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**EASTERN OREGON
COORDINATED CARE
ORGANIZATION**

Transformation Plan

February 15, 2013

EOCCO Transformation Plan

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The Eastern Oregon Coordinated Care Organization (EOCCO) transformational work up to this point has been focused on the transition of those lives from the FCHP/PCO model previously in place to the new EOCCO model of care. We began providing medical benefits in four counties (Baker, Malheur, Union and Wallowa) on 9/1/12. These four counties were previously served by ODS and GOBHI under the prior FCHP/MHO model. On 10/1/12, we began providing services to members in Sherman County, and on 11/1/12 we began providing services to members residing in Grant, Harney, Lake, Morrow, Umatilla and Wheeler counties. Our expansion on 10/1 and 11/1, respectively, resulted in the CCO providing medical benefits for approximately 20,000 of the 30,000 EOCCO lives for the first time as these seven counties were previously served by a FCHP/PCO other than ODS. We expect to begin providing services in Gilliam County in June 2013.

More specifically, our focus during this transitional period has involved assuring adequate access to care for members, assigning members to a PCP/PCPCH and assuring continuity of care for members in the middle of treatment plans. In addition to the transitional work, we have been performing case conferences for members with complex medical needs. For example, case conferences have included EOCCO staff from ODS, GOBHI, hospital discharge planners, local mental health providers and the local APD office. These conferences have allowed us to work collaboratively to provide members the best possible care while looking for and approving alternative treatment options that would not normally meet standard medical criteria requirements.

Additional transformation work has involved several face-to-face meetings with key hospitals, provider groups (both in Oregon and Idaho) and local county governments that serve EOCCO members. These discussions have resulted in our ability to build trust with the communities, which has provided us an opportunity to have a dialogue about how we can work together in a different way. For example, we plan to delegate some operations such as referral/authorization management and case management so it can be provided locally. This is one of a number of pilots we plan to pursue in the interest of better coordination and local control and accountability. Our one-on-one discussions with providers have also led to discussions on ideas for alternative payment methodologies, allowing us to gain an insight into the desire/ability for clinics to become certified as a PCPCH.

Our most significant transformational work to this point has been an agreement with five local hospitals, an IPA and a large provider group to buy into the EOCCO. We strongly believe that our collective interest in the EOCCO will serve members well and allow us to work together collaboratively to meet budget targets while improving member care. This partnership has already resulted in discussions about how hospitals can re-purpose staff to serve roles such as community health workers and patient navigators. Additionally, the

IPA has identified the need to improve primary care access in Umatilla County, which will result in the IPA opening a new clinic that will provide primary care services to Medicaid members.

EOCCO has provided a narrative summary for each of the eight transformational plan elements. Additionally, we have included a separate document that outlines our milestones and benchmarks.

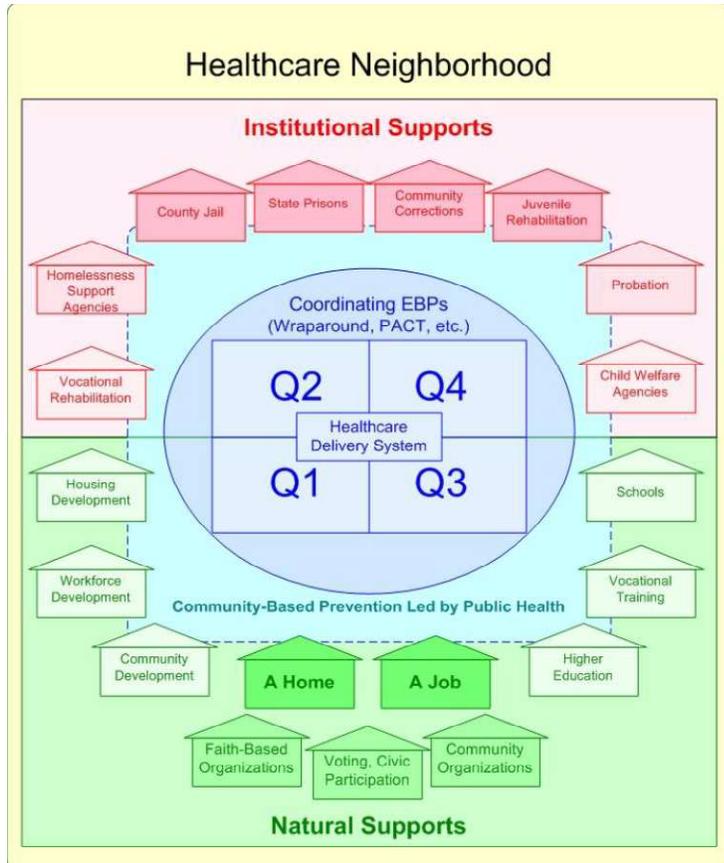
1. Developing and implementing a health care delivery model that integrates mental health and physical healthcare and addictions This plan must specifically address the needs of individuals with severe and persistent mental illness:

EOCCO recognizes integration is a broader endeavor than just placing behavioral health specialists in a primary care clinic or vice-versa. The EOCCO’s current understanding is that integration seems to be best initiated within the context of existing, differing and ongoing integration work across its 12-county region. It is clear that a mission to reduce care fragmentation is immense, particularly when considering the number of organizations that support and provide services for Oregon Medicaid members.

EOCCO strongly supports the conceptual representation of a Healthcare Neighborhood as presented in the graphic below. The organization is committed to engaging community-

based organizations/partners that have the potential to impact healthcare outcomes throughout Eastern Oregon. These partnerships will allow us to promote evidence based practices and the four quadrant model for integration.

While patients throughout Eastern Oregon receive exceptional medical and behavioral healthcare, patients may perceive that their care is fragmented. There is no single entity within a community to coordinate services and care. It is frequently only through patient self-reporting that other engaged community partners are identified. Unfortunately, patients may not even disclose other community partners, as they are concerned they



will jeopardize their current support.

However partnerships between individual entities, such as the Community Mental Health Programs, community corrections, and others, are emerging. They now frequently call together community partners for specific planning and delivery of services for individuals and families. Those partners are typically a subgroup of the institutional and natural supports within a community.

EOCCO recognizes that integrated care will require the development of a model for coordination of all service providers, in order to ensure effective care coordination for patients and their families. The initial steps to developing this system will include effective care coordination amongst the initial EOCCO entities of GOBHI and ODS. Then a care coordination model can be jointly developed with community care providers. This coordinated model of care will be designed to solidify the partnerships that already exist within the community and promote the development of new ones. The overarching goal is to reduce fragmentation and thereby promote better clinical outcomes for EOCCO members.

Our intra-EOCCO coordination has already clearly demonstrated that members within our community will benefit from behavioral and medical health care coordination. As a result, the EOCCO has identified strategies that can be created and implemented within the context of a behavioral health continuum of care to effectively deal with these issues. The section below expands and details the continuum of care and how it relates it to the EOCCO's chosen integration strategies.

EOCCO's Continuum of Care

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines a continuum of care as: "A comprehensive approach to behavioral health also means seeing prevention as part of an overall continuum of care . . . [and] there are multiple opportunities for addressing behavioral health problems and disorders. . . ". The model includes these components:

- **Promotion:** Strategies that are designed to create environments and conditions that support health and the ability of individuals to withstand challenges. Promotion strategies also reinforce the entire continuum of behavioral and medical health services.
- **Prevention:** Delivered prior to the onset of a disorder/illness, these interventions are intended to prevent or reduce the risk of developing a behavioral and/or medical health problem, such as underage alcohol use, prescription drug misuse and abuse, and illicit drug use.
- **Treatment:** Services for people diagnosed with a behavioral health disorder and/or medical condition.
- **Maintenance:** Services to support individuals' compliance with long-term treatment and aftercare." (Referenced on February 5, 2013 at <http://captus.samhsa.gov/prevention-practice/prevention-and-behavioral-health/behavioral-health-lens-prevention/3>)

Population-based efforts, such as those provided by the EOCCO, must include all components of the model presented above; however efforts do not neatly fit in any one category. The following is an informal cross-walk between strategies in this section and their link to the continuum of care

Promotion:

- The expanded Community Care Coordination Model increases awareness of health issues within the healthcare neighborhood thus creating an environment focused on cross-organizational priorities.
- Increasing Child Resilience Activities directly increases the ability of youth to withstand challenges and develop healthy community support systems for youth.
- Primary Care Providers implementation of the Screening, Brief Intervention and Referral to Treatment (SBIRT) could create a significant environmental shift in smaller communities for supporting change in the overall cultural attitudes around alcohol use.

Prevention:

- Integrated Care Management utilizes predictive modeling for early identification of problem patterns, thereby providing the opportunity to support members before their situation worsens.
- Expanded Community Care Coordination promotes the opportunity for community partners to recognize and intervene with individuals before serious problems develop.
- SBIRT use by primary care providers can help promote the early identification of members at-risk of substance misuse and abuse before serious consequences emerge.
- Expansion of Behavioral Health Best Practices, including EASA (Early Assessment and Support Alliance), specifically focuses on educating parents, teachers and law enforcement for the identification and treatment of early psychosis.

Treatment:

- Integrated Care Management will promote treatment in appropriate settings, using a full range of resources and supporting the member through transitions of care for the best level of services.
- Community Care Coordination assures treatment is carried out by all those who provide services to the member and can include in-home assessment of the environment as well as in-home support for following a treatment regime.
- Behavioral Health Best Practices assures effective treatment through the use of EASA family support groups and provision of therapeutic services for youth with

signs of early psychosis. Assertive Community Treatment and other traditional behavioral health therapeutic services support treatment and recovery for members.

- Primary Care Providers serving members by providing mental health services in their clinic setting will help to overcome the stigmatizing barrier of going to a community mental health program. Additionally, community mental health therapists are willing to provide services in a primary care setting for those members who need a higher level of care.
- Primary Care Providers use of SBIRT has been proven to increase members seeking addictions treatment.
- Addictions Integration will allow for treatment of the very common dual-diagnosis of mental health and addictions within one setting and with a single, consistent care provider. The integration will allow for the full range of continuum of care (including behavioral health best practices) to be available for treatment, vocational services, coordinated residential care and wraparound services.

Maintenance

- The Community Care Coordination, through use of multi-disciplinary community teams, will provide opportunities for continuance of wrap-around services needed to assure members are supported in continued health and recovery.
- Child Resilience Activities go beyond support of identification of children who have had adverse childhood experiences to the creation of communities which support resiliency in children through the development of family and educational supports. This creates close ties with the Early Learning Councils to assure a broad community approach.
- Behavioral Health Best Practices of EASA's support for educational/vocational training, supported employment and wrap-around services, such as housing all contribute to supporting members in new healthy behaviors and lifestyle.
- Addictions Integration provides maintenance services through supported employment and access to Dual Diagnosis Anonymous Groups and wrap around services to also support a member's economic viability

Details of these strategies are discussed below.

Integrated Care Management

EOCCO brings a set of unique strengths to Medicaid members in their service area.

ODS has a strong centralized system designed to support members throughout the continuum of care. ODS' intensive case management (ICM) program includes facilitation of services for members experiencing catastrophic or complex healthcare events. Nurse case managers work directly with the member and his or her clinical care team to support and empower members who require assistance in coordinating multiple healthcare services. Additionally, ODS has nurse care coordinators to support members with acute care needs.

Finally, ODS' team of health coaches provide specialized programs for members with chronic diseases processes; specific interventions are tailored to the members' individual level of activation.

Community partners compose a strong complement to the ODS system. These partners include GOBHI, primary care providers and hospitals that focus on community-based work with Medicaid members. The GOBHI system utilizes Exceptional Needs Care Coordinators (ENCCs) in each county. ENCCs assure coordinated delivery of services at the local level, particularly for those who are severe and persistently mentally ill. As a result, they know key community players and local services.

EOCCO plans to capitalize on the strengths of these two initial EOCCO partners. The Integrated Care Management strategies take advantage of the strengths of these two systems in utilizing the smooth functioning of ODS systems and the expertise of their nurses in combination with GOBHI and other providers in the member's community of residence. Patients are receiving services through intra-EOCCO coordination right now. These initial steps of coordination lay the groundwork for initiating conscious, community inclusive planning to develop a joint CCO and community care coordination model. In addition to the strategies identified above, the EOCCO will continue to refine and implement the following workflows to enhance our current care coordination model:

- Continued utilization of predictive modeling to stratify member use patterns and identify members before they become super-utilizers.
- Refine processes for transitions of care between clinical settings. Continued collaboration between the initial EOCCO partners (ODS and GOBHI) and APD, PCPs, specialists, facilities and community service agencies for complex patient discharges or transitions of care.
- Identify additional opportunities to promote coordinated care for EOCCO members based upon information obtained through the Health Risk Assessment process.
- Explore options for Patient System Navigators at DHS Self Sufficiency offices to assist with: 1) assuring timely completion of the Health Risk Assessment; 2) early identification of potential high risk, new enrollees (example: pregnant teens, etc.); and 3) utilize warm hand-offs to get new enrollees to a primary care home as soon as possible.
- Explore options with other CCOs and DHS to have a CCO wide Health Risk Assessment as part of the Oregon Health Plan Application document. Again, completion of this document can assist with identification of potential high risk, new enrollees.

Expanded Community Care Coordination Model

Community partners are ready and excited to be a part of this planning process. Public health personnel, primary care providers, hospital staff and county commissioners in the EOCCO area participated in two 2011 workshops on "Creating the Healthcare Neighborhood," with Dale Jarvis, a national consultant in health systems design. Many community partners who attended now participate in community-based hot-spotting teams.

Even those who have not been a part of these processes are requesting greater coordination with EOCCO and between service providers in their community. EOCCO's initiation of community discussion and planning about how to achieve this coordination will result in enhanced community participation.

There are currently six county-based hot-spotting groups operating within the EOCCO's service area. Since their formation, these groups have effectively coordinated care for some of the CCO's highest risk members. As a result, EOCCO would like to determine how it can best support these existing groups. Moving forward, EOCCO will assess if it should promote the development of comparable groups in the six counties that do not currently have active hot-spotting groups.

The EOCCO also plans to strengthen its existing relationship with the APD offices operating within its service area. Through regular meetings, the organizations plan to develop a system that will promote care coordination for some of the CCO's most complex members. A strong emphasis will be placed on supporting members during transitions of care.

While these illustrate our initial efforts to expand our current care coordination model, EOCCO recognizes and welcomes the opportunity for increased collaboration/coordination with additional community partners.

Initiate Child Resilience Activities across all EOCCO Counties

ACES (Adverse Childhood Experiences) is a best practice in prevention through the development of resilience and support for children who have been the victims of trauma and abuse. As such, it is a natural springboard into joint work with Oregon's Early Learning Councils. Early Learning Council Community-Based Coordinators are charged with assuring the use of SBIRT, PHQ-9 and postpartum depression checks. Additionally, one of their two overarching goals is assuring children are raised in stable and attached families. Achievement of this goal needs to start with the use of a family well-being assessment tool. The ACES survey instrument could be a part of that assessment process.

As the behavioral health part of EOCCO, GOBHI providers are participating in Early Learning Councils at the community level and will be encouraged to initiate discussions about the program and promote the understanding of incentives for adoption of community wide use of the ACES survey instrument.

Additionally, EOCCO/GOBHI has specific staff whose job is to develop "bridges" between behavioral health programs and Early Learning Councils. These staff specialists will be working jointly with Community-Based Coordinators in sharing the ACES survey instrument.

EOCCO/GOBHI will work on a community-by-community basis to jointly define and establish incentives for using the tool.

New Educational Focus for SBIRT

While primary care providers (PCPs) may treat the clinical symptoms of problematic drug and alcohol use, it has been demonstrated that they do not routinely screen for alcohol, illicit drugs and/or prescription drug abuse. Screening, Brief Intervention and Referral to Treatment (SBIRT) is a comprehensive and integrated public health approach to detect and deliver a spectrum of early detection and treatment services for problem substance use and related health problems in general medical care settings. The SBIRT process is accepted as effective for the reduction of problem drinking and substance use by various Public Health agencies of the United States Department of Health and Human Services and numerous medical specialty societies. Several SBIRT models have been shown to be effective and cost-effective in improving outcomes of persons with problematic alcohol and nicotine substance use in general medical care settings.

Starting in 2013, the use of SBIRT among EOCCO providers will be tracked on an annual basis as part the organization's quality outcome measurements. EOCCO believes there will be opportunities to promote and expand the use SBIRT. For example, this is an area of collaboration with the Early Learning Councils since this is a chosen screening tool for use by Community-Based Coordinators. With the joint emphasis by EOCCO and the Early Learning Councils, EOCCO intends to create an impetus for change and support for change with the PCPs.

Expand Behavioral Health Best Practices to All EOCCO Counties

Early Assessment and Support Alliance (EASA), Supported Employment (SE) and Assertive Community Treatment (ACT) are closely related best practices that utilize staffing levels that are difficult to achieve, and financially sustain, in rural communities where the number of participants in each program may be small. Maintaining fidelity to the models will yield the best outcomes and therefore, the Community Mental Health Programs (CMHPs) have already identified two potential models for effectively utilizing staff across multiple counties. The programs recognize that large population areas will likely benefit from their own full programs while smaller counties may best be served through a hub model. It is intended that the initiation of these programs occur in all 12 counties within the first transformation plan year. Full fidelity will be achieved by January 1, 2015.

Contracting with PCP for Quadrant I and III Mental Health Services

As the behavioral health side of the EOCCO, GOBHI recognizes the need for some behavioral health services to be provided in the primary care setting. That setting is appropriate for delivery of services to those people defined as being in Quadrant I and III of the Four Quadrant model, which is a nationally recognized model for integration. (See *Behavioral Health/Primary Care Integration: The Four Quadrant Model and Evidence-Based Practices*, Revised February 2006.

National Council for Community Behavioral Healthcare Prepared by Barbara J. Mauer
MCCPP Healthcare Consulting. This document can be obtained at:
<http://www.thenationalcouncil.org/galleries/business-practice%20files/4%20Quadrant.pdf>

Providing behavioral health in a primary care setting will help to increase access to services by reducing the stigma associated with going to a Community Mental Health Program (CMHP). Additionally, the current guidelines for documentation of care are far less onerous in the primary care setting, which will allow for more cost effective delivery of services to those who are without severe needs.

Best practices note that medication and talk therapy are most effective for almost any mental health diagnosis. Therefore, protocols will need to be established to facilitate joint care when a member is not recovering through the mental health treatment services provided in a primary care setting. Those will need to be co-created between CMHP and PCPs; hence the approach will be county by county. Please see the payer model section for more details on this strategy.

Addictions Integration

Behavioral health and addictions integration is a high priority to EOCCO. The current system separates behavioral health and addictions services such that episodic care is provided in a disjointed manner. The intent for unification of these services is for the creation of a continuum of care to assure wraparound services and support for long-term healthy behavior.

The unification of services will provide the opportunity for a wide continuum of care, which will include Behavioral Health courts, detox, dual diagnosis residential treatment, outpatient treatment, safe and sober housing, aggressive outpatient case management, vocational services, and access to Dual Diagnosis Anonymous Groups to help prevent relapse. When funding for these services is unified, incentives can be provided to assure members enter residential facilities with appropriate medications and transition out of residential facilities with closely managed care into aggressive outpatient case management and other wraparound services to prevent relapse.

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

Currently there are four clinics certified as a PCPCH in the EOCCO service area. These clinics serve 1,200 of the 30,000 members currently enrolled in EOCCO. Two clinics are at tier two (2) and serve 610 members and the other two clinics are at tier three (3) and serve 590 members.

Due to the rural nature of our CCO, there are perceived barriers for clinics in achieving PCPCH certification. Comments have included:

- “We don’t have enough Medicaid patient volume to justify going through the process.”
- “We cannot meet the requirements for patients to obtain clinical advice via telephone from a live person at all times.”
- “We plan to become certified but don’t have time to complete the paperwork.”

Our goal to improve development of provider PCPCH status will be focused on the following:

- Provider education and training-We will utilize our clinical consultant (who has completed the PCPCH application process) to be a resource and assist with education and training of clinics as they proceed through the PCPCH certification process.
- Developing solutions to PCPCH barriers-For example, ODS has a contracted nurse advise line that providers could utilize to meet the requirement for members to obtain clinical advice via telephone from a live person at all times.
- Exploring financial incentives through alternative payment methodologies for clinics that have achieved PCPCH recognition-See the alternative payment methodologies section for the steering committee we are forming to pursue and pilot other payment methodologies.
- Technical support - We will explore what relevant data will be provided to PCPCH certified providers to assist them in meeting quality objectives. For example, provider report cards and/or technical assistance reports (ER utilization). As part of this work we will also be able to leverage the type A hospitals expertise in the development and use of quality scorecards and the repurposing of skilled clinical staff within the rural communities.
- Patient engagement-We will assist PCPCH’s in developing resources/tools for patients to ensure they are actively involved in accessing patient information.

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

In the EOCCO service area there are 10 local hospitals each of which are classified by the Oregon Office of Rural Health as a type A hospital (less than 50 beds and more than 30 miles from nearest hospital). These hospitals are currently guaranteed cost-based reimbursement. Although we understand hospitals can contract at rates other than cost-based reimbursement, we need to ensure cost-based reimbursement is maintained as a floor while we move through transformation. It is critical that each hospital is able to maintain the level of care and services they provide in their respective communities.

EOCCO Type A hospital partners have collaborated with the Oregon Association of Hospitals and Health Systems (OAHS) Rural Health Reform Initiative (RHRI) payment reform project. This two-year project is aimed at developing alternative payment and delivery models for Oregon’s 32 small and rural hospitals that complement the vision of

CCOs, and considers the impact and various solutions for transforming the Oregon rural healthcare delivery system. EOCCO recognizes the pioneering work being done by RHRI that focuses on quality care and access to care in the rural parts of Oregon.

The RHRI body of work, guided by national rural healthcare experts, has incorporated the lessons learned from previous health reforms that led to the Medicaid and Medicare cost-based programs for access and quality measurements (i.e., the CAH designation that resulted from multiple federal demonstration projects in the 1990's). EOCCO can leverage the work done by the Type A hospitals, through the RHRI, in the development of alternative payment methodologies and delivery systems going forward EOCCO will collaborate with OHA and OAHHS to develop an actuarial basis for cost-based hospital, FQHC, and RHC payments that accounts for demographic as well as financial factors. EOCCO will work with its hospital partners and OAHHS to develop a rural hospital “Triple Aim Dashboard” using quality and cost to determine value-based reimbursement beyond cost-based payments. EOCCO will work with its partners to create a community-based model that repurposes current infrastructure and staff.

Additionally, within the EOCCO service area there are four primary care clinics that have Federally Qualified Health Center (FQHC) designation and 23 are certified as Rural Health Clinics (RHC's). These 27 clinics provide primary care services for the majority of EOCCO members and in some instances these clinics are owned by a type A hospital. Similar to the hospitals need for cost-based reimbursement, it is important that our implementation of alternate payment methodologies for FQHCs and RHCs does not interfere with the clinics ability to receive their full RQHC or RHC encounter rate.

The behavioral health benefit administered by GOBHI has been operating under a successful capitated model for over a decade. GOBHI's experience with alternative payment models will allow for early adoption of capitated payments for addictions service providers. GOBHI can also provide leadership on payment models that may be imported to physical medicine providers over time. The medical benefit administered by ODS has been operating under a fee-for-service (FFS) model up to this point with the exception being that Oregon DRG hospitals are paid using Medicare payment methodologies. EOCCO's approach to alternative payment methodologies is to ensure that the payment models will work for rural Oregon while assuring some level of cost-based reimbursement.

Working with communities to address care for those without health insurance is an important role for EOCCO. Uninsured individuals currently access care through emergency rooms, delay care until they are sicker, take on debt they cannot pay, rely on charity care, or cause providers to shift costs from other payer sources. It is in the best interest of the EOCCO to develop a mechanism that allows for affordable primary care to these individuals in one or more EOCCO counties. This intervention will utilize concepts of Direct Primary Care similar to approaches taken by QLIance in Seattle, Washington. <http://qliance.com/>

This initiative is currently being undertaken in Hood River County and being facilitated by the County Health Department. EOCCO will work to explore this concept with interested providers in Sherman and Harney Counties along with providers in other counties that have an interest in this concept.

Our approach to utilizing alternative payment methodologies for provider compensation is as follows:

- Steering Committee-We will invite a small group of primary care providers and hospitals across the EOCCO service area to participate in a “transformation steering committee.” The committee will begin meeting on several topics, which will include payment system transformation.
- Types of alternative payment methodologies-We plan to explore the following payment methodologies: Modified fee for service arrangements, PCPCH PMPM payments, shared savings, bundled payments for episodic care, pay-for-performance and capitation.
- Capitation payments -We will implement capitation pilot projects outside of the steering committee’s work, which will include capitation payments to a critical access hospital and to a primary care clinic.

4. Preparing a strategy for developing Contractor’s Community Health Assessment (CHA) and adopting an annual Community Health Improvement plan (CHIP)

To conduct Community Health Assessments and develop Community Health Improvement Plans, EOCCO has established the following strategies:

- Establishing Local Community Advisory Councils-EOCCO is currently working with county representatives in each of the 12 counties to identify, establish and finalize the membership of each counties local Community Advisory Council (CAC). EOCCO will make best efforts to ensure that each CAC has adequate OHP consumer representation and includes, whenever possible, individuals who represent the respective county and community population.

Each local CAC will be primarily responsible for conducting a Community Health Assessment (CHA) and for drafting a county Community Health Improvement Plan (CHIP) based on the needs identified in the CHA. In the longer term, local CACs will implement CHIP, monitor interventions, and track outcomes.

- Establishing a Regional Community Advisory Council-EOCCO recognizes that many of the county CACs may need assistance and accepts responsibility for providing such support. The Regional Community Advisory Council (R-CAC) will be responsible for tracking the progress, promoting consistency and quality,

assisting in identifying available resources and partnerships and serving as a forum for problem solving and the dissemination of best practices amongst local CACs. The R-CAC will regularly report to the EOCCO Governing Board on the status of county CAC activities. In addition to the responsibilities noted in this Transformation Plan around assessments and improvement plans, the R-CAC will also play a key role in ensuring health disparities are addressed by disseminating appropriate information and policies to local CACs on sub-populations at risk for health disparities (race, ethnicity, language, seniors, disability status, and mental illness).

The Regional Community Advisory Council will be comprised of one representative from each local CAC (selected by the CAC) and one County Commissioner from each county. The R-CAC will select a chair and establish a regular meeting schedule to accomplish its work. EOCCO personnel will staff the R-CAC to ensure effective and efficient meetings.

- Conducting a Survey of Existing Assessments/Plans and Current Activities- EOCCO recognizes the importance of determining existing assessment and planning efforts in order to coordinate activities and avoid duplication. EOCCO will conduct a survey involving local health departments, hospitals, and mental health authorities in each county. The survey will be concise with extensive follow up to ensure timely collection of data. EOCCO staff will attempt to reduce potential duplication and initiate assessment and planning activities in counties where such efforts are required.
- Developing a Regional Assessment through Local Community Health Assessments- The backbone of the EOCCO Regional Health Assessment will be based on assessments conducted at the county level by each local CAC. EOCCO assumes the majority of county CAC members will be unfamiliar with the health assessment and improvement planning process. Consequently, EOCCO will sponsor a number of voluntary, training workshops where local CAC members can learn about the process and find out more about their role in it. Some county CACs may have resources to facilitate the CHA. If resources do not exist, EOCCO will assist county CACs in identifying and accessing necessary resources. EOCCO will assist each local CAC in disseminating the CHA findings to providers and the general public. CHAs will be used to develop a report of regional community health information. This report will be presented to the R-CAC for review and comment before being finalized and adopted by the Governing Board.
- Developing Local and Regional Community Health Improvement Plans-EOCCO will support R-CAC and local CACs in prioritization of community health needs,

selection of topics for intervention, and development of implementation strategies. Each local CAC will create a DRAFT Community Health Improvement Plan (CHIP) that will be disseminated to providers and the general public, and will conduct at least one community forum to discuss the plan before adopting it. CHIPs will be submitted to the R-CAC for review and coordination to ensure best practices are used and determine if multi-county partnerships or collaboration may be beneficial. Upon approval, the R-CAC will present the final Regional Community Health Improvement Plan to the Governing Board for adoption and submission to the state.

5. Developing electronic health records; health information exchange; and meaningful use

EOCCO is committed to the development of a health information exchange strategy including use of electronic health records, meaningful use requirements, as well as improved access to data that provides the foundation for data analytics in support of improved patient quality outcomes.

EOCCO will assist its providers in facilitating the use of electronic health records and in the course of provider contracting efforts, currently encourages all providers in this direction. During 2013 EOCCO will contact each provider and will assess and track what type (if any) electronic health record is utilized and/or the technology capabilities of the provider. This information gathering effort will assist EOCCO in determining the next strategies to increase the adoption of EHR's. In addition, the tracking of the use of EHRs will be available via an online portal for the EOCCO members to be aware of their provider's use of this technology.

While today EOCCO focuses on measuring clinical quality outcomes and has a sophisticated analytics platform to support this process, a true health information exchange strategy needs to be developed that will provide the foundation for true electronic data interchange between providers, payers and the entire CCO. This technology collaboration will provide the real-time connectivity between providers. To accomplish this we plan to do the following:

- Heath Information Exchange (HIE) Steering Committee: EOCCO will invite provider partners to work with the EOCCO in the development of health information exchange strategies. These strategies will focus on full HIE connectivity and integration in support of the transformation to a value-based model. Focus areas for strategy development include, but are not limited, to:
 - Electronic health records adoption and meaningful use
 - Connectivity and messaging between providers regarding patient care and outcomes
 - Clinical connectivity across EOCCO providers and payer
 - Analytics and quality reporting

- Analytics and performance management reporting
 - Patient engagement and use of technology
- HIE implementation plan: Once the strategies are outlined and agreed to across the Eastern Oregon Coordinated Care Organization, an implementation plan will be created, measured and monitored. This plan will include enhancements to existing HIE efforts, as well as new efforts in line with the overall transformation plan for EOCCO.
- Electronic health records assessment and tracking: As noted above, EOCCO will assess each providers EHR implementation and/or capabilities in 2013. This will provide a baseline for strategies to increase the adoption of EHRs, which will be a key focus during 2014 and 2015.

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

6. Assuring communications, outreach, Member engagement and services are tailored to cultural, health literacy, and linguistic needs

Five of the counties in the EOCCO service area are among the most diverse Oregon counties outside the Portland metro area. Non-white Hispanics are the largest minority group in Oregon at 11.8 percent -- approximately 425,000 Hispanic Oregonians. In Eastern Oregon, this rate rises as high as 32 percent in Morrow County and 51.3 percent in Malheur County, according to US Census data. In addition to the Hispanic population, other culturally and socially diverse groups continue to experience varying levels of quality and outcomes of care.

ODS was accepted on full scholarship to participate in the Disparities Leadership Program – a yearlong executive leadership program sponsored by the Harvard Medical Medicine and Massachusetts General Hospital. This program is designed for leaders from hospitals, health insurance plans, and other healthcare organizations who are seeking to develop practical strategies to eliminate racial and ethnic disparities in healthcare. As one of just 15 organizations accepted into the program, ODS has utilized this opportunity to collaborate with various health organizations to move health equity efforts forward within the organization. The Disparities Leadership Program marks the beginning of ongoing efforts to eliminate racial and ethnic disparities in healthcare.

EOCCO will work with community advocates through the Community Advisory Councils and use county demographic data to identify and develop strategies to improve culturally competent care, increase engagement in appropriate levels of care, improve quality and effectiveness of member interactions, and integrate cultural competence health literacy into the healthcare system.

Our goals to ensure cultural, health literacy and linguistic needs are acknowledged and addressed below:

- Consumer-input based policy- EOCCO currently translates many materials into Spanish and sends those translated materials to members that OHA identifies as Spanish speaking through the OHA enrollment reports. To ensure the information we are translating is meaningful to members EOCCO will utilize the CAC's in each county to develop a health literacy and cultural competency policy. This policy will ensure that new and currently translated consumer materials are written in a health literate and culturally sensitive manner. Existing and newly developed materials will adhere to this policy. Materials will also be reviewed on a regular basis.
- Demographic assessment-EOCCO will utilize the Community Health Assessment and hot-spotting demographic data to determine the language and literacy needs of the community. EOCCO will assess member data collection and analysis methods to develop a strategy for recurring analysis of cultural and linguistic needs of membership.
- Staff training- EOCCO will conduct training for staff on cultural and linguistically appropriate services. The content and aim of the training will be developed in coordination with the CAC to ensure consumer needs are identified and met.
- Interpretation services- EOCCO will explore and identify standard certification for healthcare interpreters.
- Member engagement- EOCCO will partner with the Community Advisory Councils to identify culturally and linguistically appropriate methods of engagement with the community and clinical settings.

7. Assuring provider network and staff ability to meet cultural diverse needs of community (cultural competence training, provider composition reflects Member diversity, nontraditional health care works composition reflects Member diversity)

EOCCO has a comprehensive network of providers across the 12 county CCO, including contracts with providers where the pattern of care crosses state and county boundaries. EOCCO also contracts with those clinics that have traditionally focused on serving the Hispanic population in the EOCCO service area. These clinics have staff and physicians that speak the primary language of the member. Five of the counties in the EOCCO service area are among the most diverse Oregon counties outside the Portland metro area. Non-white Hispanics are the largest minority group in Oregon at 11.8 percent -- approximately

425,000 Hispanic Oregonians. In Eastern Oregon, this rate rises as high as 32 percent in Morrow County and 51.3 percent in Malheur County, according to US Census data. In addition to the Hispanic population, other culturally and socially diverse groups continue to experience varying levels of quality and outcomes of care.

EOCCO will work to identify and develop strategies to improve culturally competent direct patient care, increase engagement in appropriate levels of care, improve quality and effectiveness of member interactions, and integrate cultural competence and health literacy into the healthcare system.

Our goals to ensure the needs of the diverse EOCCO member population include:

- Clinic assessment- EOCCO will survey contracted providers to determine which providers serve the majority of Spanish-speaking and culturally diverse populations. EOCCO will use assessment results to identify and/or confirm important elements to be incorporated into future provider and clinic staff training. EOCCO will also compile clinic profiles, which will identify Spanish-speaking providers. These profiles can then be used in coordinating care for Spanish-speaking members.
- Clinic staff training- EOCCO will conduct health literacy and cultural competency training for contracted provider and clinic staff to ensure the highest quality and experience of care is available to all members. The training will include education and support toward clinic policies ensuring demographically representative workforce. Local Community Advisory Councils will be involved in identifying focus areas for improving quality and experience of care within each community-based on the needs identified in the Community Health Assessments. EOCCO will also assess the need for additional consultants in the development of the training, such as quality specialist and practicing physicians. EOCCO will pilot training in a determined number of clinics and collect feedback regarding content, delivery and effectiveness of the training. Findings will be utilized to improve the training prior to implementation across other EOCCO counties. EOCCO will assess the need and identify strategies for continuing education around cultural competency and health literacy.

8. Developing a quality improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, and outcomes.

Our quality improvement (QI) plan will be structured to be consistent with the Triple Aim: better care, healthier people and communities and lower cost care – for all EOCCO members. We will use an integrated approach to identify and focus on opportunities to eliminate health disparities and improve the quality of care, experience of care and outcomes of our members regardless of race, ethnicity, language, national origin, age,

disability, cultural preference, etc. The partners in the communities we serve, as well as members and their families, will be integral in the decisions we make on QI initiatives to achieve health equity in the care provided, experience and outcomes.

We will collect data at the most granular level possible to ensure we make sound decisions in selecting QI projects to help us realize our goals. Our QI plan will ensure the most robust analyses to support measurement aspects of our quality improvement activities. Our staff has the expertise in program design, statistics and analysis to derive meaning from statistical analysis and we will collaborate with community partners and consultants. Our data may include claims, encounter, enrollment, UM data, census data, member and provider surveys, medical record reviews, health risk assessments, face to face encounters, health coaching, medical management, complaint and appeals data.

In the interim, EOCCO will explore the use of indirect estimation methodology for race, ethnicity and language data collection.

Benchmarks regarding data collection were determined based on conversations with thirteen other national and regional health plans. Other managed care organizations reported that race, ethnicity and language data have been collected on 17% - 35% of their total membership. Considering EOCCO's initiative to work with OHA to improve data collection and data sharing strategies and the focus on the Medicaid population, EOCCO has determined that 30% in the first year and 70% in the second year are realistic benchmarks to achieve sustainable transformation.

Our quality improvement plan will address the key elements of our transformation plan and include measurement aspects to help us monitor progress and achievement. Examples of quality improvement initiatives and measures may be:

Outcomes measures

- Treatment adherence (PIPs)
- Improved patient engagement
- Patient safety

Access measures

- Access to urgent care and specialty care

Patient experience measures

- Integrated physical medicine, mental health and dental care (PIPs)
- Patient centered primary care home practice model
- Navigating and using plan services appropriately

Process measures

- Provider and staff education and training in understanding and responsiveness to cultural needs (taking advantage of learning collaboratives in the community)
- Community health assessment

- Communicating in the patient’s language (language access services; state interpreter services certification program or alternative, i.e., AHEC)
- Increase the number of certified patient centered primary care homes in our service area
- Increase in provider systematic preventive and early identification screenings (SBIRT & ABCD PIPs)
- Implementation of evidence-based clinical guidelines

For the current year, EOCCO’s quality improvement plan is three-fold.

- We want to lay the foundation that will help us effectively eliminate health disparities in the short and long term. This includes using accurate and reliable information at the most granular level feasible. To this end, we will develop internal strategies and processes for data collection and analysis. This plan will include collaboration with the Oregon Health Authority to develop and implement standard data collection and analysis processes.
- Our second quality improvement initiative is to train our provider community and clinic staff in understanding and responding to cultural needs; and appropriate methods of collecting racial, ethnic and linguistic data
- Our third quality improvement initiative is to establish a systematic approach to collect data via the new member and/or initial health assessment. The data will help us assure equitable access, quality of care, experience of care and outcomes for EOCCO members. The data we want to collect are: language, race, ethnicity, age, disability status (including vision impairment) and health literacy (education level/assessment of learning style).

Data collection will include the new member health assessment and the initial assessment for complex case management and health coaching.

We will measure the effectiveness of the process by assessing the collection rate and percentage of completeness. We will use tools such as the Patient Activation Measure to assess the patient’s effectiveness in self-care and claims analysis to measure equity in access to care and services, use of services and cost of care.

We will annually evaluate our performance on the equitable care and service initiatives described in our QI plan and describe our completed and ongoing QI activities. Our evaluation will include a quantitative analysis and trending of measures compared to our established performance thresholds, a barrier analysis to identify reasons for goals we do not meet, and a description of our QI plan’s overall effectiveness and whether to restructure or change our plan for the following year. We are committed to sharing our evaluation with our community partners, stakeholders, providers and members, and inviting feedback for improvement. Understandably, our quality improvement plan will evolve as we complete activities, and improve on the collection and analysis of new data to adjust/start initiatives to continuously focus on eliminating health disparities among our EOCCO members and the community.

Required Elements	Milestones/Benchmarks
<p>1. Developing and implementing a health care delivery model that <i>integrates mental health and physical health care and addictions</i>. This plan must specifically address the needs of individuals with severe and persistent mental illness.</p>	<p>How Benchmark will be measured (Baseline to July 1, 2015):</p> <ol style="list-style-type: none"> EOCCO 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. <p>Milestone(s) to be achieved as of July 1, 2014:</p> <ol style="list-style-type: none"> EOCCO develops criteria for triggering ICM for members and referrals for members identified as high risk and needing collaborative mental health, physical healthcare and addictions care coordination and intensive case management. <p>Benchmark to be achieved as of July 1, 2015:</p> <ol style="list-style-type: none"> Identification and tracking process is evaluated semi-annually. Improvement opportunities identified and implemented.
	<p>How Benchmark will be measured (Baseline to July 1, 2015):</p> <ol style="list-style-type: none"> Use existing measurement system with the state to report on these programs. <p>Milestone(s) to be achieved as of July 1, 2014:</p> <ol style="list-style-type: none"> EASA, ACT, SE and associated wrap around programs available to all EOCCO members in all 12 counties. <p>Benchmark to be achieved as of July 1, 2015:</p> <ol style="list-style-type: none"> Achieve fidelity for programs as established by state standards.
	<p>How Benchmark will be measured (Baseline to July 1, 2015):</p> <ol style="list-style-type: none"> Count the number of counties with contracts between medical clinics and CMHP clinics for provision of specific behavioral health services in medical clinics. <p>Milestone(s) to be achieved as of July 1, 2014:</p> <ol style="list-style-type: none"> Contract with medical clinics in at least three counties as voluntary early adopters. <p>Benchmark to be achieved as of July 1, 2015:</p> <ol style="list-style-type: none"> Contracts with medical clinics in at least three additional counties.

Required Elements	Milestones/Benchmarks
	<p>How Benchmark will be measured (Baseline to July 1, 2015):</p> <ol style="list-style-type: none"> 1. 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. 2. Count the number of contracts with residential addictions providers. 3. Count the number of outpatient, integrated, behavioral health and addictions contracts. (Count each county group as one contract.) <p>Milestone(s) to be achieved as of July 1, 2014:</p> <ol style="list-style-type: none"> 1. 1:1 ratio of case rate based contracts with social and medical detox providers. 2. Contract with all three existing residential addictions providers per the jointly defined payment model established at February 2013 meeting. 3. Complete pilot contracts with at least three communities as optional early adopters for outpatient behavioral health and addictions integration. <p>Benchmark to be achieved as of July 1, 2015:</p> <ol style="list-style-type: none"> 1. 1:1 ratio of case rate based contracts with social and medical detox providers. 2. Contract with all three existing residential addictions providers per the jointly defined payment model established at February 2013 meeting. 3. Complete contracts with the remaining nine counties for outpatient behavioral health and addictions integration.
<p>2. Continuing implementation and development of Patient-Centered Primary Care Home (PCPCH).</p>	<p>How Benchmark will be measured (Baseline to July 1, 2015):</p> <ol style="list-style-type: none"> 1. EOCCO will measure the number of members assigned to a certified PCPCH at each tier level. 2. Implement alternate payment methodologies for PCPCH certified providers, such as modified fee for service payments, PMPM

Required Elements	Milestones/Benchmarks
	<p>chronic disease management payments, P4P bonus payments, and a shared savings program.</p> <ol style="list-style-type: none"> 3. Implement technical assistance tools to assist PCPCH providers in meeting quality outcomes 4. Implement strategies to develop certified PCPCH patient engagement programs for EOCCO certified PCPCHs. <p>Milestone(s) to be achieved as of July 1, 2014:</p> <ol style="list-style-type: none"> 1. At least 25 percent of members in EOCCO will be assigned to a certified PCPCH at any tier level. 2. Seek agreement with and implement alternative payment methodologies in at least three (3) EOCCO certified PCPCHs. 3. Identify and seek approval of PCPCH certified providers on technical assistance tools that will assist them in meeting quality outcomes. 4. Identify and seek approval of PCPCH certified providers on how EOCCO can assist with patient engagement. <p>Benchmark to be achieved as of July 1, 2015:</p> <ol style="list-style-type: none"> 1. At least 50 percent of members in EOCCO will be assigned to a certified PCPCH at any tier level. 2. EOCCO will have all PCPCH certified providers contracted using consistent alternate payment methodologies. 3. EOCCO will have consistent technical assistance tools available to PCPCH certified providers. 4. EOCCO will have consistent patient

Required Elements	Milestones/Benchmarks
<p>3. Implementing consistent alternative payment methodologies that align payment with health outcomes.</p>	<p>engagement tools available to PCPCH certified providers.</p> <p>How Benchmark will be measured (Baseline to July 1, 2015):</p> <ol style="list-style-type: none"> 1. EOCCO will track the number of primary care providers, provider payments, and the number of members served by clinics that are piloting alternative payment methodologies. 2. EOCCO will track the number of hospitals and provider payments that are piloting alternative payment methodologies. 3. Implement alternate payment methodologies for providers that become PCPCH certified such as modified FFS payments, PMPM chronic disease management payments, P4P bonus payments and a shared savings program. 4. EOCCO will annually review its PCPCH payment methodologies to determine effectiveness; including growth in the number of certified PCPCHs, growth in enrollment and patient engagement, and improvement in value-based performance measures. <p>Milestone(s) to be achieved as of July 1, 2014:</p> <ol style="list-style-type: none"> 1. Identify and seek approval from EOCCO partners on alternative payment methodologies to be piloted with providers, certified PCPCH clinics, and hospitals. 2. EOCCO will begin piloting alternate payment methodologies via contract amendments, in compliance with OHA reimbursement requirements and OAHHS recommendations for payment of Type A and Type B hospitals. 3. EOCCO will implement a capitation payment system with a least one primary care clinic. 4. EOCCO will implement a capitation payment system with at least one Type A hospital. 5. An actuarial-based process for cost-based payments that is not solely financially based will be implemented. 6. EOCCO, with the help of OHA and OAHHS, will develop a sound

Required Elements	Milestones/Benchmarks
	<p>rationale for continuation of cost-based payment (or equivalent financial support) for hospitals, PBCs, FQHCs, RHCs utilizing variables such as demographics, geography, and financial factors.</p> <ol style="list-style-type: none"> 7. EOCCO, with the help of its hospital partners and OAHHS, will develop a rural hospital, value-based dashboard (with performance metrics) that will be used to award shared EOCCO savings to hospitals. 8. EOCCO, with the help of its hospital partners and community advisory committees, will support a community-based health care delivery model that sustains access to local services and repurposes current infrastructure and staff as needed. <p>Benchmark to be achieved as of July 1, 2015:</p> <ol style="list-style-type: none"> 1. Measure effectiveness of efforts to transform payment delivery. 2. Measure outcomes of providers that have moved to alternative payment methodologies.
<p>4. Preparing a strategy for developing Contractor’s Community Health Assessment and adopting an annual Community Health Improvement Plan consistent with 2012 Oregon Laws, Chapter 8 (Enrolled SB 1580), Section 13.</p>	<p>How Benchmark will be measured (Baseline to July 1, 2015):</p> <ol style="list-style-type: none"> 1. EOCCO will measure the number of counties with regular, continued local county and regional CAC (R-CAC) meetings. 2. EOCCO will measure the number of local county CACs with completed community needs assessment reports and CHIP selection documents. 3. The EOCCO will measure the number of counties with active CHIPS. <p>Milestone(s) to be achieved as of July 1, 2014:</p> <ol style="list-style-type: none"> 1. One hundred percent of EOCCO counties will have or be participating in an established local CAC and R-CAC with persistent, regular meeting times, as determined by the

Required Elements	Milestones/Benchmarks
	<p>committee members.</p> <ol style="list-style-type: none"> 2. One hundred percent of CAC's will have a complete Community Needs Assessment analysis and proposed CHIP. 3. EOCCO CHIP will be submitted to OHA by 6/30/2014. 4. One hundred percent of CACs will have implemented CHIP in their respective county and begin tracking outcomes. <p>Benchmark to be achieved as of July 1, 2015:</p> <ol style="list-style-type: none"> 1. One-hundred percent of local counties will have or be participating in active CACs with persistent, regular meetings and an established structure including, but not limited to, a mission, vision, goals and appointed leadership positions. 2. One hundred percent 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.
<p>5. Developing a plan for encouraging electronic health records; health information exchange; and meaningful use.</p>	<p>How Benchmark will be measured (Baseline to July 1, 2015):</p> <ol style="list-style-type: none"> 1. 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. <p>Milestone(s) to be achieved as of July 1, 2014:</p> <ol style="list-style-type: none"> 1. EOCCO will establish the HIE steering committee by mid-2013.

Required Elements	Milestones/Benchmarks
	<p>2. HIE strategy and plan will be determined in 2013.</p> <p>3. EOCCO will provide to CCO participants access to health information through an online member customized portal.</p> <p>Benchmark to be achieved as of July 1, 2015:</p> <ol style="list-style-type: none"> EOCCO 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, EOCCO 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, EOCCO will update this HIE component of our transformation plan at the next update cycle. EOCCO will begin to implement strategy and plan developed by the steering committee. EOCCO will measure the number of participants that access the online customized portal.
<p>6. Assuring communications, outreach, Member engagement, and services are tailored to cultural, health literacy, and linguistic needs.</p>	<p>How Benchmark will be measured: (Baseline to July 1, 2015):</p> <ol style="list-style-type: none"> EOCCO will measure the percentage of materials revised according to the policy. EOCCO will measure the number of demographics data reports completed and disseminated to healthcare providers. EOCCO will measure the percentage of EOCCO staff that has successfully completed training. EOCCO will measure the completion of interpreter certification plan report. <p>Milestone(s) to be achieved as of July 1, 2014:</p> <ol style="list-style-type: none"> Policy has been developed and adopted, and 10 percent of consumer materials have been revised accordingly. Seventy percent of county and/or regional demographics reports have been completed. Training has been developed and EOCCO leadership has

Required Elements	Milestones/Benchmarks
	<p>successful completed training – 10 percent of staff.</p> <p>4. Interpreter certification options have been assessed and compiled into report; decision has been made to determine next steps.</p> <p>Benchmark to be achieved as of July 1, 2015:</p> <ol style="list-style-type: none"> 1. Sixty percent of consumer materials have been revised according to the policy. 2. All county and/or regional demographics reports have been completed and disseminated to 80 percent of contracted healthcare providers. 3. Ninety-five percent of EOCCO 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. 4. Final benchmark will be developed according to interpreter certification decision based on summary report (See Milestone 4).
<p>7. Assuring that the culturally diverse needs of Members are met (cultural competence training, provider composition reflects Member diversity, non-traditional health care workers composition reflects Member diversity).</p>	<p>How Benchmark will be measured (Baseline to July 1, 2015):</p> <ol style="list-style-type: none"> 1. EOCCO will measure the number of clinics surveyed and the number of clinic profiles developed. 2. EOCCO will measure the percentage of contracted providers and clinic staff that have completed training. <p>Milestone(s) to be achieved as of July 1, 2014:</p> <ol style="list-style-type: none"> 1. One-hundred percent of surveys will be completed. 2. Training will be developed and piloted in three clinics. <p>Benchmarks to be achieved as of July 1, 2015:</p> <ol style="list-style-type: none"> 1. One hundred percent of clinic profiles will be developed and utilized in coordination of care for Spanish-speaking members. 2. Seventy-five percent of EOCCO contracted providers and clinic staff have completed training and processes have been developed for continuing education.

Required Elements	Milestones/Benchmarks
<p>8. Developing a quality improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes</p>	<p>How Benchmark will be measured (Baseline to July 1, 2015):</p> <ol style="list-style-type: none"> 1. EOCCO will assess the completion of data collection methods and the percentage of race, ethnicity and language data collected on the population. 2. EOCCO will assess the development and implementation of standard data collection and sharing methods defined by the Oregon Health Authority. 3. EOCCO will measure the percentage and satisfaction of providers and clinic staff who have completed the cultural competence training. 4. EOCCO will assess the effectiveness of the process to collect data via the health assessment. <ol style="list-style-type: none"> a. Completeness b. Utility in providing culturally competent service and care c. Surveys and claims analysis of comparison groups to measure engagement in self-care, access to care, use of services and cost of care. <p>Milestone(s) to be achieved as of July 1, 2014:</p> <ol style="list-style-type: none"> 1. EOCCO will have developed data collection methods and used existing methods to confirm demographic data has been collected on 30 percent of membership. 2. Standards for data collection and sharing will be established and operational for the Oregon Medicaid population. 3. Training and development will be completed in three clinics. 4. <ol style="list-style-type: none"> a. Data collection process using the health assessment is established, staff is trained and data is systematically captured in the EOCCO operating system (confirmed by audit process) b. Audit process demonstrates that race, ethnic, linguistic, disability, health literacy barriers identified in the health assessment are addressed. c. Specific quality indicators to measure patient engagement, access to care, use of services and cost of care are defined,

Required Elements	Milestones/Benchmarks
	<p>baselines are identified and benchmarks for 7/1/15 are established.</p> <p>Benchmarks to be achieved as of July 1, 2015:</p> <ol style="list-style-type: none"> 1. EOCCO will have reliable and accurate demographic data on 70 percent of the population. 2. Standards regarding data collection and sharing for the Oregon Medicaid population is sustained. 3. Seventy-five percent of EOCCO contracted providers and clinic staffs has completed training, and processes have been developed for continuing education. 4. Audits demonstrate data collection via the health assessment is sustained <ol style="list-style-type: none"> a. Audits demonstrate data collection via the health assessment is sustained b. Audit process demonstrates that EOCCO is meeting benchmarks to address race, ethnic, linguistic, health literacy, disability barriers identified in the health assessment. c. Defined quality indicators on patient engagement, access to care, use of services and cost of care meet benchmarks.