Transformation Plan Initial Progress Report Template
Eastern Oregon Coordinated Care Organization

Transformation Area 1: Integration of Care

Benchmark 1.1	
How Benchmark will be measured (Baseline to July 1, 2015)	• 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	• 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	• 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)	• 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	• 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	• Achieve fidelity for programs as established by State standards.
Benchmark 1.3	
How Benchmark will be measured (Baseline to July 1, 2015)	• 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	• Contract with medical clinics in at least three counties as voluntary early adopters.
Benchmark to be achieved as of July 1, 2015	• Contracts with medical clinics in at least three additional counties.
Benchmark 1.4	
How Benchmark will be measured (Baseline to July 1, 2015)	• 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	• 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	• 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 and/or benchmarks 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.	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. 1.1: Weekly communications between EOCCO behavioral health and medical staff keep everyone up to date on the status of identified complex-care members. 1.1: The Health Coaching Program and care coordinators refer all members with complex needs, as identified on the HRA or other means, to EOCCO ICM's for evaluation.	Monthly meetings are scheduled and are ongoing to refine strategies, intervention and communications. Of the nine cases identified and addressed related to medical and mental health complexities, none have been placed into a higher level of care. 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.	Improve upon: A. Tracking of interventions and resolutions of complex care cases B. Development of triggering criteria for referral to intensive case management
2.	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.	GOBHI created financial incentives for maintaining and developing fidelity ACT and SE programs for all EOCCO CMHPs, effective Jan. 1, 2013. Of the eight CMHPs, two have submitted proposals for achieving ACT	Continue to provide technical assistance, monitoring and oversight in CMHPs' progression toward EBP fidelity standards for ACT and SE, focusing on: A. Workforce development and recruitment B. Implementation of financial

		fidelity to AMH, five are within seven to 20 points of achieving ACT fidelity, and one has achieved ACT fidelity. **Of the eight CMHPs, six have proposals to achieve SE fidelity, and two have achieved SE fidelity. One CMHP has a structured EASA program but not to fidelity. The other seven use components of EASA.**	**incentive strategies to maintain FTE to meet intensive EBP requirements** **C. Outcomes monitoring and reporting** **The Addictions and Mental Health Division EASA program has been awarded grant funds to establish a Hub approach to achieve fidelity standards across all of eastern Oregon. This should begin development within the next 90 days.**
3.	**1.3: EOCCO has established contractual relationships between the behavioral health providers and medical clinics.**	**Agreements have been established in eight of the 12 EOCCO counties.**	**Establish a contractual relationship between the identified behavioral health providers and medical clinics in the remaining four EOCCO counties**
4.	**1.4: To date, case-rate-based contracts with social and medical detox providers have not been established, although discussions have taken place.** **1.4: Contracts between EOCCO and all three existing residential addictions treatment providers have been established.** **1.4: Five counties have adopted integrated outpatient behavioral health programs by entering into single-risk-bearing contracts for mental health and addictions treatment.**	**Two of the three objectives set for July 1, 2014 have been met. The case-rate contracts for medical detox have been held up at this moment because of delays in transfer of funding.**	**Continue to negotiate with medical detox facilities regarding case rates; upon completion, initiate contracts**

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

The referral process to an EOCCO intensive case manager (ICM) program exists, although communication to the entire CCO service area about this program has been difficult. EOCCO will work to develop better communications and guidelines for providers so that they know how to refer members to an ICM or other needed services. Referral communications will include an overview of how the ICM program can help members.

While EOCCO, through GOBHI, emphasized the maintenance of existing ACT and supported employment programs when fee-for-service billing was discontinued and these services were rolled into capitation rates, it is now unclear if these programs can be maintained in our rural counties. The 2013 legislature allocated additional money for these programs. However, the Addictions and Mental Health Division determined that the best way to distribute the funds was through an RFP process with applicants limited to CCOs. In communities with small populations, it is impossible to have enough people to allow for a Medicaid-only ACT or SE team. Without state funds to cover the cost of individuals who are not enrolled in the Oregon Health Plan, it will not be possible to operate existing programs let alone develop more programs.

2 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.

The Governance Board has developed a draft policy outlining the purpose, membership and activities of the Clinical Advisory Panel (CAP) and is currently recruiting potential members for the CAP. This policy establishes a panel that can review, provide direction, collect data and maintain a feedback loop to EOCCO and its providers on the creation of innovative practices that facilitate the management of complex cases.

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

The 12 local community advisory councils (LCACs) have been focused on completing their community needs assessments and developing their Community Health Improvement Plans (CHIPs). Each LCAC was provided with a copy of the transformation plan and used this document to develop their assessments. As the LCACs begin their research to develop their CHIPs, actions will be aligned with the EOCCO transformation plan.

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

This EOCCO transformation plan progress report will be provided to the regional CAC 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)	• 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	• 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	• 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 Alternative Payment Methodologies. • Contractor will have consistent technical assistance tools available to PCPCH certified Providers. • Contractor will have consistent Member engagement tools available to PCPCH certified Providers.

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

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	Effective Oct. 1, 2013, EOCCO began providing 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 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 has provided training and assistance to PCPs working toward PCPCH certification and to support practices to enhance their tier level of certification.	Since the trainings were held, a number of additional clinics have become certified as PCPCHs.	
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 a large practice becoming tier 3-certified.	
4.	In addition to the enhanced PCPCH case management payments, EOCCO has contracted with one PCPCH using a capitated payment methodology. EOCCO will implement a second alternative payment methodology agreement in early 2014 and eventually will implement risk contracts for all PCPCHs. The risk contracts provide the opportunity for physicians to share in the savings produced as a result of reduced utilization.	1. EOCCO has implemented one capitated agreement to date with a PCPCH. 2. A new alternative payment methodology agreement will be in place by	

		February 2014 with a second PCPCH. **3. EOCCO plans to implement risk contracts with other providers in 2014.**	
5.	**EOCCO will submit report cards to primary care offices 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.**	**Providers are beginning to use the report cards as a tool to improve EOCCO incentive measures.**	**EOCCO needs to work one-on-one with provider offices to make sure they are reading, understanding and using the report cards.**

2 b.) Please describe any barriers to achieving your milestones and/or benchmarks 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. In addition, Rural Health Clinics (RHCs) and Federally Qualified Health Clinics (FQHCs) resist efforts emphasizing the importance of becoming a PCPCH as well as EOCCO's 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 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.

2 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. Dr. Evan Saulino, M.D., Ph.D., PCPCH clinical advisor, and Dawn Creach, policy analyst for the PCPCH Program, provided training. 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 also provides one-on-one training to provider offices that need additional assistance in becoming a PCPCH.

For providers in our region who have traditionally been paid on a fee-for-service basis, we have been providing information and training about proposed payment alternatives and how they can be implemented into their practice without negatively impacting their RHC or FQHC reimbursement rates. We also explain how alternative payment methods can have a positive impact. We will continue to provide one-on-one training to our providers.

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

2 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 within PCPCH clinics.

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

We have started 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)	• 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	• 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.

	• 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	• 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 and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	**EOCCO has worked one-on-one with primary care practices to implement alternative methodology agreements. In 2014, we will implement risk contracts with all primary care providers with an alternative payment methodology option.**	**1. EOCCO has implemented alternative payment methodology contracts with two primary care practices.** **2. EOCCO will have an additional clinic under an alternative methodology contract by February 2014.**	
2.	**EOCCO is working with contracted hospitals to implement risk contracts in 2014. The purpose of the**	**1. EOCCO is educating**	

	risk contracts is to reward providers for the potential savings achieved as a result of transformation. This is especially important to hospitals that experience reductions in revenue as a result of decreased ER and inpatient utilization.	**providers on the risk model and is providing data to each hospital showing the potential risks and rewards for participating in the risk model.**	
3.	**EOCCO is a participant in the Rural Health Reform Initiative Workgroup (RHRI). The work group is 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 alternative payment methodology. The outcome of this work is critical in determining how EOCCO will approach alternate payment methodologies with our contracted hospitals beyond the proposed risk model.**	**1. To date, the workgroup has had three work sessions with the goal of having a recommendation to OHA no later than March 31, 2014.**	
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 providers is a good initial step.**		
5.	**The EOCCO Board has had early discussions regarding how a P4P or shared savings program could be developed around the Clinical Quality Metrics. EOCCO anticipates implementing such a program in 2014.**	**1. The board has discussed the foundation of a P4P or shared savings program, and EOCCO is in the process of developing 2014 risk contracts that include such a program.**	

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

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 (which are guaranteed cost-based reimbursement), RHCs and FQHCs. Because of their vulnerable financial status, EOCCO's providers are understandably reluctant to participate in risk contracts. Despite these barriers, the EOCCO Board has made progress in designing risk contract models that are acceptable to EOCCO providers.

2 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 are participating in OHA's RHRI workgroup to determine which hospitals can successfully transition from cost-based reimbursement to alternative payment methodologies.

As mentioned previously, we are working with primary care providers and hospitals to implement risk contracts as one way to move toward alternatives to FFS payments. The risk model rewards providers for the potential savings achieved as a result of transformation.

2 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.

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

As we move toward implementing these agreements, EOCCO will need to inform our CACs about these efforts.

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

Benchmark 4	
How Benchmark will be measured (Baseline to July 1, 2015)	• 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	• 100 % of Contractor's counties will have or be participating in an established local CAC and R-CAC with persistent, regular meeting times, as determined by the committee members. • 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	• 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 and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	EOCCO formed a CAC in each of the 12 EOCCO counties.	CACs are holding regular monthly meetings.	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.
2.	EOCCO Regional CAC has met once and is scheduled for a second meeting on Jan. 31, 2014.	The initial organizational meeting included review of a work plan and initial training to support the work plan.	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.
3.	Twelve CACs have 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 CAC participated in a forced choice matrix process (with private voting by individual LCAC members) to establish priorities.	We engaged with the communities and collected needs-assessment data. We helped establish priorities for each county's community health improvement plan.	
4.	Each CAC is currently establishing problem statements based on its priorities and beginning research for evidence-based best practices.	We completed the initial orientation within each of the 12 CACs for process guidelines, problem-statement development and research on evidence-based practices.	

2 b.) Please describe any barriers to achieving your milestones and/or benchmarks 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.

2 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.

2 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.

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

The progress report document will be provided to the LCACs and RCAC beginning in February 2014. EOCCO will highlight and discuss EOCCO's progress toward meeting the milestones and benchmarks.

Transformation Area 5: EHR, HIE and meaningful use

Benchmark 5	
How Benchmark will be measured (Baseline to July 1, 2015)	• 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	• 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	• 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 and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	**EOCCO staff members and innovator agent have completed an EHR assessment and have continued to monitor EHR implementation. In addition, EOCCO has developed an electronic EHR provider survey that was sent to all primary care clinics in the EOCCO region in January 2014.**	**To date, EOCCO has approximately 95 percent of patients enrolled in primary care clinics using an EHR.**	
2.	**EOCCO's clinical coordinator will serve on the state HIT Task Force and the state HIT Advisory Group and will be responsible for drafting EOCCO's HIE strategy and**	**Dr. Hofmann serves with both groups and has kept the board updated on the groups' activities.**	

	plan.		
3.	**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, among other duties, work with all 10 EOCCO hospitals to help facilitate participation in EDIE, implement key practices that will encourage DSM adoption and use, and promote further EHR adoption.**	**As EOCCO begins implementing its regional solution, the board will review each of the six key elements of Phase 1.5 during its next two meetings and then will begin reviewing the components of Phase 2.0. EOCCO and its innovator agent will work with OHA to secure a "EOCCO HIT Coordinator."**	
4.	**During 2013, EOCCO developed a regional HIT/HIE solution to serve as the strategy and plan for HIT/HIE implementation. The plan addresses the six key elements of the statewide Phase 1.5 implementation strategy.**	**The regional HIT/HIE solution was approved by the EOCCO Board at its December 2013 meeting.**	

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

Many of the primary care clinics in the EOCCO region are small clinics with very limited resources, making EHR adoption difficult. In addition, the vast geographical nature of EOCCO results in large HIT gaps or "white space."

2 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.

Despite these barriers, EOCCO providers have been very successful in implementing HIT. EOCCO and its innovator agent have worked very closely with the OHA office of Health Information Technology to develop EOCCO's regional HIT/HIE solution.

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

Local CACs were not involved in the development of EOCCO's regional HIT/HIE solution. EOCCO intends for its HIT coordinator to engage with LCACs particularly in the process of implementing DSM throughout our region.

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

There has not been a need to keep the LCACs informed of EOCCO HIT/HIE activities up to this point. As EOCCO moves forward implementing the 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)	• 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	• 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	• 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 and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	**EOCCO conducted inventory of all member communication materials and assessed the number of materials revised. A policy was developed and vetted with LCAC and organizational leadership.**	**Inventory has been completed; tracking of revised materials is ongoing.**	**A revision process was developed and put in place; a tracking process was developed and put in place.**
2.	**EOCCO worked with various internal departments to develop an organization wide cultural sensitivity and plain language policy for all member communications. The policy was vetted with LCACs.**	**A communications policy was developed and implemented.**	**The new policy ensures effective, clear communications for all members.**
3.	**EOCCO is awaiting the results of the county community-needs assessments, which will be used in the development of the demographic reports. In the interim, EOCCO is collecting contact information for providers and continues working to strengthen provider relationships, engagement and communications.**	**Email contact information was collected for many providers, and efforts to establish and improve provider relationships are ongoing.**	**We are experiencing improved communication via email.**
4.	**EOCCO has hired a consultant specializing in cultural competency training and workshop development. The next steps will be for EOCCO to work with the consultant to develop training materials and structure, along with a strategy to establish in-house cultural competence training and staff engagement.**	**A consultant was identified for training and development of an in-house training program, scheduled for spring 2014.**	
5.	**EOCCO has assessed various interpreter certification options and compiled it into a report. These options**	**Interpreter certification is in progress.**	**The certification will help improve communications.**

	are being explored for relevance and practical application to rural eastern Oregon. The interpreter certification information and materials are currently being disseminated to EOCCO partners and community members, including scholarship information.		
6.	**EOCCO is assisting clinics with the logistics surrounding the interpreter certification process, such as travel and relevance within the community.**	**Interpreter certification is in progress.**	

2 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.
It has been challenging to engage with LCACs for review and input on our Cultural Sensitivity and Health Literacy Policy for member communications. We need to develop an efficient process for materials review in general.

2 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.
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 marketing and 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.

We also worked with OHA, the EOCCO innovator agent, and 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 simply bounce around ideas.

2 d.) How was the Community Advisory Council involved in the activities for this transformation area?
EOCCO LCACs reviewed of the Cultural Sensitivity and Health Literacy Policy, which governs all written, verbal and Web content.

The EOCCO LCACs are informed of activities surrounding this transformation area.

2 e.) How was the CAC informed of the outcomes for activities in this transformation area?
LCAC members reviewed the initial draft and the final draft after changes (very few) 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)	• 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	• 100% of surveys will be completed. • Training will be developed and piloted in three clinics.
Benchmark to be achieved as of July 1, 2015	• One hundred percent of clinic profiles will be developed and utilized in coordination of care for Spanish-speaking Members. • 75% of Participating Providers and clinic staff have completed training and processes have been developed for continuing education.

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

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	**EOCCO developed a provider assessment survey using the National CLAS Standards in Health and Healthcare as a foundation for the survey questions.** **EOCCO is working to survey contracted providers to determine which providers serve the majority of Spanish-speaking and culturally diverse populations. EOCCO will use the assessment results to identify and confirm important elements to be incorporated into future provider and clinic staff training.**	**The provider survey was disseminated in summit workshops across eastern Oregon. Fifty-three providers from 23 clinics received the survey.** **The provider assessment survey and clinic profiles are in progress.**	**Improved communications**

2.	**EOCCO provided a basic cultural competency training at summit workshops across eastern Oregon, engaging providers from a variety of clinics in various counties.**	**Fifty-three providers from 23 clinics attended the training. Feedback was collected for review and integration into future trainings.**	
3.	**Future cultural competency training options are being assessed.**	**This assessment is in progress.**	
4.	**EOCCO continues to communicate with providers to further increase provider survey response and collaboration among all providers.**	**We engage in ongoing development activities.**	
5.	**EOCCO is developing a tool to measure the percentage of participating providers and clinic staff members who have completed the training.**	**We are developing the tool currently.**	

2 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.
The biggest barrier EOCCO encountered was simply provider engagement. It is difficult to secure collaboration and engagement with providers across 12 counties with vastly varying needs and populations.

2 c.)Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.
EOCCO's most successful strategy was to include the cultural competency training within a workshop for other provider trainings to ensure better engagement and participation from providers. The EOCCO innovator agent was not on board at the time of the workshop but has been involved in provider engagement moving forward.

2 d.) How was the Community Advisory Council involved in the activities for this transformation area?
EOCCO LCACs were notified of workshops and permitted to attend, if interested. 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.

2 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)	• 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. o Completeness o Utility in providing culturally competent service and care o 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	• 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. o 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) o Audit process demonstrates that race, ethnic, linguistic, disability, health literacy barriers identified in the health assessment are addressed. o 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	• Contractor will have reliable and accurate demographic data on 70% of the population. • Standards regarding data collection and sharing for the Oregon Medicaid population are sustained. • 75% of Participating Providers and clinic staffs have completed training, and processes have been developed for continuing education. o Audits demonstrate data collection via the health assessment is sustained. o Audits process demonstrates that Contractor is meeting benchmarks to address race, ethnic, linguistic, health literacy, disability barriers identified in the health assessment. o Defined quality indicators on Member engagement, access to care, use of services and cost of care meet benchmarks.

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

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	**An EOCCO workgroup (medical management, behavioral health, dental, quality, Medicaid Services) redesigned our initial health assessment to improve the data collection on race, ethnicity and language on our member population. EOCCO sends the initial health assessment 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.** **Changes included: check boxes (including write ins) for**	**EOCCO implemented the improved health assessment in November 2013. Return rate to date is 2%.**	**1. Study how to improve health assessment return rate to ensure we reach data collection benchmarks.** **2. Develop a process to electronically store health assessment data in a database.** **3. Develop an online fillable health assessment.**

	race, ethnicity and preferred language; bigger font size; use of plain language; improved tobacco use assessment; new questions related to mental health status; and new statements to assess the member's knowledge, skill, and confidence for self-management. **The health assessment included a Spanish version as 17% of our EOCCO households report Spanish as their preferred language.** **EOCCO implemented the new health assessment on approval of the documents by DMAP.**		
2.	**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. Confirmed enhancements included reading language and ethnicity. The state already collects spoken language and race. In anticipation of the state's target production implementation to add these enhancements to the 834 eligibility file in March 2014, we are working with our Information Services department to prepare for storage of the new data. 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.**	**The new data fields include: reading language and ethnicity and will be implemented in the 834 eligibility March 2014.**	**1. Continue to support data collection at the most granular level feasible.** **2. Determine the method to assess the quality of the state data and provide feedback to the OHA.** **3. Increase awareness of the data among staff working with EOCCO members and providers.**

3.	**In Fall 2013, EOCCO included cultural competency training in two provider summits. We also began to survey our provider community about their awareness and practice of the National Culturally and Linguistically Appropriate Services Standards (CLAS) in Health and Healthcare. The survey identifies EOCCO providers who serve culturally diverse populations and will help us to assess how well we are meeting national cultural guidelines and what actions we can take to ensure cultural and linguistic competence within our provider community.**	**To date we have distributed the survey to the 23 unique clinics which attended the provider summits. This represents 18% of our primary care, specialty care and mental health providers.**	**1. Complete the survey with our providers with an alternative survey method, i.e., Survey Monkey, and follow-up with telephone outreach to ensure high response rate.** **2. Complete assessment.**

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

The state is limited to what/how they can collect information on race, ethnicity and language due to the application process. Notably, the application at a local DHS office differs from the Cover Oregon application and there are no plans to expand the ethnicity and race in the application process. This leaves each CCO to develop ways and use their own resources to collect information that will help it to identify race, ethnic and language disparities. While we implemented a greatly improved health assessment, our historic response rate has been very poor. Also, our storage method does not lend itself easily to population based assessment of the data we have collected.

2 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.

We will continue to participate on the OHA Member Engagement Outreach Community workgroup to support a more systematic and uniform way of collecting granular race, ethnicity and language data using the Medicaid program application process. We are evaluating our options 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 with the hopes that this will increase response.

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

Our Community Advisory Councils were notified about the cultural competence training at our provider summits. We will share our 2013 annual quality report with our community advisory councils, and it will include information about our other efforts to eliminate racial, ethnic and linguistic disparities within our EOCCO service area.

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

We will share our 2013 annual quality report with our community advisory councils and it will include information about our efforts to eliminate racial, ethnic and linguistic disparities within our EOCCO service area.