



Columbia Pacific CCO
Creating Health Together

Columbia Pacific CCO 2015-17 Transformation Plan

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By: Mimi Haley
Executive Director, Columbia Pacific CCO
Email: haleym@careoregon.org
Desk: 503-416-3679
Cell: 503-319-8218

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Background:

Columbia Pacific CCO (“Columbia Pacific” or “CPCCO”) is a non-profit, wholly owned LLC of CareOregon, formed as a partnership in 2012 between CareOregon and Greater Oregon Behavioral Health, Inc. Columbia Pacific has an independent governing board, three county-specific Community Advisory Councils, and a single multidisciplinary Clinical Advisory Panel. The Board includes representatives from the following organizations:

- CareOregon
- Greater Oregon Behavioral Health, Inc. (GOBHI)
- Columbia Memorial Hospital
- Tillamook Regional Medical Center
- OHSU – Scappoose
- Public Health Foundation of Columbia County
- Columbia Community Mental Health
- Community Action Team
- Columbia County (Commissioner)
- Clatsop Behavioral Health
- Clatsop Community Advisory Council
- Health and Human Services, Tillamook County
- Tillamook County (Commissioner)
- Tillamook Family Counseling Center

Columbia Pacific contracts with CareOregon to provide numerous administrative functions, fund the statutorily-required restricted reserves and provide delegation oversight. Columbia Pacific delegates risk for the following: medical services (CareOregon), mental health and addictions services (GOBHI), dental services (Advantage Dental, Capitol Dental, ODS and Willamette Dental), and Non-Emergent Medical Transportation (Ride Care/Sunset Empire Transit District).

Columbia Pacific CCO grew almost 80% as a result of the ACA Medicaid expansion, from 14,500 members in December 2013, to just under 26,000 members in January 2015. This growth created significant challenges in assuring access to existing and new members, given the lack of attendant growth in medical, behavioral health or dental providers over the same time period. Significant resources have been devoted to increasing the capacity and capability of the existing primary care and mental health clinics, but the CCO also accomplished significant transformation, including: creation of a non-prescribing, behaviorally based pain clinic on the north coast; development of a single blended fund for additional behavioral health supports in primary care; launch of a healthy homes assessment and renovation fund for members with respiratory impairments; achievement of 100% of the 2014 incentive measures; placement of community outreach workers in high-volume/high-acuity clinics; expansion of new medical detox beds within the service area; and integration of dental and NEMT services. In addition, through the voluntary efforts of a key dental leader in Clatsop and Columbia Counties, CCO members are receiving community-based oral health preventive services through outreach programs in school, WIC and Head Start locations.

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Transformation Areas, Benchmarks, Milestones and Narratives

Transformation Area 1: Developing and implementing a health care delivery model that integrates mental health and physical health care and addictions and dental health. This plan must specifically address the needs of individuals with severe and persistent mental illness.

How Benchmark will be measured (Baseline to July 31, 2017)	Baselines: Average daily MED for Pain Clinic attendees: 39.66 MED Number of clinics participating in First Tooth: 0 Number of clinics receiving blended funding for co-locating behaviorists: 1
Milestone(s) to be achieved as of July 31, 2016	<ul style="list-style-type: none"> • Reduction in average MED equivalent in CPCCO population. • First Tooth implemented in two clinics. • Behaviorists co-located in at least three primary care clinics. • Develop reporting mechanism for identifying and determining dental screening status of CPCCO members with co-morbid SMPI and diabetes.
Milestone(s) to be achieved as of July 31, 2017	<ul style="list-style-type: none"> • Maintenance of reduction in average MED equivalent in CPCCO population. • First Tooth implemented in a minimum of three clinics across CPCCO. • Implement co-location and clinical integration of behaviorists in all major primary care clinics (those serving more than 1,000 assigned members).

Process Narrative to Support Milestone Achievement

Columbia Pacific will utilize the Clinical Advisory Panel (CAP) to provide advice and global direction to achieve the work outlined in this area. Integration efforts will be focused in two main areas of care: behavioral health and dental. Behavioral health integration will be achieved through the development and implementation of an alternative funding pool to augment co-location of behaviorists (mental health and addictions) in primary care settings, as well as evaluating the opportunities for bi-directional co-location. It also includes development and dissemination of an integration model of care and toolkit, the development of two additional pain clinics, and the upskilling of primary care providers and teams in the treatment of persistent pain and opiate prescribing practices. Dental health integration will be achieved via the implementation of First Tooth training and implementation at two primary care clinics, including completion of First Tooth training, the development and streamlining of clinical workflows, and establishment of referral mechanisms from primary care to dental homes. In dental integration efforts, there will be a special focus on screening the SPMI co-morbid diabetic population.

Pain Clinic and Opiate Prescribing

A non-prescribing, behavioral health and movement based pain clinic for patients with persistent, non-cancer and non-terminal illness pain has been successfully opened in Clatsop County. Efforts are actively underway to spread the same model to both Tillamook and Columbia Counties. Treatment is group based with individual interventions occurring on an as needed basis. Cohorts go through a 10 week program with one day of treatment per week for three hours per session. Treatment consists of movement therapy, pain education, and acceptance commitment therapy. Initial outcomes show positive movement in measureable clinical outcomes including a reduction in morphine equivalent dose per day of graduating CPCCO members.

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Columbia Pacific is also ready to implement an opiate prescribing protocol to taper members to no more than 120 MED daily dose (non-cancer, non-terminal). In conjunction with rolling out this uniform prescribing policy across the CCO clinics, the CCO will also investigate and deploy Medication Assisted Treatment programs as feasible.

Behavioral Health Co-location

An alternative funding pool has been developed which, during the first year, will function as a grant with an application process in which primary care clinics will describe the need and planned utilization of co-located behaviorists. CPCCO partner, Greater Oregon Behavioral Health, Inc. (GOBHI), will provide training and workflow assistance as needed for the successful implementation of new primary care based behaviorists. CPCCO will provide a model of care policy and toolkit for the successful utilization of behaviorists.

Co-location of augmented behavioral health treatment in primary care will begin in Columbia County via partnership between OHSU Scappoose Family Medicine and Columbia Community Mental Health (CCMH). GOBHI will also provide CCO-wide phone based addictions and psychiatric consultation services for primary care providers.

Dental

CPCCO will partner with CareOregon and its affiliated CCOs to deploy a centrally located First Tooth trainer to carry out trainings in primary care clinics. CPCCO staff will assist clinics in developing easy referral mechanisms to dental homes. In both Clatsop and Columbia Counties, the dental provider will continue to partner with schools, head start programs, school based health centers, and other community based programs to increase the number of screenings, sealants and fluoride varnishes completed via Expanded Practice Providers (EPP). In Columbia County, Health Resilience Specialists will promote dental care for individuals in their panel defined as diabetics with severe mental illness. This will be used as a pilot for additional work in other CPCCO clinics for SPMI co-morbid populations.

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

How Benchmark will be measured (Baseline to July 31, 2017)	Baselines: Number of members assigned to state-recognized PCPCHs: 83.7% Number of CAP requests for clinical input from PC3: 0
Milestone(s) to be achieved as of July 31, 2016	<ul style="list-style-type: none"> • Develop primary care delivery system infrastructure in 3-5 identified clinics across the CCO service area. • Complete training and technical assistance in the following areas: population management techniques, panel management, identification of gaps in care, EHR utilization, increasing care coordination programs, team based care, enhanced access.
Benchmark to be achieved as of July 31, 2017	<ul style="list-style-type: none"> • 85-90% of Members are enrolled with PCPCH Tier 3 clinics. • PCPCH recognized clinics and/or PC3 Steering Committee provides feedback on 3-5 projects prioritized by the CCO CAP.

Process Narrative to Support Milestone Achievement

In late 2014, CPCCO transitioned its on-going Primary Care Learning Collaborative (“PC3”) from a shared learning focus to a steering committee focus, allowing better integration of the identified infrastructure improvements needed by each clinic with the specific transformation objectives and initiatives prioritized by CPCCO’s CAP. In 2015 and beyond, this will allow for enhanced alignment of the clinical systems of care and the strategic initiatives of the CAP. Such alignment is necessary to assure that the improvements in medical home capabilities being made at the clinic level also support mezzo-level CCO objectives, such as achievement of outcomes targets, identified access enhancements and new payment methodologies outlined Transformation Area 3.

Focus for the PC3 work going forward will include increased provision of one-to-one intensive practice coaching, in such areas as:

- PCPCH recognition process and PCPCH standards achievement
- Care delivery transformation
- Increasing operational infrastructure
- Increasing positive QI culture

This will also include continued focus on multi-disciplinary integration of behavioral health, oral health, community prenatal supports and other programs into primary care settings. (See Transformation Area 1.)

Finally, CPCCO will continue to outreach to and provide technical assistance for PCPCH recognition among clinics that are not yet state-recognized.

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Transformation Area 3: Implementing consistent alternative payment methodologies that align payments with health outcomes.

How Benchmark will be measured (Baseline to July 31, 2017)	Baselines: Number of primary care clinics using APM for funding behaviorists: 1 Number of community cost of care risk sharing models: 0
Milestone(s) to be achieved as of July 31, 2016	<ul style="list-style-type: none"> • Implement alternative payment methodology to integrate behavioral health into primary care • Develop and evaluate models that support a community/CAP defined cost of care/risk sharing payment methodology
Milestone(s) to be achieved as of July 31, 2017	<ul style="list-style-type: none"> • Payment models that support community/CAP-defined clinical priorities will be implemented in at least two of the three CCO counties, affecting a minimum of 40% of CCO membership.

Process Narrative to Support Milestone Achievement

In order to support integration of physical, mental and dental health, payment methodologies that support new clinical models of care must be piloted and implemented. In the first year of the transformation plan, the priority will be on integrating behavioral health and in supporting the PCPCH model of care through implementation and spread of payment arrangements that have been developed and piloted in 2013-2015. Then CPCCO will turn its attention to developing more integrated payment models that support a community-based risk arrangement through the Finance Committee of the Board of Directors and incorporating feedback from the Clinical Advisory Panel.

In addition, CPCCO will continue to work on a parallel payment mechanism for OPCA alternative wrap-payment clinics, to allow those clinics to develop workflows and appointing/encountering mechanisms for alternative visit and provider types, e.g. RN visits, e-visits and use of scribes. All are intended to extend the limited provider resources in primary care thereby improving access to care, and allow alternatives to the traditional Fee-For-Service pay-for-volume model.

In the second year of the transformation plan, CPCCO will focus on implementation and spread of alternative payment methodologies to ensure that an increasing amount of the membership of CPCCO is impacted by these arrangements. CPCCO will focus on spreading models to community partners that serve a large number of CPCCO members. CPCCO will also focus on creating partnerships with other payers in the community to leverage the new models through multi-payer strategies.

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Transformation Area 4: Preparing a strategy for developing Contractor’s Community Health Assessment and adopting an annual Community Health Improvement Plan.

How Benchmark will be measured (Baseline to July 31, 2017)	Baselines: Percentage of adults with BMI \geq 30: 29% Suicide rate/100,000: 19.2% Percentage of adults reporting heavy or binge drinking*: 22%
Milestone(s) to be achieved as of July 31, 2016	<ul style="list-style-type: none"> • Action steps identified in the CHIP are completed. (Assessment, Outreach & Education, Participation in Policy and Planning Processes).
Milestone(s) to be achieved as of July 31, 2017	<ul style="list-style-type: none"> • CHIP-recommended improvements from baseline rates will have been achieved for all three health priority areas.

*During this Transformation period, the CCO will also work to reduce tobacco use, baseline: 46.7%

Process Narrative to Support Milestone Achievement

In partnership with the Community Advisory Councils (CACs) and in collaboration with local community partners, CPCCO will identify service gaps related to the community capacity to achieve its three priority health improvements: reduce the rate of obesity, improve the community’s mental health and reduce substance abuse. In addition, CPCCO will sponsor community outreach and education to support increased community awareness of the social factors that cause obesity; understanding and involvement in improving mental wellness; and dissemination of community wide prevention models, community events and trainings that normalize the discussion of the use and abuse of substances and their impact on the health and wellbeing of the community as a whole.

In addition, in strong partnership with local Public Health departments in each CCO county, Columbia Pacific will sponsor and promote policies that support improving health outcomes related to obesity, mental health and substance abuse with a special focus on tobacco, and recommend these policies to local governments for adoption. CPCCO will also sponsor implementation of projects in the service area that decrease the rates of low income residents who are unable to access healthy foods, thereby helping to decrease the current upward trend of obesity. A determinant of the CCO’s success in these areas will be an increase in the number of community members who are aware of services and supports that are available to improve their mental health and well-being, as well as absolute improvements in access to necessary services supporting mental health. Another measure of success will be the CACs’ ability to identify and support policies and projects that support decreases in the number of people who use tobacco products and who report using or abusing harmful substances.

Finally, as an ongoing process as needed, CPCCO will review the leadership and composition of each of its Community Advisory Councils, to assure appropriate alignment with the Board-identified strategic priorities as well as local initiatives, composition that reflects the local community values and stakeholders, and effective decision-making about resources to support integration and transformation work.

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Transformation Area 5: Developing a plan for encouraging electronic health records (EHR), health information exchange (HIE) and meaningful use.

How Benchmark will be measured (Baseline to July 31, 2017)	Baseline: Number of clinics adopting and utilizing Pre-manage as a communication tool across primary care and with behavioral health partners: 0
Milestone(s) to be achieved as of July 31, 2016	<ul style="list-style-type: none"> Inventory clinics by MU stage, with workplan for technical assistance and other supports for advancement, by clinic.
Milestone(s) to be achieved as of July 31, 2017	<ul style="list-style-type: none"> Implement Pre-Manage in all OCHIN clinics and with all CMHPs in the CCO service area. Complete business capability to integrate clinical data from OCHIN with CCO claims data, for ongoing analysis and outcomes management.

Process Narrative to Support Milestone Achievement

CPCCO will continue to participate in statewide HIE efforts such as the EDIE Governance Committee. CPCCO will look to the statewide HIE efforts and potential for state level registries for preventative care screenings across the CCO’s population. Because members seek care outside the geographic area of the CCO (e.g. in Longview, Washington, or in the Portland metro area), the CCO is evaluating the use of CareEverywhere, EDIE and Pre-Manage to help disseminate real-time information for better care transitions and coordination between acute and ambulatory settings. In addition, while almost 60% of CPCCO members are assigned to clinics using OCHIN Epic and an additional 19% of members assigned to clinics with Epic EHR, there are a number of additional small practices within the CPCCO service area using other EHR systems that do not have the same HIE capabilities. CPCCO is looking to the statewide HIE initiative to help develop the mechanism for data sharing among these diverse practices.

For this transformation plan, CPCCO will continue to explore the ability to expand clinical data reporting to other clinics utilizing OCHIN Epic. CareOregon has a partnership with OCHIN to create reporting capability for claims and clinical data via a data bridge platform called ACUERRE. CPCCO will concurrently utilize OHA dashboards to reconcile member/patient level data and ensure metric improvement throughout the year. In addition, CPCCO will continue to use the Primary Care Learning Collaborative (“PC3”) and CPCCO’s Clinical Advisory Panel to discuss better utilization of the EHR for population management, as well as other health information technology supports and opportunities to pursue in 2015 and beyond.

CPCCO will also inventory all clinics and providers related to their stage of Meaningful Use. CPCCO will develop a plan to provide technical support in assisting clinics to become MU providers or move to the next stage of MU, if applicable. CPCCO will assist in bridging communication efforts between primary care and behavioral health partners by providing resources such as technical support related to workflows and the use of Pre-manage.

Integration of behavioral health clinical data with physical health clinical data is an ongoing challenge as the CCO behavioral health clinics use differing software/EHR platforms. Through the efforts to co-locate additional behavioral health consultants in primary care settings, CPCCO will be able to advance the use of shared care plans through charting within the EMR in each primary care clinic. In addition, CPCCO staff will work with behavioral health partners to develop standardized care plans to be used within Pre-manage.

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Transformation Area 6: Assuring communications, outreach, member engagement, and services are tailored to cultural, health literacy and linguistic needs.

How Benchmark will be measured (Baseline to July 31, 2017)	Baselines: Number of cultural competence policies that utilize community defined improvement benchmarks: 0 Number of clinics trained in trauma: 1 Number of non-clinical settings trained in trauma: 0
Milestone(s) to be achieved as of July 31, 2016	<ul style="list-style-type: none"> • Update policies and procedures using community definitions of cultural competence, language access and translation services for CPCCO members. • Review member complaints regarding interpretation services provided through the CCO. • Conduct trauma/resilience training to address ACES in at least 5 clinic and 3 non-clinical settings.
Milestone(s) to be achieved as of July 31, 2017	<ul style="list-style-type: none"> • Complete a clinic-specific assessment of capacity to provide culturally responsive services to CPCCO members, and identify 2-3 specific clinics for technical assistance and supports for improvement. • Complete trauma/resilience training across the CCO service area, in all major clinics and key identified community settings (e.g schools).

Process Narrative to Support Milestone Achievement

There will be two primary bodies of work supporting achievement of milestones in this area: 1) translation/interpretation services, and 2) training in trauma and resilience.

Translation/Interpretation

Community representatives of Native American and the Latino Community are involved in the process of assessing the need for improving access, and interpretation/translation services for CPCCO members.

The Clatsop Nehalem Confederated Tribes, the Lower Columbia Hispanic Council and Northwest Regional Education Service District (and other community safety net providers) have been approached by CPCCO staff and will continue to be consulted to assess the ways that CPCCO service providers could improve access and culturally responsive health services to people who self-identify as Native American and Latino.

CPCCO Community Advisory Councils will continue to review and advise on how to improve current policies and procedures that support communication, outreach and member engagement. Community Advisory Councils also sponsor educational opportunities for the each CCO community to learn about improving health and changing behaviors.

Technical supports will be provided to CPCCO contracted providers, as appropriate, to assist with improvement and to sustain processes that improve access, interpretation and translation for CPCCO members which are culturally responsive and support the communities definition of, and standards for, cultural

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competence. Finally, the CCO communities and Community Advisory Councils identify projects to financial sponsor and/or implement that support the improvement of health outcomes for CPCCO members.

Trauma/Resilience Training

Through GOBHI, CPCCO is part of the National Council for Behavioral Health collaborative to create trauma-informed communities, and has a commitment to being a trauma-informed CCO. Through this collaborative, and in aligned with Trauma Informed Oregon efforts, CPCCO will develop and conduct trainings in trauma-informed care for all major CCO clinics, and will also provide training to other community groups as requested or prioritized by the CCO. This training will be rolled out in consultation with the CPCCO CAP members, and will include not only identification and improved care for members with a history of trauma, but will also include community-directed training as needed. Starting with the Warrenton/Hammond School District in Clatsop County, CPCCO staff and others will provide, adapt and disseminate appropriate training for identification and mitigation strategies for individuals, especially children, who have suffered from prolonged and severe trauma.

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How Benchmark will be measured (Baseline to July 31, 2017)	Baselines: Number of members engaged with Health Resilience Specialists (HRS): 15 Number of clinical pharmacists deployed in primary care clinics: 0
Milestone(s) to be achieved as of July 31, 2016	<ul style="list-style-type: none"> • <u>Health Resilience Program HRP</u> 100-120 members engaged. • <u>Clinical Pharmacy Program</u> Hire, train, and embed one clinical pharmacist in a CPCCO primary care clinic. <p>See Area 6 for <u>Trauma/Resilience</u> milestones.</p>
Milestone(s) to be achieved as of July 31, 2017	<ul style="list-style-type: none"> • <u>Health Resilience Program</u> 200-240 members engaged. • <u>Clinical Pharmacy Program</u> Complete evaluation of Drug Therapy Coordination Risk scores (DCTR) and fill dates over a 12 month rolling period for those members that receive a clinical pharmacy intervention. <p>See Area 6 for <u>Trauma/Resilience</u> milestones.</p>

Process Narrative to Support Milestone Achievement

There are two primary programs that CPCCO will deploy to help address culturally competent care teams and services, based on the profile of inter-generational poverty, health literacy, trauma and co-occurring conditions that are common to the OHP populations. In addition, as noted in Area #6, CPCCO will conduct trauma-informed care/resilience development training across the CCO service area to ensure competent and effective care strategies from primary care teams.

Health Resilience Program

The Health Resilience Program goals are accomplished through community based interventions, building connections and utilizing additional community resources for high needs, high-risk members. A trauma-informed, person-centered, culturally agile approach is utilized to engage members in the program. The members themselves identify what health related concern they want to work on. The HRS, who is generally a licensed clinical social worker, then provides access to appropriate community resources, skill building, role modeling, and information about how to access social services, insurance benefits, and communicate with the medical team. They will also coordinate with Peer Wellness Specialists who are trained in peer wellness and/or chronic disease management.

For CPCCO, the Care Oregon Health Resilience Program (HRP) will embed HRS staff into both the OHSU Scappoose and Legacy St. Helens clinics. They will work to identify high utilizing members (6 or more ED visits or 1 non-OB inpatient stay per year), with a particular focus on those with prior trauma and co-occurring conditions, and reach out to these members to engage them in determining what is driving their utilization. The HRS will work to engage members in unmanaged health issues identified by their primary care team, including diabetes, hypertension, COPD, asthma, etc., as well as to help with any behavioral

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health or substance use concerns. A key target population will be those members with serious and persistent mental illness and diabetes. To the extent possible, the HRS will reflect the diversity of the members served.

Clinical Pharmacy Program

CPCCO is developing strategies to address patients that are both high risk and high utilizers. The pharmacy intervention will consist of a clinic based pharmacist who will have a face-to-face office visits with members to perform a complete medication reconciliation and utilize the My Easy Drug System (MEDS) tool. This tool was developed specifically to address members with low health literacy and/or cognitive deficits. Through MEDS, a summary of the office visit and pharmacist recommendations will be provided to both the patient and primary care provider. Pharmacists will focus on drug interactions, contraindications, patient understanding of medications, and duplications, among other issues.

The intervention will start with those patients with an Rx Risk Score greater than or equal to eight (this is a score based on several factors of risk, including but not limited to number of prescribers, and number of pharmacies used) and 10 or more emergency department visits in a twelve-month period. Once the intervention is complete on the initial population, efforts will then move on to members with seven to nine, then four to six, and finally two to three emergency department visits in a year.

The goals will be to reduce the rate and average cost per member of inappropriate emergency department utilization by patients with an Rx Risk Score ≥ 5 who have had ≥ 10 emergency department visits in a rolling 12 month period as of August 2014.

Trauma/Resilience Training

See Area #6 for a description of this focused work.

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Transformation Area 8: Developing a Quality Improvement Plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes.

How Benchmark will be measured (Baseline to July 31, 2017)	Baselines: Prenatal timeliness: 22 of 175 (12.6%)* Colorectal Cancer (CRC) screening: 364 of 1077 (34%)
Milestone(s) to be achieved as of July 31, 2016	<ul style="list-style-type: none"> Retrospective analysis of claims with clinical data to identify true baseline CRC screening rates and prenatal timeliness in the Latino membership.
Milestone(s) to be achieved as of July 31, 2017	<ul style="list-style-type: none"> Incorporate strategies to understand and reduce disparities of health outcomes or experience of care related to racial, ethnic and linguistic status in the CCO Quality Improvement Plan. Assure that Latino members have equal rates of CRC screening and timeliness to prenatal care as the CCO population in total.

*Based on self-reported race at enrollment, using claims data only.

Process Narrative to Support Milestone Achievement

CPCCO will be working on two specific measures related to health disparities reduction, based on the demographics of the population represented in the service area: disparate rates of colorectal cancer screening and timeliness to prenatal care for Latino/non-English speaking members. In order to achieve improvements in these areas, CPCCO staff will work with the local Community Advisory Committees to assist with outreach to the Latino communities to help assess barriers to equitable access to clinical services in the CPCCO service area (see Area #6, as well). In addition, CPCCO will pilot the use of CareMessage, a text messaging service for specific programs (e.g. smoking cessation, prenatal care), to reach members with the intent of better engagement in care management. Through this program, CPCCO can track the impact on accessing services for the target population(s). In addition, for prenatal care specifically, the CCO will be piloting a program to create member incentives for seeking proactive and comprehensive supports for healthy deliveries, such as accessing smoking cessation or parenting programs, completing an oral health assessment, signing up for WIC benefits, etc.