

## Transformation Plan Final Benchmark Report Eastern Oregon Coordinated Care Organization

July 31<sup>st</sup>, 2015

### Transformation Area 1: Integration of Care

<b>Benchmark 1.1</b>	
How Benchmark will be measured (Baseline to July 1, 2015)	<ul style="list-style-type: none"> <li>Contractor will have a process for tracking Members identified as appropriate for co-management developed. Communication and referral plan in place. Number of Members co-managed, or referred, reported monthly.</li> </ul>
Milestone(s) to be achieved as of July 1, 2014	<ul style="list-style-type: none"> <li>Contractor develops criteria for triggering Intensive Case Management for Members and referrals for Members identified as high risk and needing collaborative mental health, physical health and addictions care coordination and Intensive Case Management.</li> </ul>
Benchmark to be achieved as of July 1, 2015	<ul style="list-style-type: none"> <li>Identification and tracking process is evaluated semi-annually. Improvement opportunities identified and implemented.</li> </ul>
<b>Benchmark 1.2</b>	
How Benchmark will be measured (Baseline to July 1, 2015)	<ul style="list-style-type: none"> <li>Use existing measurement system with OHA to report on Early Assessment and Support Alliance, Assertive Community Treatment, Supported Employment and associated wrap around programs.</li> </ul>
Milestone(s) to be achieved as of July 1, 2014	<ul style="list-style-type: none"> <li>Early Assessment and Support Alliance, Assertive Community Treatment, Supported Employment and associated wrap around programs available to all Members in all 12 counties.</li> </ul>
Benchmark to be achieved as of July 1, 2015	<ul style="list-style-type: none"> <li>Achieve fidelity for programs as established by State standards.</li> </ul>
<b>Benchmark 1.3</b>	
How Benchmark will be measured (Baseline to	<ul style="list-style-type: none"> <li>Count the number of counties with contracts between medical clinics and</li> </ul>

July 1, 2015)	Community Mental Health Program clinics for provision of specific behavioral health services in medical clinics.
Milestone(s) to be achieved as of July 1, 2014	<ul style="list-style-type: none"> <li>• Contract with medical clinics in at least three counties as voluntary early adopters.</li> <li>•</li> </ul>
Benchmark to be achieved as of July 1, 2015	<ul style="list-style-type: none"> <li>• Contracts with medical clinics in at least three additional counties.</li> </ul>
Benchmark 1.4	
How Benchmark will be measured (Baseline to July 1, 2015)	<ul style="list-style-type: none"> <li>• Ratio report of the number of case rate based contracts with social and medical detox Providers as compared to the total number of social and medical detox Providers.</li> <li>• Count the number of contracts with residential addictions Providers.</li> <li>• Count the number of outpatient, integrated, behavioral health and addictions contracts. (Count each county group as one contract.)</li> </ul>
Milestone(s) to be achieved as of July 1, 2014	<ul style="list-style-type: none"> <li>• 1:1 ratio of case rate based contracts with social and medical detox Providers.</li> <li>• Contract with all three existing residential addictions Providers per the jointly defined payment model established at February 2013 meeting.</li> <li>• Complete pilot contracts with at least three communities as optional early adopters for outpatient behavioral health and addictions integration.</li> </ul>
Benchmark to be achieved as of July 1, 2015	<ul style="list-style-type: none"> <li>• 1:1 ratio of case rate based contracts with social and medical detox Providers.</li> <li>• Contract with all three existing residential addictions Providers per the jointly defined payment model established at February 2013 meeting</li> <li>• Complete contracts with the remaining nine counties for outpatient behavioral health and addictions integration.</li> </ul>

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
<p>1. 1.1: Monthly meetings continue between EOCCO staff (Moda/GOBHI), hospital representatives, clinic representatives, and APD.</p> <p>1.1: Communication between EOCCO staff hospital representatives, clinic representatives, and APD continue primarily via secure e-mail, phone conversations, and monthly collaboration meetings.</p>	<p>The LTC MOU was updated in June 2014 to allow for more open communication and collaboration between key stakeholders. Currently, Baker and Malheur Counties conduct monthly collaboration meetings. Participants in these meetings include EOCCO staff (Moda/GOBHI), APD, hospital representatives, and clinic representatives.</p> <p>A report has been developed for use at these monthly collaboration meetings. This is a report that includes risk scores based on predictive modeling using claim information such as diagnoses, ER visits and clinic visits. Behavioral health diagnoses have recently been added to this report. Additional information includes:</p> <ul style="list-style-type: none"> <li>• Members already receiving APD services <ul style="list-style-type: none"> <li>○ Changes in member condition/situation are reported to APD.</li> </ul> </li> <li>• Members not yet receiving APD services <ul style="list-style-type: none"> <li>○ Members are referred to transition coordinators as necessary and appropriate. <ul style="list-style-type: none"> <li>▪ Moda case managers and inpatient care coordinators receive ongoing training regarding referral and continued communication processes between and amongst key stakeholders: <ul style="list-style-type: none"> <li>• APD</li> <li>• PCP</li> <li>• Specialty Clinics</li> </ul> </li> </ul> </li> </ul> </li> </ul>	<p>The EOCCO ICM and Care Coordinators are working together with APD District Manager to initiate the collaboration team program in Umatilla County.</p> <p>Develop a system to have comprehensive, shared care plans involving everyone working with the member. Currently, communications and plans of care are shared at the monthly meetings and ongoing throughout the month via secure e-mails and phone conversations.</p> <p>A formal tracking system has not yet been developed. Communications continue with the current</p>

	<p><b>1.1: Members with complex needs continue to be referred to ICMs for evaluation from multiple sources</b></p>	<ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Members</li> <li>• GOBHI</li> <li>• CMHPs</li> </ul> <p><b>Members with complex needs are identified and referred to ICM via:</b></p> <ul style="list-style-type: none"> <li>• Prior Authorization Process</li> <li>• Inpatient Concurrent Review</li> <li>• Health Risk Assessment Review</li> <li>• Referrals from Clinics</li> <li>• Referrals from APD</li> <li>• Internal High Dollar Report (claims report)</li> <li>• Self-Referrals</li> </ul>	<p><b>collaboratives.</b></p> <p><b>Formal meetings have begun to initiate multidisciplinary collaboratives in Umatilla and other counties.</b></p> <p><b>EOCCO continues to explore options for initial review and triage for HRA's to ensure they are reviewed on a consistent and timely basis.</b></p>
<p><b>2.</b></p>	<p><b>1.2: All eight community mental health programs (CMHPs) in EOCCO are actively pursuing and some have achieved evidence-based practice (EBP) fidelity for assertive community treatment (ACT) and supported employment (SE). Most of the CMHP's are still actively recruiting for various positions required for fidelity, such as psychiatrists, nurses, QMHP's, or QMHA's. The inability to find or retain qualified personnel has hampered efforts towards achieving fidelity, yet all are actively working with OSEACT to problem solve this situation and EOCCO is providing technical support in workforce development.</b></p>	<p><b>Of the eight CMHPs, three have maintained ACT fidelity, and five are within seven to 20 points of achieving ACT fidelity</b></p> <p><b>Of the eight CMHPs, two have maintained SE fidelity and the remaining six continue developing the program.</b></p> <p><b>The EASA HUB design is working efficiently within the EOCCO counties. Fidelity has been achieved.</b></p> <p><b>Not all Counties have enrolled members into Wrap Around. The program is operational and all counties have received assistance in identifying potential members who would benefit from engagement. Reporting has been improved, yet there are still some areas within the reporting that need to be improved upon. Technical assistance to counties continues.</b></p>	<p><b>Continue to provide technical assistance, monitoring and oversight in CMHPs' progression toward EBP fidelity standards for ACT and SE, focusing on:</b></p> <p><b>A. Workforce development and recruitment. We are in the process of hiring a "Recruitment HR Specialist" for the purpose of targeting specifically these positions. Workforce shortages are impacting CMHP's in all general operations and a major</b></p>

<p>Early Assessment and Support Alliance (EASA) certification is still being developed utilizing a HUD design. Eastern Oregon CCO hired an EASA Coordinator on 1/5/15. This position is employed by Center for Human Development (CHD) in La Grande, Oregon. CHD currently holds a direct contract with OHA for the provision of these services. EOCCO is utilizing the service coordination model by focusing on the five (5) Counties who are collaborating together (Malheur/Umatilla, Wallowa, Baker, and Union). The EASA Coordinator will begin working with the EASA lead in each of these Counties to develop their program.</p> <p>SOC/WI is still under development with the site leads planning and implementing. The program is underway in the following four (4) Counties – Baker, Malheur, Umatilla, and Union.</p>		<p>impediment to recruitment is the lack of specific focus on ACT/SE positions. Efforts are underway to establish collaborations with EOU and PSU for placement of MSW interns into our CMHP's,</p> <p>B. Implementation of financial incentive strategies to maintain FTE to meet intensive EBP requirements. Approval for a incentive based award allocation has been given for CMHP's that meets a specific threshold of services delivered within the ACT/SE programs. County Directors were instrumental in this design and support its potential impact at increasing achievement of fidelity.</p> <p>C. Outcomes monitoring and reporting. Improved methods of providing CMHP's with information on performance within</p>
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			<p><b>the ACT/SE programs has been established.</b> <b>Though this is not real time, the reports reflect current performance with at worst a 60 day delay. This is highly dependent on submission of clean claims.</b></p> <p><b>Recruitment of another EASA Coordinator has happened. The new EASA Coordinator has been very effective in achieving an approved model. See notes in "Outcomes to date."</b></p> <p><b>The process of identification and enrollment of potential youth in this program has occurred in all Counties. There are still some coordination issues, but generally a well-designed process has been created to identify, refer, monitor, and report current activity, outcomes, and areas for improvement.</b></p>
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3.	<p><b>1.3: EOCCO has established contractual relationships between the behavioral health providers and medical clinics.</b></p>	<p><b>Agreement has been reached with physical health clinics and Hospitals in four high population catchment areas to establish integrated care.</b></p>	<p><b>Formal relationship exists with Grand Ronde Hospital.</b></p> <p><b>Contracts with Grande Ronde hospital and Treasure Valley Pediatrics are in place.</b></p> <p><b>Harney District Hospital, St. Anthony's, Winding Waters and Marisol Family Health Center are pending.</b></p>
4.	<p><b>1.4 (a): To date, case-rate-based contracts with social and medical detox providers have been established.</b></p> <p><b>1.4 (b): Contracts between EOCCO and all three existing residential addictions treatment providers have been established.</b></p> <p><b>1.4 (c): All nine (9) catchment areas (CMHP's + Substance Use Disorder treatment providers*) have adopted integrated outpatient behavioral health programs by entering into single-risk-bearing contracts for mental health and addictions treatment.</b></p> <p><b>* Only one catchment area has a segregated MH and SUD provider;</b></p>	<p><b>(a) - Contractual relationships have been established with Medical and Social detox facilities within the EOCCO catchment area, plus those within other network areas. This has provided sufficient capacity to meet the needs of the EOCCO enrolled membership.</b></p> <p><b>(b) – All three residential providers have established contracts that have been operational for one and a half (1.5) years.</b></p> <p><b>(c) – All nine (9) catchment areas have established joint risk bearing agreements for the delivery of outpatient mental health and substance use disorder treatment.</b></p>	<p><b>Monitor utilization patterns of both Medical and Social Detox programs to ensure adequate capacity exists and utilization is medically appropriate.</b></p> <p><b>Monitor utilization patterns within the residential addiction field to ensure medical appropriateness and adequate capacity.</b></p>

	<p><b>the remainders are already integrated.</b></p>		<p><b>Monitor outpatient provision of both MH and SUD treatment to ensure delivery of integrated care based on medical appropriateness and adequate capacity to mitigate undue risk.</b></p> <p><b>July 2015: Monitoring has shown that adequate capacity exists within the EOCCO region for these services.</b></p>
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**1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.**

**Barriers in 1.1:** Development of the updated MOU proved to be more difficult than initially anticipated. This was primarily due to concerns among the key stakeholders related to sharing of members’ personal health information. Other barriers to achieving milestones have primarily been related to time constraints, staffing, and scheduling conflicts. As a result, the collaboration teams do not currently have a formal or a consistent method for documentation of collaboration meeting content, results, and/or required follow up. The collaboration teams have not identified and/or implemented a process for tracking referrals to APD or to monitor process improvements and member outcomes. The collaboration teams have not yet developed a comprehensive shared care plan. The Health Risk Assessment reviews are not completed consistent and timely.

Primary barriers in 1.2: The ability to recruit and retain qualified professionals for these fidelity based programs. However, in all catchment areas these services are available and being delivered in a modified fashion that approximates fidelity.

Primary barrier to 1.3: Ability to establish terms and conditions within the contracting language.

Primary barrier to 1.4: No barriers.

**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.**

**Strategies for 1.1:** Development of the updated MOU evolved as a result of the persistence of all the key stakeholders in researching rules and regulations and sharing feedback. The collaboration teams have established set days/times for their monthly meetings, resulting in improved and more consistent attendance. The collaboration teams will begin to develop a more formal and consistent process for documentation of collaboration meeting content, results, and/or required follow up including, but not limited to structured minutes. The collaboration teams will begin to develop a multidisciplinary shared care plan unique to the collaboration team composition. The collaboration teams will begin to develop a consistent method for tracking referrals to APD and to monitor the process. Additionally, the collaboration team will explore data analytics designed to evaluate member utilization and outcomes both before and after collaboration team interventions. New nurses are being trained on an updated HRA review process and plans are being formulated to include more nurses and health coaches in the HRA review process. Additional staffing resources are being explore for review and triage of the HRA's.

**Strategies for 1.2:** Have included enhanced funding to support workforce development and incentives and the provision of human resources technical assistance. This would include the hiring of a "Recruitment HR Specialist" for ACT/SE programs, plus other programs as necessary to maintain fidelity achieved in other areas. A new incentive methodology has been approved and sanctioned by the CMHP Directors for ACT/SE that should improve ability to achieve, then "sustain" fidelity.

**Strategies for 1.3:** Have included continued discussions with local CMHP's and medical clinics/hospitals to create contract language, performance standards, and risk bearing methodology that can be supported by both sides and within one organization.

**Strategies for 1.4:** Will include continued monitoring for contract compliance, utilization management, and quality assurance/improvement.

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

While the LCACs were not involved directly in these transformation activities, some of the LCAC members are providers or staff of the entities working on these transformation activities.

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

EOCCO medical staff communicates regularly with community agency representative who are on the RCAC.

This EOCCO transformation plan progress report will be provided to the RCAC at their next meeting and presented to each of the LCACs during their next meetings.

### Transformation Area 2: PCPCH

Benchmark 2	
How Benchmark will be measured (Baseline to July 1, 2015)	<ul style="list-style-type: none"> <li>• Contractor will measure the number of Members assigned to a certified PCPCH at each tier level.</li> <li>• Implement Alternative Payment Methodologies for PCPCH certified Providers, such as modified fee for service payments, PMPM chronic disease management payments, Pay for Performance bonus payments, and a shared savings program</li> <li>• Implement technical assistance tools to assist PCPCH Providers in meeting quality outcomes.</li> <li>• Implement strategies to develop certified PCPCH Member engagement programs for certified PCPCHs.</li> </ul>
Milestone to be achieved as of July 1, 2014	<ul style="list-style-type: none"> <li>• At least 25 % of Members will be assigned to a certified PCPCH at any tier level.</li> <li>• Seek agreement with and implement Alternative Payment Methodologies in at least three certified PCPCHs.</li> <li>• Identify and seek approval of PCPCH certified Providers on technical assistance tools that will assist them in meeting quality outcomes.</li> <li>• Identify and seek approval of PCPCH certified Providers on how Contractor can assist with Member engagement.</li> </ul>
Benchmark to be achieved as of July 1, 2015	<ul style="list-style-type: none"> <li>• At least 50 % of Members will be assigned to a certified PCPCH at any tier level.</li> <li>• Contractor will have all PCPCH certified Providers contracted using consistent Alternative Payment Methodologies.</li> <li>• Contractor will have consistent technical assistance tools available to PCPCH certified Providers.</li> <li>• Contractor will have consistent Member engagement tools available to PCPCH certified Providers.</li> </ul>

1. a) Please describe the actions taken or being taken to achieve milestones in this transformation area. For each activity, describe the outcome and any associated process improvements.

Activity (Action taken or being taken to achieve milestones)		Outcome to Date	Process Improvements
1.	EOCCO continues to provide enhanced payments on a per member per month basis for each EOCCO patient enrolled with a certified PCPCH, based on the tier level of the provider’s certification. These additional payments help encourage providers who are not yet PCPCHs and to reward providers who are currently certified.	According to our records, EOCCO now has over 64% of patients enrolled in a PCPCH.	Enhanced payments provide additional revenue to PCPCHs to support staffing and infrastructure associated with maintaining or improving PCPCH certification. The EOCCO Board appointed a Risk Contract Surplus and Incentive Measures Subcommittee in April, 2015, charging it with creating recommendations for distribution of any 2014 risk contract surplus and quality measure distributions. The Subcommittee met several times and in May, 2015 the Board accepted the Subcommittee’s recommendation including a recommendation to increase the enhanced PCPCH payments for tier 3 medical homes to \$15 PMPM.
2.	EOCCO continues providing training and assistance to PCPs working toward PCPCH certification and to support practices to enhance their tier level of certification.	Since our January 2015 progress report two additional clinics have obtained PCPCH certification and two clinics have increased their tier level.	In an attempt to incent Tier 2 PCPCHs to become certified as a Tier 3, the Board accepted the Subcommittee’s recommendation to increase Tier 2 PCPCH payments by \$2 PMPM if the clinic signs a pledge stating that they will achieve Tier 3 status within 6 months. EOCCO is also proud that one of our PCPCHs, Winding Waters Clinic in Enterprise, has become the state’s first 3 Star PCPCH.

3.	<p>EOCCO is providing one-on-one training to providers who need additional assistance in becoming a PCPCH. These trainings are provided by physicians and staff experts with experience in PCPCH certification or with experience assisting clinics in transforming their practice into a PCPCH.</p>	<p>To date, one-on-one assistance by EOCCO's clinical consultant resulted in one additional practice receiving PCPCH certification.</p>	<p>EOCCO has dedicated staff to provide PCPCH certification training to providers.</p>
4.	<p>In addition to the enhanced PCPCH case management payments, EOCCO has contracts with two PCPCH's using a capitated payment methodology.</p> <p>In April 2015, EOCCO implemented a revised shared savings/APM risk model. Through our 2015 shared savings/APM risk model primary care providers were given the option of participating at full risk or without risk. Participation by primary care providers in our 2015 shared savings/APM risk model increased compared with 2014 participation levels.</p>	<p>EOCCO has implemented two capitated agreements to date with PCPCH clinics.</p> <p>EOCCO implemented revised shared savings/APM risk contracts with primary care practices in April 2015</p> <p>Participation in our shared savings/APM risk model increased compared with 2014 participation.</p>	<p>EOCCO's 2014 shared savings/APM risk contract had a surplus. As a result savings were shared back with participating primary care clinics, physicians and advanced practice providers who participated. In addition, funds were returned to those participating providers who submitted clinical quality metric data to EOCCO for calendar year 2014.</p>
5.	<p>EOCCO is sending progress reports to primary care practices in the EOCCO service areas on a quarterly basis. The progress reports focus on seven of the 17 CCO incentive measures that we believe providers can have the most impact on. Within the progress reports, we provide our CCO baseline and target goals for the calendar year.</p> <p>In addition, we provide member-level information on the patients assigned to the respective clinic or provider and include details on which members are eligible for specific screenings, which members have received the needed screenings and which members still require the needed screenings. We also provide</p>	<p>Providers are using the progress reports as a tool to improve EOCCO incentive measures.</p> <p>EOCCO's Clinical Advisory Committee provides input on the progress report design.</p> <p>EOCCO includes a list of high cost/high risk members as part of the progress report.</p>	<p>EOCCO has refined the progress report based on provider input and will include a session on "best uses" at its annual Provider and Staff Summit to be held on September 11, 2015.</p> <p>EOCCO anticipates including opioid prescription information in the progress reports beginning in the third quarter of 2015 as requested by our clinical advisory panel.</p>

	<p><b>details on the number of ER visits each member has accumulated during the year highlighting those members with three or more ED visits in the calendar year.</b></p> <p><b>EOCCO is also providing behavioral health information and anticipates providing opioid prescribing patterns in the progress reports by third quarter 2015.</b></p>		
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**1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.**

To date, we have exceeded our expectations with respect to the number of patients enrolled with a PCPCH. With an initial 2011 baseline of only 3.7 percent of patients enrolled in a PCPCH, we are very happy with our progress. For our very small clinics, 24/7 access to medical advice continues to be a barrier. EOCCO will continue to provide additional assistance in transforming small practices into PCPCHs.

Providers in our region have traditionally been paid on a fee-for-service basis in large part because of our high number of critical access hospitals, rural health clinics and federally qualified health centers. Acceptance of other payment models has been met with some resistance but as time goes on that resistance is decreasing.

EOCCO provides “progress reports” to primary care offices as a tool to assist EOCCO in meeting incentive measures. We have discovered that not all providers review the progress reports and may not understand how to read them despite our efforts to inform them. EOCCO’s Clinical Advisory Panel continues working on improving progress report design, content and usage.

**1 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.**

EOCCO sponsored and hosted two PCPCH forums in eastern Oregon in October 2013. The forums were attended by 70 clinicians and administrators throughout the EOCCO service area. EOCCO sponsored a Provider Summit in October 2014 that included a PCPCH Panel composed of providers from four PCPCHs which discussed the issues facing PCPCHs in eastern Oregon and solutions to those problems. The Panel was well received by the approximate 70 attendees. EOCCO’s next provider and staff summit will be 9/11/2015 and will include a session on Adolescent Well Care Visits, SBIRT, First Tooth, One Key Question, and progress report “best uses.”

EOCCO’s Clinical Advisory Panel meets bimonthly and regularly discusses how EOCCO can improve care provided by our PCPCHs. The panel includes representative from six different certified PCPCHs.

EOCCO continues to provide one-on-one training to provider offices that need additional assistance in becoming a PCPCH.

EOCCO will continue to work one-on-one with provider offices to make sure they are reading, understanding and using the progress reports.

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

The EOCCO Board will be distributing funds from its 2014 shared savings/APM risk contract surplus and quality measure returns to its twelve Local Community Advisory Councils. The LCAC’s will implement activities which will help EOCCO meet future quality measure targets.

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

We are educating LCACs about EOCCO’s performance on the incentive measures, which includes the percent of EOCCO members enrolled in a certified PCPCH. EOCCO is also working out the guidelines for how the LCAC’s will use of the 2014 shared savings/APM risk contract surplus and quality measure returns mentioned above.

**Transformation Area 3: Alternative Payment Methodologies**

Benchmark 3	
How Benchmark will be measured (Baseline to July 1, 2015)	<ul style="list-style-type: none"> <li>• Contractor will track the number of Primary Care Providers, Provider payments, and the number of Members served by clinics that are piloting Alternative Payment Methodologies.</li> <li>• Contractor will track the number of hospitals and Provider payments that are piloting Alternative Payment Methodologies.</li> <li>• Implement Alternative Payment Methodologies for Providers who become PCPCH certified such as modified FFS payments, PMPM chronic disease management payments, P4P bonus payments and a shared savings program.</li> <li>• Contractor will annually review its PCPCH payment methodologies to determine effectiveness; including growth in the number of certified PCPCHs, growth in enrollment and Member engagement, and improvement in value-based performance measures.</li> </ul>

<p>Milestone to be achieved as of July 1, 2014</p>	<ul style="list-style-type: none"> <li>• Identify and seek approval from Participating Providers on Alternative Payment Methodologies to be piloted with Providers, certified PCPCH clinics, and hospitals.</li> <li>• Contractor will begin piloting Alternative Payment Methodologies via contract amendments, in compliance with OHA reimbursement requirements and Oregon Association of Hospitals and Health Systems (OAHHS) recommendations for payment of Type A and Type B hospitals.</li> <li>• Contractor will implement a capitation payment system with a least one primary care clinic.</li> <li>• Contractor will implement a capitation payment system with at least one Type A hospital.</li> <li>• Contractor will implement an actuarial-based process for cost-based payments that is not solely financially based.</li> <li>• Contractor, with the help of OHA and OAHHS, will develop a sound rationale for continuation of cost-based payment (or equivalent financial support) for hospitals, Provider based clinics, Fully Qualified Health Clinics, and Rural Health Clinics utilizing variables such as demographics, geography, and financial factors.</li> <li>• Contractor, with the help of its hospitals and OAHHS, will develop a rural hospital, value-based dashboard (with performance metrics) that will be used to award shared Contractor savings to hospitals.</li> <li>• Contractor, with the help of its hospitals and community CAC, will support a community-based health care delivery model that sustains access to local services and repurposes current infrastructure and staff as needed.</li> </ul>
<p>Benchmark to be achieved as of July 1, 2015</p>	<ul style="list-style-type: none"> <li>• Measure effectiveness of efforts to transform payment delivery.</li> <li>• Measure outcomes of Providers who have moved to Alternative Payment Methodologies.</li> </ul>

1. a) Please describe the actions taken or being taken to achieve milestones in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Activity (Action taken or being taken to achieve milestones)	Outcome to Date	Process Improvements
1.	<p>EOCCO has worked one-on-one with primary care practices to implement alternative methodology agreements (capitation agreements).</p> <p>EOCCO implemented shared savings/APM risk contracts with primary care practices beginning 4/1/14. The goal of the risk contracts is to reward providers for the savings achieved as a result of transformation.</p> <p>EOCCO implemented a revised shared savings/APM risk contract that provided primary care practices the option to assume 100% of the risk for primary care services or have no downside risk</p> <p>The 2015 EOCCO shared savings/APM risk model was expanded to include specialists and GOBHI as participants in the model.</p>	<ol style="list-style-type: none"> <li>1. EOCCO has implemented alternative payment methodology contracts (capitation agreements) with four primary care practices.</li> <li>2. EOCCO implemented shared savings/APM contracts with primary care practices that chose to participate.</li> <li>3. EOCCO is providing quarterly progress reports to primary care practices to support their efforts with member engagement.</li> </ol>	<p>EOCCO is providing routine shared savings/APM risk model performance reports to participating primary care providers.</p> <p>EOCCO is providing quarterly report cards and high risk member reports to primary care practices.</p> <p>EOCCO increased the number of entities participating in its shared savings/APM model in 2015 compared with 2014 participation levels.</p>

		<ol style="list-style-type: none"> <li>4. EOCCO finalized and implemented its 2015 shared savings/APM risk model and included Specialists and GOBHI in the model.</li> <li>5. EOCCO's 2014 shared savings/APM risk model had a surplus and savings were redistributed back to participating providers.</li> </ol>	
2.	<p>EOCCO implemented shared savings/APM risk contracts in 2014 with all 10 hospitals in the 12 county EOCCO region and with two tertiary hospitals outside the EOCCO region.</p> <p>The goal of the risk contracts is to reward hospitals for the savings achieved as a result of transformation. This is especially important for hospitals that are experiencing reductions in revenue as a result of decreased utilization.</p> <p>EOCCO implemented its 2015 shared savings/APM risk in April 2015.</p>	<ol style="list-style-type: none"> <li>1. EOCCO implemented shared savings/APM risk contracts beginning 4/1/2014.</li> <li>2. EOCCO implemented its 2015 shared savings/APM risk contracts beginning in April 2015.</li> <li>3. EOCCO's 2014 shared</li> </ol>	<p>EOCCO is providing routine shared savings/APM risk model performance reports to participating hospitals.</p> <p>EOCCO increased the number of hospitals participating in its shared savings/APM model in 2015 compared with 2014 participation levels.</p>

		<p>savings/APM risk model had a surplus and savings were redistributed back to participating hospitals.</p>	
3.	<p>EOCCO participated in the Rural Health Reform Initiative Workgroup (RHRI). The work group was an advisory workgroup that made recommendations to OHA regarding which hospitals in our service area should stay on cost-based reimbursement and which hospitals should move to an alternate payment methodology. The outcome of this work is critical in determining how EOCCO will approach alternate payment methodologies with our contracted hospitals beyond the shared savings/APM risk contract.</p> <p>EOCCO working closely with OHA and OAHHS developed agreements with three of our 10 area hospitals to transition them from a cost based payment model to an alternate payment methodology.</p>	<p>1. EOCCO moved three of our 10 hospitals from a cost base reimbursement model to an alternate payment methodology model effective 1/1/15.</p>	
4.	<p>The EOCCO Board acknowledges that improved collaboration between hospitals and the LCACs needs to occur so that we can move toward a community-based healthcare delivery model that sustains access to local services and repurposes current infrastructure and staff as needed. This is a long-term initiative. EOCCO believes that implementing shared savings/APM risk contracts with providers is a good step.</p>	<p>1. Through the EOCCO transformation grant several hospitals received funding to repurpose existing staff to fill care coordination roles including the use</p>	

	EOCCO is working to evaluate successful transformation grant programs to determine which programs EOCCO may want to fund once the transformation grant dollars are exhausted.	of community health workers.	
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**1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.**

Providers in our region have traditionally been paid on a fee-for-service basis in large part because of the high number of critical access hospitals, rural health clinics and federally qualified health centers. Despite these barriers 100% of the hospitals in our service area and primary care practices that service about 60% of our membership have agreed to participate in our 2014 shared savings/APM risk contracts.

We increased primary care practice participation in our 2015 shared savings/APM risk contracts.

**1 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.**

For primary care practices, we have been informing providers about the proposed payment alternatives including how these alternatives can be implemented into their practices without negatively impacting their RHC or FQHC reimbursement rates. We will continue providing one-on-one assistance to our primary care providers.

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

While the LCACs were not involved directly in these transformation activities, some of the LCAC members are providers or staff working at the primary care clinics or hospitals that would be impacted by these changes. However, the 2014 shared savings/APM risk contract attributed a percentage of any surpluses to the LCAC's. Because there was a surplus in 2014 LCAC's will receive funding which will be used to assist EOCCO in meeting future quality measures.

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

EOCCO will continue to share our shared savings/APM risk model performance with LCAC's. Additionally, LCAC's will receive funding as a result of EOCCO's 2014 shared savings/APM risk model surplus. LCAC's are also eligible for funding if there is a surplus from our 2015 shared savings/APM risk model.

#### Transformation Area 4: Community Health Assessment and Community Health Improvement Plan

Benchmark 4	
How Benchmark will be measured (Baseline to July 1, 2015)	<ul style="list-style-type: none"> <li>• Contractor will measure the number of counties with regular, continued local county and regional CAC (R-CAC) meetings.</li> <li>• Contractor will measure the number of local county CACs with completed community needs assessment reports and CHIP selection documents.</li> <li>• Contractor will measure the number of counties with active CHIP committee members.</li> </ul>
Milestone to be achieved as of July 1, 2014	<ul style="list-style-type: none"> <li>• 100 % of Contractor’s counties will have or be participating in an established local CAC and R-CAC with persistent, regular meeting times, as determined by the committee members.</li> <li>• 100% of CAC’s will have a complete Community Needs Assessment analysis and proposed CHIP.</li> <li>• Contractor’s CHIP will be submitted to OHA by 6/30/2014.</li> <li>• 100% of CACs will have implemented CHIP in their respective county and begin tracking outcomes.</li> </ul>
Benchmark to be achieved as of July 1, 2015	<ul style="list-style-type: none"> <li>• 100% of local counties will have or be participating in active CACs with consistent regular meetings and an established structure including, but not limited to, a mission, vision, goals and appointed leadership positions.</li> <li>• 100% of CACs will have implemented or be participating in a CHIP in their respective county, actively track outcomes measurements and begin making necessary changes and improvements, and provide an annual progress report.</li> </ul>

**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.	All 12 of the EOCCO counties have an established LCAC.	LCACs have regularly scheduled meetings. Seven meet monthly and four meet every other month. One meets monthly but has LCAC meetings every quarter. The other two meetings are dedicated to patient care quality improvement efforts among providers. The LCAC charter calls for meetings at least quarterly.	<p>The LCACs have established a routine schedule which seems to accommodate the most people. There are occasional “tweaks” to the meeting schedules due to holidays.</p> <p>Some LCACs decided to meet every other month after completing their CHIP. However, continuing workload increases have one switching back to every month (as of January 2015) and another considering it.</p> <p>One LCAC uses the format to also convene their “Network of Care.” EOCCO attends each of the monthly meetings whether it is LCAC or Network of Care.</p> <p>The key is having meaningful items to discuss and report.</p> <p>EOCCO added another 1.0 FTE dedicated to LCAC support in mid-2015 and another Director of Community Health Development in April 2016.</p> <p>To increase the level of OHP member participation, we have created a reimbursement process. This has recently been updated from \$35 plus expenses to a flat \$70 per meeting.</p>

	<p>There is also a Regional CAC comprised of the Chair of each LCAC and an elected county official or their designee.</p>	<p>The RCAC meets quarterly on the 4<sup>th</sup> Monday in March, June, September and December.</p>	<p>Further, we used OHA Technical Assistance resources to have a consultant work with our RCAC to devise better strategies for recruitment and retention of OHP members.</p> <p>We are attempting to improve attendance through deployment of “Go to Meeting” technology.</p>
2.	<p>All 12 LCACs completed a Community Health Assessment and a Community Health Improvement Plan.</p> <p>The EOCCO Regional CHIP was submitted to the OHA and approved with no compliance issues delineated.</p>	<p>The documents are all posted at <a href="http://www.eocco.com">www.eocco.com</a> under the Community tab.</p> <p>Each of the 12 counties has their own Community Health Assessment and individual CHIP.</p> <p>The CHIP is used as a focus for LCAC and RCAC activities.</p>	<p>The LCACs have mixed some of their Local CHIP activities with the receipt of OHA Transformation grant dollars which the EOCCO Board made available in a competitive grant process. As such, several LCACs are beginning to track outcomes around those activities in their Local CHIP that were funded under the grants. However, parts of the Local CHIPs have not garnered attention because there are no funds to implement them. Still, many LCACs review their Local CHIPs periodically at meetings.</p> <p>The EOCCO helped form an independent non-profit organization called the Eastern Oregon Healthy Living Alliance (EOHLA). EOHLA is designed to raise foundation and government grants to implement the Regional CHIP. This group has successfully incorporated, approved bylaws, established a bank account and is currently applying for IRS tax exempt status as a 501 c 3. EOHLA</p>

			<p>held a Funder’s Brief to describe to invited participants what is in the CHIP and the resources needed for implementation.</p> <p>The EOHLA held interviews for its first Executive Director position and selected a candidate who will begin the job on September 1, 2015.</p>
3.	<p>The 12 LCACs and the RCAC have been in the process of recruiting and electing new leadership positions.</p> <p>The LCAC Charter calls for each LCAC to determine methods of voting, quorum etc.</p> <p>Annual progress reports for the 12 LCACs and the RCAC are being developed.</p>	<p>Elections for new officers were held as called for in the charters.</p> <p>Other than approving the Local CHIP, there has not been a need to “vote” on anything. Consensus works for the most part until money is being discussed and used. The RCAC and LCACs have reviewed their charters and those revisions include a method of voting. The full EOCCO Board of Directors will review and hopefully approve the changes at its meeting on August 25, 2015.</p> <p>Staff compiled an annual report from the RCAC to the EOCCO Board of</p>	<p>The EOCCO Board of Directors responded well to the challenges identified by the RCAC in the Annual Report. They increased the resources available to the LCACs to meet Incentive Measures, Moda Health and GOBHI staff are building closer relationships around data and resources are deployed to increase the number of consumers on the LCACs.</p>

		<p><b>Directors. It was accepted by the Board in April 2015.</b></p> <p><b>Each of the 12 LCAC's also produced a Annual Report describing their process on Transformation Grants, use of Incentive Measure dollars and progress on recruiting OHP members to the LCAC</b></p>	
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**1 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.**

Achieving benchmarks around process has been accomplished but with limited challenges. The challenges mainly revolve around the distance needed to cover in this large geographic area. Staff travel time in support of the LCACs involves driving many miles. It is difficult to get representation from all 12 LCACs at regional meetings. Travel support for participation varies depending on the location of the meeting, but generally it costs between \$3,000 and \$5,000.

OHP membership on the LCACs has been a constant concern and continues to be despite using OHA technical Assistance dollars to have the Oregon Public Health Institute work with the RCAC in developing a plan.

Planning without knowing if there is money to implement is a constant problem. The Community Health Assessments were fine. However, when the LCACs were developing their CHIPs they constantly asked “how much money do we have to plan with?” Not having an answer was problematic. New resources made available to the LCACs totaling \$422,000 will help efforts to improve Incentive Measures which MAY align with their CHIP but many portions of the CHIPs continue to not be funded.

To address this concern the EOCCO will update the quantitative portion of the Community Health Assessments in 2016 and produce more realistic CHIPs that align better with potential resources.

**1 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.**

As stated in previous reports, we are trying to rely more on technology. We have Go to Meeting accounts and use Turning Point Audience participation software to facilitate discussions and resulting in quicker decision making. Still, when the technology is made available, that gives participants “permission” to not travel the necessary miles to attend meetings.

If the EOCCO Board had not determined to allow for grants across the region using OHA Transformation funds, it is likely we would have lost meaningful engagement. As we wait to “bend the cost curve” population-based approaches will have to wait for funds to become available. Sustaining the activities of the grants (ending in July 2015) will be a concern for some of the LCACs. The EOCCO Board of Directors dedicated \$750,000 to continue some of the more successful Transformation Grants and will also offer a portion of that toward funding new ideas.

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

The LCACs and RCAC are involved in this transformation area intensively. It is their work plan and activities that drive this area.

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

LCACs and RCACs were informed of all these activities through written documents and reports at their meetings.

**Transformation Area 5: EHR, HIE and meaningful use**

Benchmark 5	
How Benchmark will be measured (Baseline to July 1, 2015)	<ul style="list-style-type: none"> <li>• Electronic Health Record assessment and tracking will be started in 2013 and completed in 2014. Baselines will be established at that time and benchmarks to increase usage will be confirmed.</li> </ul>
Milestone to be achieved as of July 1, 2014	<ul style="list-style-type: none"> <li>• Contractor will establish the HIE steering committee by mid-2013.</li> <li>• HIE strategy and plan will be determined in 2013.</li> <li>• Contractor will provide Members access to health information through an online Member customized portal.</li> </ul>

<p>Benchmark to be achieved as of July 1, 2015</p>	<ul style="list-style-type: none"> <li>• Contractor agrees to participate in OHA’s upcoming process to assess the next phase of statewide HIE development (including assessing the scope, financing and governance of statewide HIE services). In particular, Contractor will make appropriate executive and staff resources available for an interview with an OHA consultant, and will participate in a brief series of stakeholder workgroup meetings if requested by OHA. After the OHA process concludes and the next phase of statewide HIE services are defined, Contractor will update the HIE component of this transformation plan at the next update cycle.</li> <li>• Contractor will begin to implement strategy and plan developed by the steering committee.</li> <li>• Contractor will measure the number of Members that access the online customized portal.</li> </ul>
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1. a) Please describe the actions taken or being taken to achieve milestones in this transformation area. For each activity, describe the outcome and any associated process improvements.

	<b>Activity (Action taken or being taken to achieve milestones or benchmarks)</b>	<b>Outcome to Date</b>	<b>Process Improvements</b>
<p>1.</p>	<p>EOCCO staff and our Innovator Agent completed an EHR assessment and continue to monitor EHR implementation. EOCCO developed an online EHR provider survey in January 2014. The results of that survey have been shared with the Oregon Office of HIT and it is being used to help complete the Office’s Technical Assistance Needs Assessment.</p>	<p>Over 95% of EOCCO patients are enrolled in a primary care clinic that uses an EHR.</p>	
<p>2.</p>	<p>EOCCO’s Clinical Coordinator serves on the state HIT Advisory Group (HITAG).</p>	<p>EOCCO has kept the Board up to date on the work of HITAG.</p>	<p>EOCCO will be participating in a “Deeper Dive” meeting with Office of Health Information staff regarding the Office’s Technical Assistance program.</p>

3.	EOCCO's Clinical Coordinator prepared an EOCCO HIT/HIE Regional Solution to serve as its strategy and plan for HIT/HIE implementation and to align EOCCO with Phase 1.5 implementation.	EOCCO Board approved the Regional Solution in December 2013.	
4.	EOCCO uses its Clinical Advisory Panel as a tool to assist the EOCCO Medical Director and Clinical Coordinator in HIT/HIE implementation.	EOCCO has expanded its Clinical Advisory Panel to nine members composed of primary care physicians, mid-level practitioners, behavioral health providers, and dental providers. The group meets bimonthly.	
5.	EOCCO's Clinical Advisory Panel invited Susan Otter, Director of the Oregon Office of Health Information Technology, to their 4 <sup>th</sup> Quarter meeting where she presented information on HITAG progress and on Direct Secure Messaging (DSM).	EOCCO is working with clinics and other providers to implement DSM.	The EOCCO CAP invited the Director to its July, 2015 meeting to discuss EDIE and PreManage.
6.	EOCCO has reserved \$1.5 Million in funding to provide Technical Assistance to key practices and assist them with establishing work flows and CQM data extraction support maximizing the use of their EHR. EOCCO has been in discussions with two separate vendors to provide this TA.  EOCCO plans to have an established vendor contract in place by 9/1/15	EOCCO continues to have in-depth discussions with vendors and expects to present a proposal to the Board by the Fall of 2015.  EOCCO plans to begin extracting CQM data from key practices in the Fall of 2015.	

**1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.**

Most of the remaining primary care clinics in EOCCO's region that have not adopted EHRs are small clinics with very limited resources which makes EHR adoption difficult. Nonetheless, adoption continues in many of these clinics. In addition, EOCCO's vast geographical size has resulted in some HIT gaps.

EOCCO has not yet provided members access to health information through an online member portal. This work is planned for implementation later in 2015.

**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.**

Despite these barriers, EOCCO providers have been very successful in implementing HIT. In addition, EOCCO and its Innovator agent have worked closely with the OHA Office of Health Information Technology to ensure we overcome the barriers we face.

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

LCAC's have not been involved in the process of HIT implementation to date. EOCCO intends to focus on improved communication between providers and LCACs as we proceed with implementation, particularly in the process of implementing DSM.

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

There has not been the need to keep the LCACs aware of EOCCO's HIT/HIE activities up to this point. As EOCCO moves forward on implementing its regional solution, we will inform our LCACs about these efforts.

## Transformation Area 6: Communications, Outreach and Member Engagement

Benchmark 6	
How Benchmark will be measured (Baseline to July 1, 2015)	<ul style="list-style-type: none"> <li>• Contractor will measure the percentage of materials revised according to the policy.</li> <li>• Contractor will measure the number of demographics data reports completed and disseminated to Providers.</li> <li>• Contractor will measure the percentage of Contractor staff who have successfully completed training.</li> <li>• Contractor will measure the completion of interpreter certification plan report.</li> </ul>
Milestone to be achieved as of July 1, 2014	<ul style="list-style-type: none"> <li>• Contractor will develop and adopt policy, and 10% of consumer materials have been revised accordingly.</li> <li>• 70% of county and/or regional demographics reports have been completed.</li> <li>• Contractor will develop training and Contractor leadership has successful completed training – 10% of staff.</li> <li>• Interpreter certification options have been assessed and compiled into report; decision has been made to determine next steps.</li> </ul>
Benchmark to be achieved as of July 1, 2015	<ul style="list-style-type: none"> <li>• 60% of consumer materials have been revised according to the policy.</li> <li>• All county and/or regional demographics reports have been completed and disseminated to 80% of Participating Providers.</li> <li>• 95% of Contractor 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.</li> <li>• Final benchmark will be developed according to interpreter certification decision based on summary report (See Milestone 4).</li> </ul>

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.	<p>EOCCO implemented cultural sensitivity and health literacy standards in 2013. The goal of implementing these standards is to broaden and disseminate culturally and linguistically appropriate policies and procedures across EOCCO and in collaboration with partner organizations.</p> <p>Beginning February 2015 educational material targeting EOCCO members, will be assessed for Health Literacy to ensure material meets CLAS standards.</p> <p>EOCCO is studying a pilot strategy to implement in 2015, looking at the effectiveness of the “teach back” technique to assess consumers understanding of member material content.</p> <p>A health plain language quick reference guide was disseminated to internal staff.</p> <p>A cultural competency and health literacy-training component was incorporated in EOCCO’s Patient Centered Primary Care Home (PCPCH) Learning Collaborative curriculum. The trainings were conducted in July 2015, targeting clinical staff and providers.</p>	<p>We are meeting the July 1, 2015 benchmark.</p> <p>75-85% of EOCCO member materials have been revised to meet the cultural sensitivity and health literacy standards.</p> <p>Inventory of member communication materials was completed in January 2015.</p> <p>EOCCO Member Handbook is being updated.</p>	<p>A revision process was developed and put in place, which improves EOCCO’s ability to monitor and adjust member communications, as needed.</p> <p>An internal Health Literacy Committee is being convened to plan for adoption of new tools and to deliver system wide change in the member material review process. The work group is focusing on creating a workflow to develop new material using best practice standards in assessing health literacy.</p> <p>EOCCO is conducting training to staff responsible for development of member educational material on use of the PEMAT score assessment.</p> <p>EOCCO will continue to track material revisions.</p>
2.	<p>EOCCO compiled the results of the LCAC community-health needs assessments to develop member level demographic reports. EOCCO continues to inform LCAC’s of the patient demographics in their region.</p>	<p>We are meeting the July 1, 2015 benchmark.</p> <p>Demographic data is</p>	<p>Reports are disseminated to providers via email, fax, and mail.</p> <p>EOCCO will continue working to</p>

	<p>Beginning 3<sup>rd</sup> quarter of 2013, EOCCO reports clinic level data on member utilization rates on 7 of the 17 incentive measures. The report card is disseminated to clinics/providers on a quarterly basis. This list includes contact information to encourage provider-member outreach, specifically for new members.</p> <p>Based on CAC feedback, in 3<sup>rd</sup> quarter 2014, EOCCO added a behavioral health component to the utilization report so that member outreach is conducted with a more holistic view of the patient and their needs.</p> <p>EOCCO offers one on one technical support to providers in the utilization of reports.</p> <p>EOCCO conducts regular in person and paper surveys to assess user satisfaction. This data is used to improve content and user friendliness on a quarterly basis.</p>	<p>distributed to at least 70% of participating providers and CAC members quarterly.</p> <p>EOCCO reports member utilization rates for seven of the 17 incentive measures to clinics and providers on a quarterly basis. Based on feedback from our Community Advisory Councils, in 2015 EOCCO added race/ethnicity, behavioral health utilization, and a high-risk report looking at cost, diagnosis, and a prospective risk score, to the report. This allows clinics to minimize gaps in care while also outreaching and delivering services in a culturally competent manner.</p> <p>Quarterly demographic reports compiled for each county based on LCAC community needs and requests.</p>	<p>strengthen provider relationships, engagement and communications.</p> <p>EOCCO will continue to support providers in understanding demographics of their panel and meeting needs of culturally diverse patients.</p>
3.	EOCCO is working towards reducing and eliminating health disparities by developing and implementing	The type of trainings conducted throughout	The establishment of an internal training program ensures commitment to

	<p>workforce training opportunities and processes for current and new hires. Training/orientation programs include providing culturally and linguistically appropriate services.</p> <p>EOCCO hired a consultant specializing in cultural competency training and workshop development. The consultant provided a train-the-trainer workshop to leadership and designated staff to develop training materials and structure, as well as a strategy to establish in-house cultural competence training and staff engagement. The consultant will continue to work with staff through the development of an internal training program.</p>	<p>EOCCO region has varied.</p> <p>EOCCO is unable to calculate a rate of the number of staff who has received training. There is no standardized reporting database to track activities among varying entities and ownership.</p> <p>Below are examples of the wide range of trainings:</p> <p>In December 2014, a cultural competency consultant developed an in-house train-the trainer cultural competency training manual called Preparing for Diversity in Healthcare.</p> <p>24 champion staff members who oversee departments with direct communication with EOCCO members have been trained to use the train the trainer curriculum.</p> <p>The champions have conducted two staff</p>	<p>ongoing and ever-evolving cultural competency training.</p> <p>EOCCO is working to disseminate the Preparing for Diversity in Healthcare manual to cultural competency champions so that they can deliver the training in their respective department. Departments expected to conduct the diversity training are customer service, pharmacy, and health care services.</p> <p>EOCCO is conducting training to staff responsible for development of member educational material on use of the PEMAT score assessment.</p>
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		<p>trainings with a total of 35 attendees.</p> <p>In 2015, the EOCCO Member and Diversity Coordinator was certified in Cross-Cultural Communications.</p> <p>Cultural competency and health equity trainings have been scheduled with Community Counseling behavioral health clinics, including Grant, Gilliam, Morrow, and Wheeler counties.</p> <p>EOCCO conducted training to staff responsible for development of member educational material on use of the Patient Education Materials Assessment Tool (PEMAT-P) score assessment.</p>	
4.	<p>EOCCO has assessed various interpreter qualification and certification options to determine relevance and practical use for providers and healthcare staff in rural Eastern Oregon. In efforts to increase health equity capacity within the EOCCO, educational components that focus on increased awareness, language, access for limited-English proficiency (LEP) patients and interpreter qualification/certification is important. In</p>	<p>We are meeting the July 1, 2015 benchmark.</p> <p>100% of EOCCO members who speak a primary language other than</p>	<p>Continue to assess language needs within community and member population.</p> <p>Engage clinics and providers in utilizing qualified/certified interpreters.</p>

<p>an effort to increase health equity capacity we will be encouraging CLAS standards in providing culturally and linguistically appropriate services.</p> <p>In order to adequately engage EOCCO providers within the Eastern Oregon region with providing culturally and linguistically appropriate services, EOCCO will be utilizing technology suitable for conducting live/recorded health equity webinars and other related health equity material.</p> <p>Based on recommendation from the clinical advisory panel, EOCCO is developing a quarterly EOCCO newsletter to increase communication channels and keep providers up to date with relevant information on CLAS standards.</p> <p>As of May 2014, 13.7% of EOCCO members have listed Spanish as their preferred language.</p> <p>EOCCO currently contracts with a health interpreter service (accredited by American Translators Association, The Association of Language Companies, Globalization and Localization Association, and American Council on the Teaching of Foreign Languages) to translate health plan member material into Spanish.</p>	<p>English are provided translated materials in the members' primary language. Spanish is the primary translated language in the EOCCO service area.</p> <p>In 2015, the EOCCO Member and Diversity Coordinator attended a 60 hour medical interpreter training program, Bridging the Gap.</p>	<p>In 2014, EOCCO identified barriers for health care staff to get certified as Healthcare Interpreters.</p> <p>Examples of identified barriers included training locations, cost of trainings, time, and commitment. As a result, EOCCO is focused on promoting the OHA Office of Equity and Inclusion Health Care Interpreter Learning Collaborative in September 2015. This Learning Collaborative is training, qualifying, and certifying Health Care Interpreters in Pendleton, Oregon.</p>
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**1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.**

It is an ongoing challenge to assess effectiveness of our member communication. We are unable to measure a response rate since historically our health promotion campaigns do not require a response or solicit any feedback.

EOCCO's rural geography pose challenges as many organizations prefer to engage in face-to-face personal activity rather than call/emails. Engaging partnership and collaboration in providing health equity information within the context of delivering culturally and appropriate services is proving to be cumbersome and challenging.

The number of certified health care interpreters is low, and has been identified by EOCCO as a health care disparity. EOCCO staff met with EOCCO network nurses, receptionists, medical assistants from Lifeways, Good Shepherd, Columbia River Community Health Services and other surrounding service areas to identify barriers. Barriers include geography, cost of trainings and time required to commit to training. For example, the final exam in order to receive the certificate for completion must be taken in a classroom setting. Testing sites for the National HCI exams are located in Portland and other larger cities within the state. Additionally, the cost of the OHA approved training program is \$750-1200, and \$145 for the language proficiency portion.

**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**

In regard to member material, EOCCO created an intervention to incentivize members to access a specific wellness appointment. In the promotion of the intervention, EOCCO asked the member to return a card signifying a completed visit. This provided EOCCO a unique opportunity to track which members not only received the material but opened it and were ultimately impacted by it through a change in health behavior.

Integrating community based organizations into this intervention increased the frequency and effectiveness of member outreach and also improved EOCCO's ability to track communication efforts. EOCCO will continue to use methods such as this to improve our member outreach and engagement.

Additionally, we are piloting the "teach back" technique to improve health literacy and further engage members. We plan to test this model so that EOCCO entities, such as LCACs, have a tool to engage community members for continuous feedback.

EOCCO and its Innovator Agent participated in the 2014 IHI Improvement Science cohort. The cohort was tasked with creating a health improvement project surrounding cultural competency and assuring that the culturally diverse needs of EOCCO members are met. The training focused on ways to assess cultural competency needs/gaps within each clinic by using the 15 National CLAS Standards (Culturally and Linguistically Appropriate Services) in Health and Health Care. The aim of the project is to advance health equity, improve quality and reduce and eliminate health care disparities by establishing continuous commitment to cultural competency within the EOCCO.

Additionally EOCCO attended OHA training, Best Practices for Advanced Patient Centered Communication.

EOCCO is part of OHA Transformation Center's Health Equity Learning Committee devoted towards building collaborative health equity efforts and collective impact within the state's coordinated care organizations. Being able to share best practices, barriers and challenges surrounding this Transformation Plan area is a key component to achieving our collective goals.

EOCCO's diversity coordinator reached out to the Health Care Interpreter Program Coordinator with the Office of Equity and Inclusion about the above-identified barriers. Additionally, EOCCO staff joined an Oregon Health Care Interpreter stakeholder group with the Office of Equity and Inclusion. Through these communications, our diversity coordinator was able to advocate for EOCCO by voicing our concerns.

As a result, the Office of Equity and Inclusion will be hosting 5 Health Care Interpreter Learning Collaborative throughout the state of Oregon. The aim is to train, qualify, and certify 150 Health Care Interpreters by September 2016. The training will take place in Eastern Oregon, is at no cost, and is offering online training for the bulk of the curriculum. Additionally, priority for program enrollment will be given to CCO staff.

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

The EOCCO LCACs and RCAC are informed of activities surrounding this transformation area on an ongoing basis.

The EOCCO RCAC recently received technical assistance from the Transformation Center surrounding recruitment activity and member engagement.

A report on the culturally and Linguistically Appropriate Services (CLAS) assessment will be presented to the RCAC during their next quarterly meeting.

We worked closely with LCACs to identify key resources needed in the implementation of a school aged targeted interventions. Based on LCAC feedback we formed a partnership with local School Based Health Centers (SBHC), media, and even the Wallowa Chamber of Commerce. We also utilized our Innovator Agent to disseminate material to our community partners, as well as identify key stakeholders at DHS to expand our outreach to foster parents.

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

Information pertinent to communications, outreach and member engagement is disseminated to the LCAC's and RCAC on a continuous basis.

## Transformation Area 7: Meeting the culturally diverse needs of Members

Benchmark 7	
How Benchmark will be measured (Baseline to July 1, 2015)	<ul style="list-style-type: none"> <li>Contractor will measure the number of clinics surveyed and the number of clinic profiles developed.</li> <li>Contractor will measure the percentage of Participating Providers and clinic staff that have completed training.</li> </ul>
Milestone to be achieved as of July 1, 2014	<ul style="list-style-type: none"> <li>100% of surveys will be completed.</li> <li>Training will be developed and piloted in three clinics.</li> </ul>
Benchmark to be achieved as of July 1, 2015	<ul style="list-style-type: none"> <li>One hundred percent of clinic profiles will be developed and utilized in coordination of care for Spanish-speaking Members.</li> <li>75% of Participating Providers and clinic staff have completed training and processes have been developed for continuing education.</li> </ul>

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.	<p>In 2013, EOCCO developed an assessment survey utilizing the 15 National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Healthcare as a foundation for survey questions.</p> <p>Three behavioral health clinics and three medical clinics have been identified to serve as pilot clinics for this transformation plan element. These clinics currently have high diverse patient populations within EOCCO or are highly engaged in the advancement of CCO transformation; therefore, they are ideal pilot</p>	<p>We are partially meeting the July 1, 2015 benchmark.</p> <p>CLAS survey tool produced cultural competency and health equity roadmap report based on the survey results.</p>	<p>GOBHI and Moda Health Quality Improvement staff are working together to overcome provider engagement and geography barriers on behalf of EOCCO.</p>

	<p>sites in implementing cultural competence training and providing culturally and linguistically appropriate services.</p> <p>The IHI Improvement Science in Action project delivers Cultural Competency education and awareness to EOCCO behavioral health and medical clinics. This project provides complimentary tools and process improvement methods to meet the culturally and linguistically diverse needs of members by incorporating educational components to providers and clinic staff.</p> <p>EOCCO staff participated and graduated from the 2014 OHA Office of Equity and Inclusion DELTA Program, a 9-month training program focused on establishing health equity best practices within an organizational framework. Training elements from this program will be applied to executing cultural competency elements of healthcare transformation.</p>	<p>Three behavioral health and three medical provider sites have been identified for training development collaboration and pilot implementation of culturally and linguistically appropriate services.</p> <p>Cultural competency and health equity trainings have been scheduled with Community Counseling behavioral health clinics, including Grant, Gilliam, Morrow, and Wheeler counties.</p>	
2.	<p>In October 2014, EOCCO provided Trauma Informed Care training at a Clinician Summit workshop, engaging providers across eastern Oregon from a variety of clinics and roles.</p> <p>GOBHI Annual Spring Conference in Bend, OR offered 4-hour cultural competency training to conference attendees. Various mental health providers, clinicians, and peers actively participated.</p> <p>EOCCO manages community grants that focus on care coordination, utilizing workforces such as nurse</p>	<p>40 providers from 23 clinics attended the Trauma Informed Care training. A total of 25 behavioral providers, administrative staff and clinic staff participated in the cultural competency training workshop at GOBHI's annual conference.</p>	<p>Cultural competency topics will be incorporated into future summit workshops, which are expected to occur annually.</p>

	<p>navigators, LCSW, transportation services, and non-traditional health workers. The grantees are piloting methods for delivering culturally competent services to enrollees from diverse cultural and ethnic backgrounds as well as those who experience disparities in access to care due to chronic illness and location.</p> <p>EOCCO continues to engage in communications with various providers to further increase cultural competency education and establish health equity awareness within the network.</p>	<p>EOCCO/GOBHI sponsored eastern Oregon wide Peer Support Specialist training and assisted individuals in obtaining Traditional Health Worker certification.</p> <p>EOCCO disseminated NEON's Free Community Health Worker training to eastern Oregon communities.</p> <p>Implementation of the Transformation Grant, AHA, piloting a school based adolescent health program to develop culturally and linguistically competent health service delivery, co-management and referral services for Hispanic families.</p> <p>September 2015 Clinician Summit agenda includes a Community Health Worker panel that will address how to use the workforce to address health disparities.</p>	
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**1 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.**

EOCCO’s geography is a challenge in actively engaging providers within the context of health equity and delivering cultural competency trainings. Another challenging barrier in this milestone was engaging providers in survey completion and return of survey results.

**1 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.**

EOCCO’s most successful strategy was to include the cultural competency training as part of other larger conferences to ensure better engagement and participation from providers.

EOCCO’s Innovator Agent was an active member in the IHI Improvement Science in Action Project and assisted in developing strategies to overcoming unique barriers for our rural members.

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

EOCCO LCACs were notified of workshops and invited to attend. LCAC members are also notified of any new developments related to this transformation plan. A presentation to the RCAC on Culturally and Linguistically Appropriate Services (CLAS) survey outcomes will be scheduled.

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

LCACs were notified of trainings and other activities pertinent to this area.

**Transformation Area 8: Eliminating racial, ethnic and linguistic disparities**

<p>Benchmark 8</p>	
<p>How Benchmark will be measured (Baseline to July 1, 2015)</p>	<ul style="list-style-type: none"> <li>• Contractor will assess the completion of data collection methods and the percentage of race, ethnicity and language data collected on the population.</li> <li>• Contractor will assess the development and implementation of standard data collection and sharing methods defined by OHA.</li> <li>• Contractor will measure the percentage and satisfaction of Providers and clinic staff who have completed the cultural competence training.</li> <li>• Contractor will assess the effectiveness of the process to collect data via the health assessment.             <ul style="list-style-type: none"> <li>○ Completeness</li> <li>○ Utility in providing culturally competent service and care</li> <li>○ Surveys and claims analysis of comparison groups to measure engagement in self-care, access to care, use of services and cost of care.</li> </ul> </li> </ul>
<p>Milestone to be achieved as of July 1, 2014</p>	<ul style="list-style-type: none"> <li>• Contractor will have developed data collection methods and used existing methods to confirm demographic data has been collected on 30% of Members.</li> <li>• Standards for data collection and sharing will be established and operational for the Oregon Medicaid population.</li> <li>• Training and development will be completed in three clinics.             <ul style="list-style-type: none"> <li>○ Data collection process using the health assessment is established, staff is trained and data is systematically captured in the Contractor operating system (confirmed by audit process)</li> <li>○ Audit process demonstrates that race, ethnic, linguistic, disability, health literacy barriers identified in the health assessment are addressed.</li> <li>○ Specific quality indicators to measure Member engagement, access to care, use of services and cost of care are defined, Baselines are identified and Benchmarks for 7/1/15 are established.</li> </ul> </li> </ul>
<p>Benchmark to be achieved as of July 1, 2015</p>	<ul style="list-style-type: none"> <li>• Contractor will have reliable and accurate demographic data on 70% of the population.</li> <li>• Standards regarding data collection and sharing for the Oregon Medicaid population</li> </ul>

	<p>are sustained.</p> <ul style="list-style-type: none"> <li>• 75% of Participating Providers and clinic staffs have completed training, and processes have been developed for continuing education.</li> <li>○ Audits demonstrate data collection via the health assessment is sustained.</li> <li>○ Audits process demonstrates that Contractor is meeting benchmarks to address race, ethnic, linguistic, health literacy, disability barriers identified in the health assessment.</li> <li>○ Defined quality indicators on Member engagement, access to care, use of services and cost of care meet benchmarks.</li> </ul>
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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.

Action Taken or Being Taken to Achieve Milestones or Benchmarks		Outcome to Date	Process Improvements
1.	<p>An EOCCO workgroup (medical management, behavioral health, dental, quality, Medicaid Services) redesigned our initial health risk assessment (HRA) to improve the data collection on race, ethnicity and language on our member population. EOCCO sends the initial HRA on all EOCCO members within 90 days of enrollment. The EOCCO RN case coordinator/case manager reviews completed assessments to identify medical, dental or mental health needs, and follow-up, as appropriate.</p> <p>Changes included: check boxes (including write ins) for race, ethnicity and preferred language; bigger font size; use of plain language; improved tobacco use assessment; new questions related to mental health</p>	<p>The health assessment initiative is partially meeting the July 1, 2015 benchmark. EOCCO implemented the improved health assessment in November 2013. Average HRA return rate in 2014 was 26.2%. Return rate for Q1 2015 was 12.3%.</p> <ul style="list-style-type: none"> <li>• While the HRA has been implemented and staff trained in follow-up, the HRA data is yet to be</li> </ul>	<p>In Q4 2014, we hired more intensive case managers (ICM) to address the EOCCO case management workload and staff are currently in training.</p> <p>The ICM team is looking at the health assessment data entry process to identify improvement opportunities.</p>

	<p>status; and new statements to assess the member’s knowledge, skill, and confidence for self-management.</p> <p>The health assessment included a Spanish version as 13.7% of our EOCCO members (as of May 2014) report Spanish as their spoken language.</p> <p>EOCCO implemented the new HRA on approval of the documents by DMAP.</p>	<p>systematically captured in our operating system.</p> <ul style="list-style-type: none"> <li>• Because the data is not systematically stored in a database, we are unable to conduct aggregate analysis to identify race, ethnicity, language, health literacy, or disability barriers reported in the health assessment.</li> </ul> <p>The exponential growth in our EOCCO population in 2014 required that we direct our resources to the transition of new members into the CCO and developing a care plan for each new member. This prevented us from doing the health assessment reviews and follow-up as of Q2 2014- Q2 2015.</p>	
2.	<p>Regarding the development and implementation of standard data collection and sharing methods defined by OHA, EOCCO participates in the OHA Member Engagement Outreach Community workgroup. In 2013, we actively supported the systematic collection of race, ethnicity and language at the most granular level feasible. The state already collects spoken language and race, which is included in the 834 eligibility files. Effective March 2014, reading language and ethnicity data were included in the 834s. We continue to work</p>	<p>Regarding collection and sharing ReL data, we have met our July 1, 2015 benchmark. We confirm receipt and use of race, ethnicity and language data for over 86% of our EOCCO members. We store race and spoken language data received in</p>	

	<p>with our Information Services department to store the new data in our operating system. The state is limited to what/how they can collect information on race, ethnicity and language due to the application process. The application at a local DHS office is different from the Oregon marketplace application and there are no plans to expand the ethnicity and race in the application process.</p>	<p>the 834 eligibility files in our operating system.</p>	
3.	<p>The EOCCO incentive metrics workgroup is responsible for developing quality improvement initiatives that address racial, ethnic and linguistic disparities in access, quality of care and outcomes. This workgroup includes representatives from EOCCO Medicaid operations, quality improvement, medical management, behavioral health services, innovator agent, data analytics, liaison EOCCO community advisory councils, pharmacy services and dental services. In fall 2014, the group completed two reviews to help identify health disparities due to race/ethnicity and language. We measured our performance with the OHA 2014 benchmarks and 2014 target rates set by the OHA for our CCO. We reviewed:</p> <ol style="list-style-type: none"> <li>1. The Office of Equity and Inclusion reports on race, ethnicity and language of our EOCCO membership and the overall CCO population. <ul style="list-style-type: none"> <li>• Of our nearly 45,000 members, the largest segments of our members are Caucasian (57.9% versus 59% all CCOs) and Hispanic (29.7% versus 20.8% all CCOs) and the remaining races/ethnic groups comprise &lt;3% of the population with almost 10% unknown.</li> <li>• 77.7% of EOCCO members speak English (78% for all CCOs), 13.7% speak Spanish</li> </ul> </li> </ol>	<p>We are meeting the July 1, 2015 benchmark. We defined the quality indicators to identify and eliminate race and language disparities.</p> <p>We use our CCO incentive metric improvement target rates to analyze for race and language disparities.</p> <p>We use the annual CAHPS report from the OHA to analyze survey results for access to care (access), satisfaction with care (outcome), cultural competence and health literacy.</p> <p>Upon realizing EOCCO</p>	<p>Complete the analysis of the final rates of specific 2014 incentive measures broken out by race, language, gender, county and city.</p> <p>Complete analysis of CAHPS 2015 survey results.</p>

	<p>(9% for all CCOs), &lt;1% is other and 8.8% are undetermined.</p> <ul style="list-style-type: none"> <li>• Our EOCCO population has a significantly higher rate of members with Hispanic race/ethnicity and Spanish-speaking members than the overall CCO population.</li> </ul> <p>2. An analysis of the final rates of specific 2013 incentive measures broken out by race, language, gender, county and city. We studied adolescent well care visits, early developmental screening, colorectal cancer screening and emergency utilization – all ages. As examples:</p> <ul style="list-style-type: none"> <li>• 26.2% of Hispanic/Latino adolescents ages 12 through 21 or 27.8% of Spanish speaking adolescent received at least one comprehensive well-care visit during the 2013 measurement year compared with the 25.8% 2014 target rate. The data showed improvement opportunities for Baker, Lake and Grant counties but not because of race/ethnicity or language issues. This led us to look at access and member/provider education as potential barriers.</li> <li>• The rates of emergency department visits per 1,000 member months for all ages among English speaking and Caucasian members were significantly higher (67.2%; 67.6%) than our 2014 improvement target (57.7%) and the rates for Spanish speaking and Hispanic/Latino members (31.6%; 42.6%).</li> <li>• Overall, our analysis of these measures did not reveal disparities in the quality of care</li> </ul>	<p>would meet the ED measure target when the data was corrected, we shifted priorities and discontinued the planned targeted member</p>	
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	<p style="text-align: center;">due to race, ethnicity or language.</p> <p>3. Our 2013 CAHPS rate for access to care was 83.7% compared with the 2014 CCO benchmark of 88% and improvement target of 85.7%. Our CAHPS rate for satisfaction with care (outcome) was 84.5% compared with the 2014 CCO benchmark of 89% and improvement target of 86.5%. We did not have race, ethnicity and language member-level data to do further analysis.</p> <p>It is a standard EOCCO practice to develop member educational material using cultural competence and health literacy guidelines. The EOCCO incentive metrics workgroup meets on alternate weeks to discuss progress in our quality improvement initiatives and identify improvement opportunities and barriers, including those related to race/ethnicity and language.</p>		
4.	Cultural competence training for EOCCO providers – see update in Element 7.		

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

**Health assessment:** The exponential growth in our EOCCO population required us to prioritize the transition of new members and developing care plans for each. There has been no further development in a database for the health assessment and we temporarily stopped reviews as of Q2 2014 because of other priorities.

**Incentive metrics:** We have not completed a detailed analysis of the CAHPS measures for access to and satisfaction with care due to the absence of member level data.

**1 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.**

**Health assessment:** We recruited more intensive case managers who are in training and we are evaluating options regarding the data entry process.

**Incentive metrics:** We have asked the OHA for CAHPS member level data so we can evaluate the health status and access measures using race, ethnicity and language data. Our Innovator Agent is a member of the Incentive Metrics workgroup and has taken the lead on our behalf to make these data requests.

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

**Health assessment:** We have not involved the Community Advisory Councils in the health assessment.

**Incentive metrics:** Our Community Advisory Councils received reports about the cultural competence training for our provider community, our incentive metrics rates and existing interventions to improve targeted measures, and progress in our performance improvement projects (PIPs), which includes culturally- and linguistically-appropriate interventions, when applicable. We have received suggestions from our LCACs about our PIPs and as the result of their feedback, are revamping our PIP on maternity health beginning with a pilot in select counties. The goal of the revised PIP is to increase enrollment in maternity case management (MCM) through a pilot reimbursement plan for MCM services. We surveyed our LCACs to get feedback on incentive gifts appropriate to each county for our planned intervention to increase adolescent well care visits.

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

**Incentive metrics:** We report EOCCO activities in this transformation area at LCAC/RCAC meetings. We will continue to report on quality activities, including race, ethnicity and language data, whether we identified racial, ethnic and linguistic disparities in access, quality of care or outcomes and ask for their feedback on how to address them.