

**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, 2015.) 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 Fischer (DAVID.H.FISCHER@state.or.us) by no later than 5:00 pm on Friday, January 31, 2015.

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.

	<p>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.	Co-location of behaviorists.	Almost all CCO clinics have at least one FTE of co-located behaviorists. The largest exception is the FQHC in Astoria, which has space limitations creating barriers to co-location.	Elimination of barriers to access behavioral health care.
2.	Creation of new funding stream to better facilitate behavioral health integration in primary care clinics.	New funding stream was created within CPCCO wherein 1% is taken out of the global budget, prior to dispersal of funds to CareOregon and GOBHI, and placed in a separate funding pool. During the first year, funding will occur via a grant process where clinics will submit a strategic plan for onboarding and appropriately utilizing a behavioral health provider within the clinic. After the first year, the funding stream will transition to reimbursement based on behavioral health claims submissions. See Transformation Area 3, below.	<p>Funding stream was designed in partnership with CareOregon and GOBHI; previously CCO members could only obtain reimbursable behavioral healthcare through GOBHI employed providers.</p> <p>Elimination of barriers to access behavioral health in the primary care setting.</p> <p>All behavioral health providers employed through this process will be given access to and trained in documentation within GOBHI’s EHR.</p>
3.	Develop alternative pain management	The North Coast Pain Clinic ended the pilot phase	The North Coast Pain Clinic has

	<p>model.</p>	<p>of development on November 14th, 2014 and has successfully continued operations. As of January 1, 2015, the clinic had received 297 referrals from across the CPCCO service area, oriented 149 patients (50% of those referred), done individual intakes on 84 patients (56% of those oriented), and had 27 patients graduate from the program (32% of individuals that completed intake.).</p> <p>There has been an average of positive movement in all clinical outcomes measures including:</p> <ul style="list-style-type: none"> • Fear of Movement – average decrease of 4.7; • PHQ-9 – average decrease of 7.3; • Pain Self Efficacy Questionnaire – average increase of 17; • Oswestry Disability Index – average decrease of 10%. <p>As of the January 2015 OHA CCO Metrics Update Report for 2014, CPCCO had improved SBIRT screening 4.8% from the 2013 final rate and exceeded the improvement target for 2015.</p>	<p>provided access for persistent pain management to all residents of Tillamook, Clatsop, and Columbia counties. As a result of the success of the program, CPCCO is funding the spread of the model to both Columbia and Tillamook counties.</p> <p>CPCCO will continue to track overall opiate prescribing rates and will continue efforts to effect a decrease in overall prescriptions and rate of prescriptions exceeding 120 MED.</p>
<p>4.</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 and staffing support for Columbia County Public Health SBHCs to apply for grant funds with the goal of becoming Patient Centered Primary Care Homes.</p>	<p>Columbia County Public Health was awarded grant dollars to fund 1.0 FTE staff time dedicated to development of SBHCs as Patient Centered Primary Care Homes. CPCCO will continue to provide technical, training, and staff support as needed for the PCPCH efforts.</p>

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

Barriers included recruitment of behaviorists for placement in primary care settings due to the rural nature of CPCCO. This barrier continued to be exacerbated due to the roughly 70% increase in OHP enrollment since January 1, 2014 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.

1 c.) 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 is 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.

1 d.) How was the Community Advisory Council involved in the activities for 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) occur throughout the year.

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

The CACs were updated as needed during scheduled meetings.

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	<ol style="list-style-type: none"> 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.	Achievement of member enrollment target into PCPCH Tier 3 recognized clinics.	As of December 2014, CPCCO had 81% of members assigned to Tier 3 PCPCH clinics. This improved from 73% in January 2014.	See activities, following. The CCO continues to build out clinic leadership and capacity to achieve Triple Aim goals.
2.	Began a potential template for intensive technical assistance to key clinics for the CPCCO region. This allowed a coach to spend 1-2 days per week for 6-8 months with a clinic. Key barriers to success are identified collaboratively and worked together. During this process a key operational person is identified and trained up by the coach to continue the work after the practice coach exits each clinic.	<p>Able to help clinic work through identified barriers: organizational structure to optimize implementation of clinic identified priorities, redevelopment/definition of roles, financial sustainability, communication strategies, etc.</p> <p>Work with another key clinic is in beginning stages of evaluation.</p>	<p>Continue to evaluate internal resources to be able to continue to offer this level of support to key clinics.</p> <p>Verify that we have diversity of strength among CCO staff to meet regional technical assistance needs of clinics.</p> <p>Continue to work with leadership of clinics to be ready for assistance.</p>
3.	Changed focus and intent of the PC3 from a	This restructuring has resulted in	Increased tie between operational

	<p>learning collaborative to a steering committee closely linked with the CCO's CAP. The PC3 clinics are able to provide constructive feedback to the CAP regarding operationalizing some initiatives.</p>	<p>Increased communication between PC3 clinics and the CAP.</p> <p>By closer linking the work of the PC3 clinics with the leadership represented on the CAP, the CCO has been able to get a more complete picture of strategic focus but also opportunities to partner with clinics and community partners to achieve the triple aim.</p>	<p>implementation of clinical priorities set by CAP and CAP/Finance Committees.</p> <p>Able to better inform the CAP of clinical needs across the region from the different geographic areas represented.</p> <p>Encourage CAP members to communicate back to their clinics strategic goals of CCO</p>
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2 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

A barrier that we are currently facing is the ability of the clinics to build internal capacity to carry out improvement work achieved both through the PC3 group and the intensive technical assistance model. Another area of improvement is the clinic level knowledge of techniques to use and optimize their electronic health record to increase clinic efficiencies. The CCO has also found a need for further clinic leadership development and increased internal communication between leadership and staff.

2 c.) 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 is working to incorporate leadership training and responsibilities into PC3 meeting agendas as well as having enough staffing time to follow-up more consistently individually with clinic leadership.

CCO leadership and PC3 coaches are investigating reaching out to clinic leadership directly regarding specific identified issues. It would also be beneficial to work through the CAP members using a peer to peer model.

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

N/A

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

N/A

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.	Two CCO clinics have opted into the second round of the Oregon Primary Care Association alternative wrap payment model. These clinics are moving towards a CareOregon model of alternative payment for primary care services, to be completed in the first half of 2015.	Increase in the interest into enhancing the integration and expansion of services and the funding models to support both.	
2.	The CAP and Finance committee working together developed and approved the creation of a blended funding pool that is financed by a 1% contribution of the entire global budget. This alternative payment pool will be dedicated to the expansion of behavioral health capacity in our PCPCH settings. See Transformation Area 1, above.	Approval was finalized in November 2014. Application finalized and distributed in December 2014. First applications were received in January 2015.	

3.	The second round of Community Wellness Investment Fund (CWIF) proposals have been received and are being reviewed for funding via a dedicated pool that CareOregon and GOBHI created to fund nontraditional, wellness interventions developed by members in our local communities.	Nine proposals were received from across the CCO service area.	This round of proposals were required to be in support of the priority health improvements identified in the CCO's Community Health Improvement Plan (CHIP).
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2 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

The biggest barrier to achieving these benchmarks continues to be the siloed reporting and billing requirements of the current fee-for-service medical and behavioral health systems. These rigid requirements, coupled with the relatively small scale of Medicaid for some of the primary care clinics, make implementation of alternative payment models very difficult.

2 c.) 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 process improvement strategy of holding joint meetings of the CAP and Finance Committee three times each year has improved the CCO's ability to achieve consensus and move potential initiatives through the board structure. The most recent example of this improvement has been the creation of the blended funding pool (described above).

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

The local Community Needs Assessments developed by the CCO's CACs all prioritized the need for expanded capacity for behavioral health services as two of their top three priorities. The creation of the blended funding pool as an early APM is responsive to the CACs' priorities.

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

The CACs were directly involved in rating the CWIF proposals in this current funding phase. The CACs will be informed of the final grantees, as well as the status of clinics applying for, and receiving, funds from the blended funding pool.

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.	Community Advisory Councils continue to meet and discuss opportunities to meet the goals of the Community Health Improvement Plan.	In 2014, the CCO's Community Advisory Councils agreed that they would like to sponsor community education events in 2015 that support increasing knowledge regarding available services and health improvement outcome goals/process(s). This process has increased awareness of community services and gaps that are available to support the improvement of health outcomes.	In each county, the CAC will sponsor learning events that the community and local content experts to have a facilitated discussion about a specific health topic related to the CHIP. These events will be promoted in the community and open to anyone who would like to attend.
2.	Development of community resources (in-kind) and funding to meet the objectives of the Community Health Improvement Plan.	Have participated in the development of several grant opportunities. Development of the Strategic Advisory Council for Clatsop County health improvement activities. The Council includes key leaders	Community Wellness Investment Funds community application process included all proposals being screened by local community advisory council members. In this process, the CACs made funding recommendations to the CPCCO Board.

		<p>from a variety of sectors, including education, business, and economic development, in addition to health.</p> <p>Development of local staffing in Clatsop County to work toward health improvement goals that are part of national The Way to Wellville health initiative.</p>	
3.	Development of a three year strategic plan to meet the goals of the Community Health Improvement Plan.	In its annual planning retreat, the CPCCO Board prioritized clear delineation of CAC accountabilities towards achievement of community health, clinical improvements and other CPCCO initiatives. This will be an outcome of a strategic planning process to occur in the late winter/early spring, 2015.	Greater alignment and clarity of the work of CACs, the CAP and the overall CCO Board.
4.	Participating in Trauma Informed Learning Collaborative sponsored by the National Behavioral Health Council.	<p>CCO staff have helped developed a process to inform contracted clinics and the CPCCO Board of this work.</p> <p>Inclusion of community advisory council members in the development of a community coalition that supports the use of the trauma informed perspective.</p>	The CCO has identified and developed initial materials to be used to educate providers and Board members about trauma informed care with the goal of having official approval to be a trauma informed organization.

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

CPCCO has experienced difficulty obtaining resources to support prevention work in the community that supports improving the health outcome goals of the Community Health Improvement Plan.

2 c.) 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 is utilizing the resources available through the Transformation Center, as well as promoting the CCO’s own Community Wellness Investment Fund (CWIF) in the community and encouraging non-traditional/ innovative programs to apply.

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

The community advisory councils are overseeing the work of the CHIP. The community advisory councils participated in the rating of the CWIF and made recommendations to the CCO’s Board of Directors.

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

The CACs have a discussion of CHIP activities as part of their monthly agenda. The CACs are involved in the planning of improving the communities’ knowledge of the CHIP health priorities and will be involved in the strategic plan for 2016 activities that work toward improving health outcomes in the community.

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	<p>Contractor supports at least two clinics in its Service Area with attaining Stage 1 HIE meaningful use standards, or moving from Stage 1 to Stage 2 HIE meaningful use standards.</p> <p>Contractor ensures that appropriate Contractor representatives participate in the OHA statewide HIE development process and help establish HIE Benchmarks.</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.	CPCCO participated in OHA’s 2014 HIT Deeper Dive meeting to create a CCO specific HIT/HIE Profile.	A draft profile by OHA of the CCO’s HIE and Meaningful Use status is currently in review by the CCO. This profile will help inform the CCO on priorities to address in order to achieve milestones and benchmarks.	
2.	CCO has assigned a dedicated individual to represent it at the OHA HITAG group.	A dedicated CPCCO analyst started 12/8 and has attended the January HITAG meeting.	

2 b.) 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 continue to be a challenge, but the CCO is continuing to participate with the state’s HIT/HIE efforts for alternatives.

2 c.) 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 will continue to seek the state’s leadership for integration of mental health and physical health clinical records. The CCO has just this month assigned an individual who will represent it on the HITAG group.

It would be beneficial to have OHA assist with asking OCHIN for additional support/capability around reporting discrete, patient- level data, rather than the CCO asking each clinic individually. The clinics need actionable information they do not obtain from the aggregate data. They emphasized that a single request by a larger entity would convey the importance and priority of the needed additions/changes.

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

Due to significant restructuring in this transformation area #5, the CAC has not been involved in activities during this reporting period. However, with the development of QI and analytic resources at CareOregon on behalf of CPCCO, it is expected that this communication will resume in Q1 2015.

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

See above.

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 implements cultural competence policy and in process with Community-specific improvement Benchmarks.	<p>Cultural competence policy has been in place since June 2014. The policy is in the implementation process across the departments of CCO plan operations.</p> <p>Work is on-going to create community-specific benchmarks. The narrative story gathering process, through Cognitive Edge SenseMaker, did not generate the CCO anticipated benchmarks.</p>	
2.	Contractor populates the Member materials registry and ensures that 80% of vital documents are translated into predominant languages or meet "Plain English" standards.	<p>The vital documents and member handbook currently meet Plain Language standards. Attempts are underway to lower the necessary reading level of documents to the 5th grade level.</p>	<p>The vital member documents identified are being posted on the CCO website as soon as yearly document reviews occur. The documents are also being modified and translated as necessary to meet readability and language standards.</p> <p>The usability of the website is also being examined, to ensure that all important materials are easily accessible to members with varying levels of computer literacy.</p>

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

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

CPCCO’s goal of having member materials at 5th grade readability is also challenging. It is difficult to balance readability goals with sometimes complex ideas about managed Medicaid – particularly when working under the assumption that an individual has no prior knowledge of the system itself.

2 c.) 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 has worked at identifying possible partners who have existing relationships with the Latino community. The educational service districts are examples of partners that work to increase educational access and engagement among Latinos. The shared mission of access and engagement has allowed planning for future collaborations that will be meaningful to both organizations. Additionally, the educational service districts have existing relationships with members of the Latino community and have allowed the CCO to enlarge its network through local Latino organizations, like the Lower Columbia Hispanic Council.

Improving the member materials and the goal of lowering the readability to a 5th grade level is closely tied to the Health Literacy Trainings sponsored by OHA. The training taught a useful lens to examine member documents and helped broaden the member materials improvements to include a lower reading level that more accurately reflects the needs of CPCCO members.

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

The policies will be presented to the CAC for feedback and improvement in April. Policies will be revised and brought back to the CACs for approval in June. These discussions will be part of a larger educational series within the CAC which aims to spark policy proposals at the county level.

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

The CAC receives monthly updates at meeting as appropriate. During the Cognitive Edge survey process, CAC members were active partners in raising awareness and the distribution of the survey materials.

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.	Identify clinic-specific opportunities and pilots to help better manage care and outcomes for high risk patients.	<p>In 2014, the CPCCO CAP developed and approved two intervention strategies to be piloted in different parts of the CPCCO service area. The intervention strategies are:</p> <ul style="list-style-type: none"> • Placement of clinical pharmacists; one in the hospital setting to focus on transitions of care and one in the clinic setting. • Placement of Health Resilience Specialists (Masters level behaviorists) in two clinics. <p>To date, one Health Resilience Specialist has been hired and will begin working at</p>	<p>Creation of separate subgroups focusing on each intervention strategy including pharmaceutical and health resilience expertise respectively.</p> <p>Development of clinical pharmacy job description.</p> <p>Development of a pharmacy residency program which will also support clinically based pharmaceutical work in the CPCCO service area and ideally serve as a source of recruitment for</p>

		the end of February, 2015. Job postings are being created for clinical pharmacists. A second job posting is still up for another Health Resilience Specialist.	permanent employment in the service area.
2.	Develop a written plan to improve cultural competence of participating providers.	A modified CLAS standards assessment was completed with participations from major clinics within the CPCCO service area to identify clinic-specific gaps in culturally competent care.	Clinical quality improvement efforts are being planned, using responses from the modified CLAS standards assessment to identify clinic-specific opportunities.

2 b.) 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 a majority of which is asked of those clinics without additional funding.

The CCO's Transformation Specialist served as a short term bridge for the work around cultural competency after which the work was transitioned to a CareOregon Project Coordinator to manage.

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

N/A

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

The CACs were not involved in this work during this period, but will be involved again in early 2015.

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

N/A

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.	Building capability to analyze ethnic disparities in incentive metrics.	Preliminary data set for 2014 performance by ethnicity has been created for colorectal cancer screening, adolescent well checks, developmental screening, timely prenatal care.	
2.	Developed organizational structure to align dedicated QI resources within the CPCCO region.	Dedicated QI analyst hired and deployed in December 2014.	
3.	Consider factors outside of ethnicity that drive	QI Analyst working on	

	disparities, specifically poverty.	analytical plan.	
4.	Develop a written plan to improve cultural competence of participating providers. (See Transformation Area #7.)	A modified CLAS standards assessment was completed with participations from major clinics within the CPCCO service area to identify clinic-specific gaps in culturally competent care.	Clinical quality improvement efforts are being planned, using responses from the modified CLAS standards assessment to identify clinic-specific opportunities.

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

The physician leader who had been leading the CCO's efforts in cultural competence and disparities left the area, leaving a leadership vacuum. It has been difficult to fill this void, even with the Transformation Specialist serving in an interim role.

2 c.) 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.

A full-time Quality Analyst has been hired who will partner with the CCO's new medical director to look specifically at health care disparities.

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

N/A

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

N/A