

Eastern Oregon Coordinated Care Organization (EOCCO)

Transformation Plan Summary

Background

The Eastern Oregon Coordinated Care Organization (EOCCO) transformational work up to this point has been focused on the transition of those lives from the FCHP/PCO model previously in place to the new EOCCO model of care. They have begun providing medical benefits in 11 counties, and expect to begin providing services in Gilliam County in June 2013. Focus during this period has been on continuity of care and transitional case management for complex medical needs.

EOCCO has engaged their stakeholders via collaborative case conferences, face-to-face meetings with key local stakeholders, and one-on-one conversations with providers. Their most significant work to this point has been an agreement with five local hospitals, an IPA and a large provider group to buy into the EOCCO. These stakeholders have already begun to identify collaborative strategies to expand the non-traditional health care workforce and add primary care services for Medicaid members.

Transformation Initiative Descriptions

(1) Area of Transformation: Developing and implementing a health care delivery model that integrates mental health and physical health care and addictions and dental health, when dental services are included. This area of transformation must specifically address the needs of individuals with severe and persistent mental illness.

EOCCO is working in the context of existing, differing and ongoing integration work across its 12-county region. Their approach is based on the Healthcare Neighborhood concept, the SAMHSA continuum of care model, integrated case management, expanded community care coordination, child resilience activities, provider education about SBIRT, behavioral and addictions integration.

The initial steps to developing this system will include effective care coordination amongst the initial EOCCO entities of GOBHI and ODS, and further partnerships with community based organizations and providers. The overarching goal is to reduce fragmentation and thereby promote better clinical outcomes for EOCCO members.

Benchmarks for July 1, 2015 include: reporting on Early Assessment and Support Alliance, Assertive Community Treatment, Supported Employment and associated wrap around programs; contracting with medical clinics in at least three counties as voluntary early adopters; achieving a 1:1 ratio of case rate based contracts with social and medical detox Providers; contracting with

all residential addictions providers; and completing contracts with the remaining nine counties for outpatient behavioral health and addictions integration.

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

Currently there are four clinics certified as a PCPCH in the EOCCO service area. Based on community feedback, EOCCO's goal to improve development of provider PCPCH status will be focused on several areas: provider education and training; developing solutions to PCPCH barriers; exploring financial incentives through alternative payment methodologies for clinics that have achieved PCPCH recognition; providing technical support; and patient engagement.

Benchmarks for 2015 include: at least 50 % of Members assigned to a certified PCPCH at any tier level; all PCPCH certified Providers contracted using consistent Alternative Payment Methodologies; making consistent technical assistance tools and member engagement tools available to PCPCH certified Providers.

(3) Area of Transformation: Implementing consistent Alternative Payment Methodologies that align payment with health outcomes.

EOCCO's service area includes many rural hospitals, health clinics, and FQHCs. The Type A hospitals in the EOCCO service area have collaborated with the Oregon Association of Hospitals and Health Systems (OAHHS) Rural Health Reform Initiative (RHRI) payment reform project. EOCCO will also leverage the existing GOBHI behavioral health alternative payment model. EOCCO plans to utilize concepts of Direct Primary Care (similar to approaches taken in Hood River County) to improve delivery of primary care to rural uninsured members.

EOCCO will develop a steering committee of primary care providers and hospitals to explore payment methodologies including: Modified fee for service arrangements, PCPCH PMPM payments, shared savings, bundled payments for episodic care, pay-for-performance and capitation. They will also begin capitation pilot projects to a critical access hospital and to a primary care clinic.

Benchmarks by July 1 2015 include: developing and piloting APMs; tracking the number of providers and hospitals adopting APMs; developing a rural hospital value-based dashboard (with performance metrics) that will be used to award shared Contractor savings to hospitals; and measuring outcomes of providers who have implemented APMs.

(4) Area of Transformation: Preparing a strategy for developing Contractor's Community Health Assessment and adopting an annual Community Health Improvement Plan consistent with SB 1580 (2012), Section 13.

EOCCO is currently working with representatives in each of the 12 counties to identify, establish and finalize the membership of each counties local Community Advisory Council (CAC). Each local CAC will be primarily responsible for conducting a Community Health Assessment (CHA) and for drafting a county Community Health Improvement

Plan (CHIP) based on the needs identified in the CHA. EOCCO is also establishing a Regional Community Advisory Council to assist the county CACs with resources and oversight, to aid in coordination of regional community health information, and oversee regional CHA and CHIP plans. The R-CAC will be comprised of one representative from each local CAC and one County Commissioner from each county. The RAC presents final CHA and CHIP plans to the EOCCO Governing Board.

EOCCO's CHIP will be submitted to OHA by 6/30/2014. By July 1 2015, all of the CACs will have implemented CHIP in their respective county and begin tracking outcomes; be participating in active CACs with consistent regular meetings and an established structure; and will have implemented or be participating in a CHIP in their respective county. All CACs will actively track outcomes measurements and begin making necessary changes and improvements, and provide an annual progress report.

(5) Area of Transformation: Developing a plan for encouraging Electronic Health Records; health information exchange; and meaningful use.

EOCCO will assist its providers in facilitating the use of electronic health records and in the course of provider contracting efforts. EOCCO will establish a Health Information Exchange (HIE) Steering Committee to focus on HIE adoption, meaningful use, provider connectivity regarding patient care, clinical connectivity between providers and payer, tracking analytics/quality reporting, and patient engagement.

EOCCO is planning to roll out EHR to patients an online web portal that will provide electronic health information to focus the member on being involved in the process to improve their health. This platform will also capture patient email addresses and other information to begin the electronic experience with the patient.

Benchmarks by July 1, 2015 include working with the state-level HIE planning through OHA; implementing the steering committee's plan; assessing and tracking the success of the implementation; and measuring the number of Members that access the online customized portal.

(6) Area of Transformation: Assuring communications, Outreach, Member engagement, and services are tailored to cultural, health literacy, and linguistic needs.

Five of the counties in the EOCCO service area are among the most diverse Oregon counties outside the Portland metro area. In Eastern Oregon, the rate of Non-White Hispanics rises as high as 32% in Morrow County and 51.3% in Malheur County, according to US Census data.

EOCCO will work with the CACs to ensure that cultural, health literacy and linguistic needs are acknowledged and addressed. Goals include developing local CAC health literacy and cultural competency policies for member materials; conducting demographic assessment; providing staff training on cultural competency; implementing certification for health interpreters; and engaging members through the CACs.

Benchmarks for July 1 2015 include: 60% of consumer materials have been revised according to the policy; all county and/or regional demographics reports have been completed and disseminated to 80% of Participating Providers; 95% of staff has completed training; and processes have been implemented to ensure ongoing and new hire training incorporate key elements of culturally and linguistically appropriate services training.

(7) Area of Transformation: Assuring that the culturally diverse needs of Members are met (Cultural Competence training, provider composition reflects Member diversity, non-traditional health care workers composition reflects Member diversity).

EOCCO providers include those whose patterns of care cross state boundaries, and clinics that have traditionally focused on serving the Hispanic population. EOCCO will work to identify and develop strategies to improve culturally competent direct patient care, increase engagement in appropriate levels of care, improve quality and effectiveness of member interactions, and integrate cultural competence and health literacy into the healthcare system.

EOCCO will conduct a clinic assessment of providers to determine where culturally diverse populations are being served and to create clinic profiles identifying Spanish-speaking providers. EOCCO will also conduct clinic staff trainings on health literacy and cultural competency (including material from the local CACs).

Benchmarks for July 1 2015 include: 100% of clinic profiles will be developed and utilized in coordination of care for Spanish-speaking Members; 75% of Participating Providers and clinic staff have completed training and processes have been developed for continuing education.

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

EOCCO is developing a QI plan, and will explore the use of indirect estimation methodology for race, ethnicity and language data collection. They have developed benchmarks to collect data on 30% - 70% of their members. EOCCO is considering outcome, access, patient experience, and process measures among their quality improvement initiatives.

For the current year, EOCCO is focusing on laying a data foundation for their plan and training the provider community and clinic staff in understanding and responding to cultural needs and appropriate methods of collecting racial, ethnic and linguistic data. EOCCO is also establishing a systematic approach to collect data via the new member and/or initial health assessment.

Benchmarks for July 1, 2015 include: obtaining reliable and accurate demographic data on 70% of the population, and training 75% of the Participating Providers and clinics. EOCCO will conduct audits on continuing education; data collection via the health assessment. QI measures will address race, ethnic, linguistic, health literacy, disability barriers identified in the health assessment.