Meet with key PCPCH practices to review CCO definition(s) of “high risk”/”super user” members and identify drivers.	Three clinic meetings completed in January 2014. Additional clinic meetings being scheduled.	Testing having PCPs identify individual drivers to create aggregate picture of drivers in the community.

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.

Moved to deploying a Preventative Medicine resident to key practices as the second test of practice coach deployment.

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.	1 FQHC in the service area selected for Phase 2 of the FQHC Alternative Payment Methodology	Providing support to identified FQHC 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>Introduced model in joint CAP/Finance committee meeting.</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.

Implement quarterly joint Finance Committee and CAP meetings 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?

CAP is involved through the joint finance committee/CAP meetings that discuss issues related to payment and model 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 are working on identifying health priorities and potential community actions that the advisory councils will champion for each county and the Reedsport area.</p> <p>Identified health priority recommendations will be moved forward to the Regional Advisory Council by 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.	
3.	Schedule joint and public Board and CAC(s) meetings to prioritize gaps and opportunities identified in meta-analysis	Local CACs in two of the CCO service areas have presented information to and held public events to present information regarding the community needs assessments and identified health priorities. Joint meeting of the R-CAC and Board scheduled for February 2014.	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 3 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.	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 members to process and identify health priority issues.
5.	Convene focus groups, stakeholder	Seven our community meetings have been held where	Data analyst developed power

	<p>meetings and other data-gathering and community conversations in order to finalize prioritized community health needs.</p>	<p>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>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>6.</p>	<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</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 will be completed in February.</p>	

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

It has been a long and difficult process 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 continues to be challenges around getting information to CAC members who do not have social services or health care provider backgrounds that helps the CAC member to 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.

It was difficult to get the community survey out to underrepresented areas regionally.

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.

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

Membership status and goals are discussed as part of the 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 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 CAC(s) are given updates at their monthly 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 advisory council 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 mid- to late 2014. CPCCO will work with OCHIN clinics to successfully move from MU 1 to MU 2 by July 2015.	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.	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.	
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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 development process for strategies at the state level for HIE development to aid in the integration of mental health and physical health data.

CPCCO currently has representation on the state HIE subcommittee.

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

The CAC has not been engaged in this transformation area to date.

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 level in the identification of current EHR systems in use within the CCO and the current barriers for information sharing.

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 that will pilot through the CPCCO. CPCCO will use narrative methodology to identify the community definition of, and standards for, cultural competence.</p> <p>This process will be accomplished by using Cognitive Edge SenseMaker™ software.</p> <p>Community definitions of cultural competence will be</p>	

		<p>included in the CHIP report submitted to OHA in June 2014.</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 are currently being updated regarding cultural competence, language access, and translation services that are available to all CPCCO members</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>Website launched that 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 CCO is currently identifying members for an on-going workgroup, likely a subgroup of CAC and CAP members, to guide on-going strategies for health</p>	

		disparities reduction.	
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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 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.

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 best understand and apply OHA approaches and resources to address cultural competence for participating providers.

CPCCO, in partnership with JCC CCO and CareOregon, are negotiating 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 will be given to the advisory councils and communities that the CCO's serve. 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.

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

Advisory Council members will be invited to be part of the narrative collection process including being trained to use this survey collection tool.

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

The Community Advisory Council has been informed of the CCO's intent to use Cognitive Edge methods and were given an opportunity to give feedback regarding the use of the narrative methodology to gather information.

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>CAP adopted the Health Commons Grant CMMI definition of high utilizer (also called super-users).</p> <p>January 2014, CCO staff began outreach to the largest CCO clinics with their list of cross-matched high utilizers</p>	<p>High utilizer subgroup of the CAP formed to determine next steps and recommendations.</p> <p>Comprehensive SAS Business Intelligence data base developed</p>

		and patients with chronic, persistent mental illness. Three clinic meetings are completed with remaining clinics to be scheduled.	to produce detailed demographic and utilization production reports on super-users.
2.	Develop a written plan to improve cultural competence of participating providers.	<p>Clinic-specific cultural competence assessment tool has been developed consistent with CLAS.</p> <p>Contacts are being made at each major CCO participating provider clinic site to determine optimal assessment tool respondent, and set up appointments for completing the assessments.</p>	<p>A physician leader has been assigned to develop the clinic assessment and participating provider training plan. This leader will also serve 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>
3.	See Progress Report for Element 4, and 2 above.		

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.

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 best understand and apply OHA approaches and resources to address cultural competence for participating providers.

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

See Progress Report for Element 4.

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

CAC meetings are attended by a representative of the CAP, as well as the Board, in order to receive appropriate updates and provide input into CCO activities.

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 identified those CPCCO members meeting this definition. In early 2014, CCO staff will meet with individual clinics to share data, and identify aggregate interventions for the CAP to approve and implement.

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.

		<p>Initial data for January 2013 – September 2013 4 of the CCO incentive metrics are available for analysis. A year end analysis will be performed in March 2014.</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. HEDIS data will be available for a number of adult and pediatric utilization and preventative care measures. Data for 2013 HEDIS metrics will be available late Q1 2014 and an analysis to identify any areas of health disparity will be conducted.</p> <p>This data analysis will be used to help inform the CHIP in the identification of health disparities related to preventative care services and OHA identified CCO quality metrics.</p>	<p>Increased sharing of meaningful data with our provider and community partners.</p>
3.	Develop 2015 QI plan	<p>Evaluation of 2013 and 2014 data will inform 2015 QI plan.</p> <p>The QI plan will include identified CCO targets and strategies for improvement identified based on the results of the CHNA, the CHIP, the CCO cultural competency assessment, and the analysis of member and administrative data for health disparities.</p>	

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

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

Lack of data for identified members eligible for ACA expansion to incorporate into the analysis of health disparities. Baseline demographic data will be used in the assessment of this new member population as well as the results of the CHNA; 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 is internally identifying ACA expansion members to analyze utilization of primary care services, acute care service, and preventative care services.

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

By end of Q2 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, CAP, and the Board of Directors.

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

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

By end of Q2 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, CAP, and the Board of Directors.

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?

By end of Q2 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, CAP, and the Board of Directors.