

Transformation Plan Milestone Report Eastern Oregon Coordinated Care Organization

June 30th, 2014

Transformation Area 1: Integration of Care

Benchmark 1.1	
How Benchmark will be measured (Baseline to July 1, 2015)	<ul style="list-style-type: none"> 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.
Milestone(s) to be achieved as of July 1, 2014	<ul style="list-style-type: none"> 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.
Benchmark to be achieved as of July 1, 2015	<ul style="list-style-type: none"> Identification and tracking process is evaluated semi-annually. Improvement opportunities identified and implemented.
Benchmark 1.2	
How Benchmark will be measured (Baseline to July 1, 2015)	<ul style="list-style-type: none"> Use existing measurement system with OHA to report on Early Assessment and Support Alliance, Assertive Community Treatment, Supported Employment and associated wrap around programs.
Milestone(s) to be achieved as of July 1, 2014	<ul style="list-style-type: none"> Early Assessment and Support Alliance, Assertive Community Treatment, Supported Employment and associated wrap around programs available to all Members in all 12 counties.
Benchmark to be achieved as of July 1, 2015	<ul style="list-style-type: none"> Achieve fidelity for programs as established by State standards.

Benchmark 1.3	
How Benchmark will be measured (Baseline to July 1, 2015)	<ul style="list-style-type: none"> Count the number of counties with contracts between medical clinics and 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"> Contract with medical clinics in at least three counties as voluntary early adopters.
Benchmark to be achieved as of July 1, 2015	<ul style="list-style-type: none"> Contracts with medical clinics in at least three additional counties.
Benchmark 1.4	
How Benchmark will be measured (Baseline to July 1, 2015)	<ul style="list-style-type: none"> 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. Count the number of contracts with residential addictions Providers. Count the number of outpatient, integrated, behavioral health and addictions contracts. (Count each county group as one contract.)
Milestone(s) to be achieved as of July 1, 2014	<ul style="list-style-type: none"> 1:1 ratio of case rate based contracts with social and medical detox Providers. Contract with all three existing residential addictions Providers per the jointly defined payment model established at February 2013 meeting. Complete pilot contracts with at least three communities as optional early adopters for outpatient behavioral health and addictions integration.
Benchmark to be achieved as of July 1, 2015	<ul style="list-style-type: none"> 1:1 ratio of case rate based contracts with social and medical detox Providers. Contract with all three existing residential addictions Providers per the jointly defined payment model established at February 2013 meeting Complete contracts with the remaining nine counties for outpatient behavioral health and addictions integration.

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 <i>(Action taken or being taken to achieve milestones)</i>	Outcome to Date	Process Improvements
1.	<p>1.1: Beginning February 2013, we established monthly meetings between EOCCO behavioral health and medical staff and Aging and Persons with Disabilities (APD) to identify intervention strategies for complex care members.</p> <p>1.1 Communications between EOCCO behavioral health and medical staff continue as needed to keep everyone up to date on the status of identified complex-care members.</p> <p>1.1: The Health Coaching Program and care coordinators refer all members with complex needs, as identified on the HA or other means, to EOCCO ICM's for evaluation.</p>	<p>Monthly meetings are taking place between Moda Health, GOBHI, and Regional APD staff. EOCCO, in conjunction with APD and their Innovator Agents developed an MOU that outlines agreed upon strategies for managing complex care cases. This was updated and is in effect July 1, 2014, through June 2015.</p> <p>Of the initial nine cases identified and addressed related to medical and mental health complexities, none have been placed into a higher level of care.</p> <p>Collaborations between the ICM, clinic and hospital staff, and the APD staff take place several times a month for members identified for transition-of-care needs.</p>	<p>Improve upon:</p> <p>A. Implementation is underway for agreed upon collaborative strategies. This work will be monitored for efficiency and effectiveness.</p> <p>B. Development of triggering criteria and a formal referral process between mental health, physical health, and long term care (APD), using the intensive case manager position to effect changes.</p> <p>C. Develop a system to have comprehensive, shared care plans, involving everyone working with the member.</p>

2.	<p>1.2: All eight community mental health programs (CMHPs) in EOCCO are actively pursuing or have achieved evidence-based practice (EBP) fidelity for assertive community treatment (ACT), supported employment (SE), and Early Assessment and Support Alliance (EASA) certification.</p>	<p>Of the eight CMHPs, three have achieved ACT fidelity, five are within seven to 20 points of achieving ACT fidelity</p> <p>GOBHI was awarded a RFP from AMH that will support the enhancement and/or development of the CMHP's efforts towards ACT fidelity.</p> <p>Of the eight CMHPs, two have achieved fidelity and the remaining six are in the implementation stage of development.</p> <p>In January 2014 EOCCO was awarded additional funding for a regional EASA program. Eastern Oregon has a Regional Coordinator that is working with all eight CMHP's on progressing towards fidelity.</p>	<p>Continue to provide technical assistance, monitoring and oversight in CMHPs' progression toward EBP fidelity standards for ACT and SE, focusing on:</p> <ul style="list-style-type: none"> A. Workforce development and recruitment B. Implementation of financial incentive strategies to maintain FTE to meet intensive EBP requirements C. Outcomes monitoring and reporting <p>EOCCO is currently recruiting for another Coordinator position and will continue to work with EASA Center for Excellence (PSU) to design an approach for meeting fidelity; EOCCO is unique in that we are developing a rural/frontier approach to EASA with Center for Excellence. Trainings are scheduled to create a champion in each CMHP that will be tasked with moving their agency forward in these efforts.</p>
3.	<p>1.3: EOCCO has established contractual relationships between the behavioral health providers and medical clinics.</p>	<p>Agreements have been established in eight of the 12 EOCCO counties.</p>	<p>Establish a contractual relationship between the identified behavioral health providers and medical clinics in the remaining four EOCCO counties</p>
4.	<p>1.4: To date, case-rate-based contracts with social and medical detox providers have not been established, although discussions have taken place.</p>	<p>Two of the three objectives set for July 1, 2014 have been met. The case-rate contracts</p>	<p>Continue to negotiate with medical detox facilities regarding case rates; upon completion, initiate contracts</p>

	<p>1.4: Contracts between EOCCO and all three existing residential addictions treatment providers have been established.</p> <p>1.4: Five counties have adopted integrated outpatient behavioral health programs by entering into single-risk-bearing contracts for mental health and addictions treatment.</p>	<p>for medical detox have been held up at this moment because of delays in transfer of funding.</p>	
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1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.

EOCCO has been able to communicate with more of the providers and other community partners about the Intensive Case Manager (ICM) and other services available from EOCCO. Referral communications included an overview of how the ICM program can help members.

Communication throughout the entire EOCCO region regarding intensive case management options still remains problematic; however improvements have been noted with increased promotion of the program.

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.

Medical staff and medical directors have attended OHA Transformation Center sponsored collaboration and education programs. The OHA Innovator Agent has been invited and has attended the EOCCO- APD collaboration meetings to formulate a fully revised Memorandum of Understand for the next 2 years.

The Governance Board finalized a policy that incorporates a Clinical Advisory Panel (CAP) within the EOCCO structure. The CAP has been formed is actively in the stage of further development of EOCCO clinical processes. EOCCO anticipates further improvement within this area via the MOU established with Regional APD staff.

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

The 12 local community advisory councils (LCAC's) have finalized both the community needs assessments and community health improvement plans. Activities are currently focused on data collection and monitoring. The regional community advisory council (RCAC), which includes members of all LCAC's, has oversight of all 12 LCAC's and establishes a feedback loop between the LCAC's and Governance Board.

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"> • Contractor will measure the number of Members assigned to a certified PCPCH at each tier level. • 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 • Implement technical assistance tools to assist PCPCH Providers in meeting quality outcomes. • Implement strategies to develop certified PCPCH Member engagement programs for certified PCPCHs.
Milestone to be achieved as of July 1, 2014	<ul style="list-style-type: none"> • At least 25 % of Members will be assigned to a certified PCPCH at any tier level. • Seek agreement with and implement Alternative Payment Methodologies in at least three certified PCPCHs. • Identify and seek approval of PCPCH certified Providers on technical assistance tools that will assist them in meeting quality outcomes. • Identify and seek approval of PCPCH certified Providers on how Contractor can assist with Member engagement.
Benchmark to be achieved as of July 1, 2015	<ul style="list-style-type: none"> • At least 50 % of Members will be assigned to a certified PCPCH at any tier level. • Contractor will have all PCPCH certified Providers contracted using consistent

	<p>Alternative Payment Methodologies.</p> <ul style="list-style-type: none"> • Contractor will have consistent technical assistance tools available to PCPCH certified Providers. • Contractor will have consistent Member engagement tools available to PCPCH certified Providers.
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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.

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 Medicaid 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 60 percent 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.
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 progress report additional clinics have received PCPCH certification.	
3.	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.	To date, one-on-one assistance by EOCCO's clinical consultant resulted in one additional practice receiving PCPCH certification.	
4.	In addition to the enhanced PCPCH case management	1. EOCCO has	

	<p>payments, EOCCO has contracted with two PCPCH's using a capitated payment methodology.</p> <p>Starting 4/1/2014 EOCCO implemented risk contracts with primary care practices. The risk contracts were voluntary. Through the risk contracts PCP's put a small amount of their reimbursement at risk but at the same time they have the opportunity to share in the savings produced as a result of reduced utilization and better care management.</p>	<p>implemented two capitated agreements to date with PCPCH clinics.</p> <p>2. EOCCO implemented risk contracts with primary care practices beginning 4/1/14.</p>	
5.	<p>EOCCO is sending report cards to primary care practices in the EOCCO service areas on a quarterly basis. The report cards focus on seven of the 17 CCO incentive measures that we believe providers can have the most impact on. Within the report cards, we provide our CCO baseline and target goals for the calendar year. In addition, we provide member-level detail for 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 details on the number of ER visits each member has accumulated during the year. By providing these tools, we are engaging providers to focus on system wide quality improvements for the populations they serve.</p>	<p>Providers are beginning to use the report cards as a tool to improve EOCCO incentive measures.</p>	<p>EOCCO needs to work one-on-one with provider offices to make sure they are reading, understanding and using the report cards.</p> <p>In third quarter 2014 EOCCO will begin including a list of high cost/high risk members including their primary diagnosis in the report cards. This information will be an additional tool to assist providers with population management of their highest cost EOCCO patients.</p>

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 needs 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.

EOCCO started providing “report cards” to primary care offices as a tool to assist EOCCO in meeting incentive measures. We have discovered that not all providers review the report cards and may not understand how to read them despite our efforts to inform them.

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 worked with Dr. Evan Saulino, M.D., Ph.D., PCPCH clinical advisor, and Dawn Creach, policy analyst for the PCPCH Program to provide trainings in Eastern Oregon. The trainings gave providers the opportunity to learn about the evidence behind the PCPCH model and how to apply to become a PCPCH, including the standards for recognition, as well as ask questions about how to achieve the maximum tier level of certification. EOCCO will be hosting additional provider summits in the fall of 2014.

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 report cards. EOCCO is working with OHA to determine if DSM would be a better alternative to secure email for sending report cards to 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 within PCPCH clinics. The LCAC’s are informed about the number of clinics that are PCPCH certified in EOCCO’s service area.

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

We are educating CACs about EOCCO’s performance on the incentive measures, which includes the percent of EOCCO members enrolled in a certified PCPCH.

Transformation Area 3: Alternative Payment Methodologies

Benchmark 3	
How Benchmark will be measured (Baseline to July 1, 2015)	<ul style="list-style-type: none"> • 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. • Contractor will track the number of hospitals and Provider payments that are piloting Alternative Payment Methodologies. • 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. • 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.
Milestone to be achieved as of July 1, 2014	<ul style="list-style-type: none"> • Identify and seek approval from Participating Providers on Alternative Payment Methodologies to be piloted with Providers, certified PCPCH clinics, and hospitals. • 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. • Contractor will implement a capitation payment system with a least one primary care clinic. • Contractor will implement a capitation payment system with at least one Type A hospital. • Contractor will implement an actuarial-based process for cost-based payments that is not solely financially based. • 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, Federally Qualified Health Clinics, and Rural Health Clinics utilizing variables such as demographics, geography, and financial factors.

	<ul style="list-style-type: none"> • 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. • 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.
Benchmark to be achieved as of July 1, 2015	<ul style="list-style-type: none"> • Measure effectiveness of efforts to transform payment delivery. • Measure outcomes of Providers who have moved to Alternative Payment Methodologies.

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 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>	<ol style="list-style-type: none"> 1. EOCCO has implemented alternative payment methodology contracts (capitation agreements) with three primary care practices. 2. EOCCO implemented risk contracts with primary care practices that chose to 	<p>In August 2014 EOCCO will provide risk model performance reports to primary care practices.</p>

		participate in the risk model.	
2.	<p>EOCCO implemented risk contracts 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 providers 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>	1. EOCCO implemented risk contracts beginning 4/1/2014.	In August 2014 EOCCO will provide risk model performance reports to hospitals.
3.	EOCCO was a participant in the Rural Health Reform Initiative Workgroup (RHRI). The work group was an advisory workgroup that will make 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 risk model.	1. To date, the workgroup and OHA have made their recommendations as to which hospitals will lose cost base reimbursement. We are awaiting further guidance from OHA on the details of the alternate payment methodology.	
4.	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 risk contracts with	1. Through the EOCCO transformation grant several hospitals will receive funding to repurpose existing	

	<p>providers is a good initial step.</p>	<p>staff to fill care coordination roles including the use of community health workers.</p>	
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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 risk contracts.

We need to further engage primary care practices to achieve 100% participation in our 2015 risk model. We also need additional guidance from OHA so that we can appropriately implement the alternate payment methodology for hospitals moving off of cost base reimbursement.

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.

With respect to hospitals, we will continue to participate in OHA’s RHRI workgroup to determine how we will need to implement the alternate payment methodology for hospitals moving off cost base reimbursement.

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

While the CACs were not involved directly in these transformation activities, some of the CAC members are providers or staff working at the primary care clinics or hospitals that would be impacted by these changes.

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

EOCCO will share the risk model performance with CAC’s.

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"> • Contractor will measure the number of counties with regular, continued local county and regional CAC (R-CAC) meetings. • Contractor will measure the number of local county CACs with completed community needs assessment reports and CHIP selection documents. • Contractor will measure the number of counties with active CHIP committee members.
Milestone to be achieved as of July 1, 2014	<ul style="list-style-type: none"> • 100 % of Contractor’s counties will have or be participating in an established local CAC and regional CAC with persistent, regular meeting times, as determined by the committee members. • 100% of CAC’s will have a complete Community Needs Assessment analysis and proposed CHIP. • Contractor’s CHIP will be submitted to OHA by 6/30/2014. • 100% of CACs will have implemented CHIP in their respective county and begin tracking outcomes.
Benchmark to be achieved as of July 1, 2015	<ul style="list-style-type: none"> • 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. • 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.

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 or benchmarks)	Outcome to Date	Process Improvements
1.	EOCCO formed a LCAC in each of the 12 EOCCO counties.	LCACs are holding regular monthly meetings. The LCAC Charter calls for at least quarterly meetings.	<p>Process improvements have included adjusting the length of the meetings and time of day of the meetings to accommodate the workload and participant schedules, thereby maximizing participation.</p> <p>Each LCAC was given approximately \$4,500 to have a local coordinator who could arrange meeting space, send agendas, record minutes and secure necessary equipment. This allows for local connections and a reliable assistant for EOCCO staff.</p>
2.	EOCCO Regional CAC has met four times. One meeting was conducted via teleconference.	The initial organizational meeting included review of a work plan and initial training to support the work plan. The second meeting focused on support for LCAC planning and sharing utilization data sets, alternative payment methods. The third meeting focused on development of the Region-wide CHIP. During	<p>Per participant feedback, we have determined that we need to move the location of the meeting throughout the region over the course of a year to provide equity in driving time. Further, we are trying to use more teleconferencing to enable more participation.</p> <p>EOCCO acquired Turning Point Audience Participation software. This tool was used to initiate discussion during the RCAC meeting where decisions were</p>

		the teleconference a DRAFT of the EOCCO CHIP was reviewed which was then sent to the EOCCO Board of Directors for approval.	made regarding priority areas across the entire region.
3.	Each of the 12 LCACs completed a needs assessment process that has included at least two community engagement sessions. Both primary and secondary data was summarized in a triangulation report and each LCAC participated in a forced choice matrix process (with private voting by individual LCAC members) to establish priorities.	<p>We engaged with the communities and collected needs-assessment data.</p> <p>We helped establish priorities for each county's community health improvement plan.</p>	
4.	<p>Each of the 12 LCACs established problem statements based on its priorities, conducted research for evidence-based best practices, selected strategies and developed a plan.</p> <p>Many of the LCACs prepared and submitted grant applications to the EOCCO for use of Transformation Funds provided by the OHA. These plans addressed Care Coordination, IT, co-located mental health services, transportation, health promotion and screenings.</p> <p>One LCAC (Lake) has made a presentation to the broader community as an annual progress report. The others will be urged to make an annual progress report.</p>	<p>We completed the initial orientation within each of the 12 LCACs for process guidelines, problem-statement development and research on evidence-based practices.</p> <p>All 12 LCACs developed a CHIP based on their particular county needs.</p>	<p>Each of the twelve LCAC CHIPs was shared with the RCAC. It was sorted by county and then by priority issue with all of the individual LCAC objectives under the priority area listed.</p> <p>The 12 CHAs were standardized and in combination with the CHIP can be used as the base for the annual report.</p>

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

The large geographic area resulted in a slower than desired startup for the LCACs because of the travel time needed to establish working relationships in each county. However, each county was highly motivated to engage with its communities. Distance was a factor in being able to provide on-site technical assistance in conducting rigorous reviews of evidence-based practices with the LCACs. Peer reviewed manuscripts and other tools were shared via e-mail with the group. Committee meetings of some of the LCACs were held without the benefit of EOCCO staff being present. This resulted in mixed quality of LCAC CHIPs.

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.

To address the distance barriers, EOCCO staff members are implementing the use of technology to help maintain a consistent meeting schedule once the Community Health Improvement Plan (CHIP) is completed. EOCCO's innovator agent attends a number of the LCAC meetings throughout our region. Further, EOCCO staff continues to emphasize the need to use evidence-based approaches to problem solving. However, evidence-based strategies do not always translate well to the context of being delivered in frontier areas. The need for some innovation and adjustment to programs is encouraged.

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

The LCACs have had a significant amount of work completing their community-engagement and needs-assessment work. Each LCAC and the RCAC has received a copy of the EOCCO transformation plan. To date, the LCACs have focused primarily on the work needed to complete the Community Health Assessment and the Community Health Improvement Plan and applying for EOCCO Transformation fund resources.

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

The LCACs have been directly involved in all these activities. Their CHIPs were used as a basis for the Region-wide EOCCO CHIP. The EOCCO CHIP will be shared with all the LCACs. Further, the RCAC has requested EOCCO board meeting minutes and reports are routinely part of LCAC agendas.

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"> 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.
Milestone to be achieved as of July 1, 2014	<ul style="list-style-type: none"> Contractor will establish the HIE steering committee by mid-2013. HIE strategy and plan will be determined in 2013. Contractor will provide Members access to health information through an online Member customized portal.
Benchmark to be achieved as of July 1, 2015	<ul style="list-style-type: none"> 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. Contractor will begin to implement strategy and plan developed by the steering committee. Contractor will measure the number of Members that access the online customized portal.

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 or benchmarks)	Outcome to Date	Process Improvements
1.	EOCCO staff and our Innovator Agent have completed	Over 95% of EOCCO	

	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.	patients are enrolled in a primary care clinic that uses an EHR.	
2.	EOCCO's Clinical Coordinator serves on the state HIT Task Force and the state HIT Advisory Group.	EOCCO has kept the Board up to date on Phase 1.5 implementation.	
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.	As part of its Regional Solution, EOCCO has agreed to work with OHA to identify funds to hire a half-time EOCCO HIT Coordinator to work with all 10 EOCCO hospitals to help facilitate participation in EDIE and PreManage, to work with providers on DSM adoption, and to promote further EHR adoption.	EOCCO and its Innovator Agent are working with OHA to secure a HIT Coordinator. EOCCO has reached out to another CCO to see if it would be interested in sharing a full-time person.	
5.	EOCCO is embarking on a plan to use DSM to transmit its quarterly provider "Report Cards" as the first attempt to promote DSM utilization by EOCCO's providers.	EOCCO's Clinical Coordinator has established an account with CareAccord and will pilot the project.	
6.	EOCCO plans to use its Clinical Advisory Panel as a tool to assist the EOCCO Medical Director and Clinical Coordinator in HIT/HIE implementation.	EOCCO has appointed an 8 member Clinical Advisory Panel composed of primary care physicians, mid-level practitioners, behavioral health providers, and dental	

		providers. The group has met once and will be meeting again in September.	
7.	EOCCO will place HIT/HIE implementation issues on the agenda for its next Provider Summit.	EOCCO's next Provider Summit is scheduled for October 1, 2014.	
8.	EOCCO has been in discussions with two separate vendors to provide a clinical integration solution for EOCCO. Through this solution EOCCO would provide technical assistance to key practices and assist practices with establishing work flows and CQM data extraction support maximizing the use of their EHR. In return key practices would receive enhanced reporting to assist them with management of their patients.	EOCCO is setting up more in-depth discussions with vendors in August 2014.	

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. In addition, EOCCO's vast geographical size has resulted in large HIT gaps.

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?

Local CACs have not been involved in the process of HIT implementation to date. EOCCO intends for its HIT Coordinator to serve as the liaison 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 CACs 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"> • Contractor will measure the percentage of materials revised according to the policy. • Contractor will measure the number of demographics data reports completed and disseminated to Providers. • Contractor will measure the percentage of Contractor staff who have successfully completed training. • Contractor will measure the completion of interpreter certification plan report.
Milestone to be achieved as of July 1, 2014	<ul style="list-style-type: none"> • Contractor will develop and adopt policy, and 10% of consumer materials have been revised accordingly. • 70% of county and/or regional demographics reports have been completed. • Contractor will develop training and Contractor leadership has successful completed training – 10% of staff. • Interpreter certification options have been assessed and compiled into report; decision has been made to determine next steps.
Benchmark to be achieved as of July 1, 2015	<ul style="list-style-type: none"> • 60% of consumer materials have been revised according to the policy. • All county and/or regional demographics reports have been completed and disseminated to 80% of Participating Providers. • 95% of 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. • Final benchmark will be developed according to interpreter certification decision based on summary report (See Milestone 4).

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 or benchmarks)	Outcome to Date	Process Improvements
1.	<p>EOCCO worked with various internal departments to develop a set of Cultural Sensitivity and Health Literacy standards to ensure effective and appropriate member communications. The standards were vetted by organizational leadership and LCAC members.</p> <p>EOCCO conducted inventory of all member communication materials sent.</p>	<p>Cultural Sensitivity and Health Literacy standards implemented in 2013.</p> <p>Inventory of member communication materials has been completed.</p> <p>45-50% of member Marketing materials have been revised to meet the Cultural Sensitivity and Health Literacy standards.</p> <p>EOCCO will continue to track materials revision.</p> <p>An Equity and Inclusion email list serve is currently available to behavioral health partners and staff.</p>	<p>A revision process was developed and put in place, which improves overall member communication; a tracking process was developed and put in place, which improves EOCCO's ability to monitor and adjust member communications, as needed.</p> <p>The new policy ensures effective, clear communications for all members.</p> <p>A Health Equity Learning Series to be developed on Health Literacy and Cross Cultural Communications.</p>
2.	<p>EOCCO compiled the results of the LCAC community-health needs assessments to develop demographic reports. EOCCO disseminates these reports to providers to better inform the provider of the demographics of the patients in their region. EOCCO will continue working to strengthen provider</p>	<p>Reports compiled for each county based on LCAC community needs assessment data.</p> <p>Reports were</p>	<p>We are experiencing improved communication via email.</p> <p>We will continue to support providers in understanding demographics of their panel and meeting needs of culturally</p>

	relationships, engagement and communications.	disseminated to providers via email.	diverse patients.
3.	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.	The consultant provided training in June 2014. In-house cultural competency training program set for implementation in fall 2014.	The establishment of an internal training program ensures commitment to ongoing and ever-evolving cultural competency training.
5.	EOCCO has assessed various interpreter qualification and certification options to determine relevance and practical application for providers and healthcare staff in rural eastern Oregon. EOCCO has decided to provide education to providers through the Health Equity Learning Series, which focuses on increased awareness, language access for limited-English proficiency (LEP) patients, and interpreter qualification/certification.	Through partnership with OHA, EOCCO will offer a Health Equity Learning Series to EOCCO partners to encourage language access and interpreter qualification and certification.	

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

It was a challenge to engage with LCACs for review and input on our Cultural Sensitivity and Health Literacy standards for member communications. Consumer (LCAC) feedback is important and valuable, but LCAC focus diverted to other issues and topics with limited response and thoughtful input regarding the standards. It is also difficult to ensure realistic interpreter qualification and certification options for providers in the rural regions of the state.

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.

We worked with LCAC facilitators and chairs to circulate the policy for review and feedback. We received minimal feedback, but responses were incorporated into our final policy. We worked with our communications development teams to create a process, contacted other organizations for feedback and best practices, and implemented the CDC clear communication checklist as a practical application of the policy and standard metric for scoring all materials.

OHA Office of Equity and Inclusion is involved in the implementation of the Health Equity Learning Series for Eastern Oregon providers. A Health Equity Learning Series, through a partnership with OEI has been developed to increase access to education and increase awareness on topics related to health equity within EOCCO. A topic on best practices for diverse engagement on CACs will be implemented, which will address engagement barriers. We also worked with OHA, the EOCCO innovator agent, and the Office of Equity and Inclusion staff members to identify alternate strategies to transformation plan elements when faced with questions and roadblocks, as well as to discuss ideas.

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

The EOCCO LCACs were enlisted for input on the Cultural Sensitivity and Health Literacy standards, as discussed above. LCACs are also informed of activities surrounding this transformation area on an ongoing basis.

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

LCAC members reviewed the initial draft of the Cultural Sensitivity and Health Literacy standards and the final draft after changes were incorporated. They were also notified verbally of its implementation.

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

	<ul style="list-style-type: none"> 75% of Participating Providers and clinic staff have completed training and processes have been developed for continuing education.
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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.

Activity (Action taken or being taken to achieve milestones or benchmarks)	Outcome to Date	Process Improvements
<p>1. EOCCO developed a provider assessment survey using the 15 National CLAS Standards in Health and Healthcare as a foundation for the survey questions.</p> <p>EOCCO issued the survey to all medical and behavioral health providers. Three behavioral health clinics and three medical clinics have been identified to serve as pilot clinics for collaboration in the development of future provider and clinic staff training to ensure diverse needs of patients are met. 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 testing sites in implementing cultural competence training.</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 diverse needs of members by incorporating educational components to providers and clinic staff.</p>	<p>A Provider assessment survey was developed and disseminated. Results are still being processed.</p> <p>Three behavioral health and three medical provider sites have been identified for training development collaboration and pilot implementation.</p>	<p>Improved communications all around with EOCCO behavioral and health providers via email, face-to-face, and site visits.</p> <p>Health Equity Learning Series to be developed in order to address Cultural Competency within an organizational structure and health professionals.</p>

	<p>EOCCO is involved in the 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>		
2.	<p>EOCCO provided basic cultural competency training at summit workshops across eastern Oregon, engaging providers from a variety of clinics in various counties. Cultural competency topics will also be incorporated into future summit workshops, which are expected to occur annually.</p> <p>GOBHI Annual Spring Conference in Bend, OR offered a 4-hour cultural competency training to participants. Various administrative, clinical personnel and clinic staff attended.</p>	<p>Fifty-three providers from 23 clinics attended the training. Feedback was collected for review and integration into future trainings.</p> <p>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>Information and power point slides from both workshops were disseminated to all partners via email.</p>	
3.	<p>EOCCO continues to communicate with providers to further increase provider survey response and collaboration among all providers.</p>	<p>We engage in ongoing development activities. Current engagement is by email, phone calls, and mail.</p> <p>Due to an increase in</p>	<p>Bolstering communication mediums is necessary in order to establish good communication throughout the EOCCO region.</p> <p>An Equity and Inclusion email list serve will be offered to EOCCO health and</p>

		<p>equity and inclusion material from behavioral providers, an email list serve was created to meet the demand for health equity material and awareness within behavioral health.</p>	<p>dental partners in order to increase awareness/education for these benchmarks and milestones.</p>
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1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.

The biggest barrier EOCCO encountered was provider engagement in survey completion and cultural competency trainings. It is difficult to secure collaboration and engagement with providers across 12 counties with varying needs and populations.

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.

EOCCO’s most successful strategy was to include the cultural competency training within a workshop for other provider trainings and within an annual conference to ensure better engagement and participation from providers. EOCCO has also been engaging the largest provider groups to gain useful feedback through the survey to build effective cultural competency training tools.

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 element. They also will be informed of provider survey outcomes and future cultural competency trainings.

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

LCACs were notified of trainings and will be notified of outcomes.

Transformation Area 8: Eliminating racial, ethnic and linguistic disparities

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

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

Activity (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 assessment (HA) to improve the data collection on race, ethnicity and language on our member population. EOCCO sends the initial HA 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 follows-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</p>	<p>EOCCO implemented the improved health assessment in November 2013. Return rate as of June 2014 is 3 percent.</p> <ul style="list-style-type: none"> • Implement new health assessment. This milestone is partially met in that while the HA has been implemented and staff trained in follow-up, the HA data is yet to 	

	<p>assessment; new questions related to mental health 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 HA on approval of the documents by DMAP.</p>	<p>be systematically captured in our operating system.</p> <p>Address disparity issues identified in the health assessment. A nurse reviews each returned HA and assesses the need for care coordination and other interventions. 2014 reporting of the HA results and follow-up will include race, ethnic, linguistic, disability, health literacy barriers identified and addressed. This milestone is partially met.</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 with our Information Services department to store the</p>	<ul style="list-style-type: none"> • We store race and spoken language data received in the 834 eligibility files in our operating system. • Since March 2014, we are receiving new data fields— reading language and ethnicity— in the 834 eligibility files <p>We confirm receipt and</p>	

	<p>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 Cover Oregon application and there are no plans to expand the ethnicity and race in the application process.</p>	<p>use of race data for 90% of our EOCCO members and spoken language data for almost 94% of our members, thereby meeting our July 2014 milestone.</p>	
3.	<p>We received our 2013 final CCO incentive metrics report June 23, 2014. We are using the CCO incentive metrics as quality indicators to measure member engagement, access to care, use of services and cost of care. We will use race and spoken language data to drill down on the metrics to identify potential disparities in member engagement and access to and use of services. This analysis will establish our baselines. Our benchmarks will be the 2014 incentive metrics benchmarks set by the OHA for our CCO.</p>	<ul style="list-style-type: none"> • We have defined the quality indicators to identify and eliminate race and language disparities. • We need to establish baselines for these quality indicators (final metric rates received June 23, 2014). • Our 7/1/15 benchmarks for these quality indicators will be the same as the 2014 incentive measures benchmarks established by the OHA for our CCO. <p>This milestone is partially met.</p>	

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

While we implemented a greatly improved health assessment (HA), our historic response rate has been very poor – 3% year to date. We have yet to complete the process to store HA data in a database to increase tracking and reporting capabilities and to report disparities identified in the HA and how we addressed them.

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.

Our participation on the OHA Member Engagement Outreach Community workgroup enables us to support a more systematic and uniform way of collecting granular race, ethnicity and language data using the Medicaid program application process. We continue the work to automate the capture/storage of the health assessment data to increase functionality. We are looking at posting a fillable health assessment on our website to give members an alternative to responding in hard copy the objective being to increase the response rate.

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

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 CACs about our PIPs. We surveyed our CACs 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?

We report EOCCO activities in this transformation area to the CACs at their regularly scheduled meetings. We will continue to report on quality activities, such as the breakdown of our 2013 incentive metrics rates using race and language data to establish baselines, identify healthcare disparities and our plans to correct them.