

**CCO 2015 – 2017 Transformation Plan Contract Amendment Benchmarks**

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

Benchmark 1	
How Benchmark will be measured (Baseline to July 31, 2017)	<ul style="list-style-type: none"> <li>• EOCCO will continue to communicate and collaborate with key stakeholders; Moda, GOBHI, APD, hospital representatives and clinic representatives at county collaborative meetings to achieve optimal member outcomes, e.g. coordinating care between medical, behavioral health and dental through intensive case management, dental case management, behavioral health providers, members, and the county collaborative representatives.</li> <li>• EOCCO will continue to work with the APD Innovator Agent(s) to initiate collaboration programs in other EOCCO counties to expand the opportunities for communication and to support continuity of care for the members.</li> <li>• EOCCO and key stakeholders will continue to explore methods for tracking referrals to APD transition coordinators to ensure appropriate transitions of care for members and to identify potential long term care needs.</li> <li>• EOCCO will continue to identify members with complex needs and refer to ICM to provide assistance with navigation, care transitions, and identification of resources for members with complex medical, dental, and/or behavioral health needs; transportation, medical equipment and supplies, and evaluate requests for flexible services. ICM will provide assistance to the providers and will coordinate communication between and among the providers and with the member.</li> <li>• EOCCO will use existing fidelity based self-assessments and technical assistance from CCO/OSEACT, et.al, to score program and measurement systems with OHA to report on Early Assessment and Support Alliance, Assertive Community Treatment, Supported Employment, Systems of Care/Wrap around, Rental Assistance, and other Evidence Based Practices currently being used by EOCCO. Maximizing the principles contained within the fidelity requirements will ensure appropriate connections with substance abuse, occupational, and physical health providers that support a systematic system wide approach in a culturally appropriate manner.</li> <li>• EOCCO will count the number of counties with contracts between medical clinics and community mental health program clinics for provision of specific behavioral</li> </ul>

	<p>health services and shared risk management in medical clinics. Focus will be on the shared responsibility for care management between PCPCH and CMHP's concerning high risk members and those needing placement in higher levels of care.</p> <ul style="list-style-type: none"> <li>• Contract with OHA/AMH will exist as an early adopter of mental health residential treatment, that transitions into the permanent OHA contract. During the early adopter phase creating connections with community based services, physical health, dental, landlords, substance abuse providers, and others that lead to permanent arrangements that facilitate appropriate and timely discharges from residential levels of care.</li> <li>• EOCCO will have established UM guidelines and pre-authorization processes for mental health, addictions, and detoxification facility based care that will be based on processes and connections developed during the early adoption of mental health residential, along with on-going efforts within the SUD/Detox residential community.</li> <li>• EOCCO will track and count the number of EOCCO members utilizing each of these facility based care services, including successful transitions to lower levels of care. Tracking utilization, discharge and transition to community based care will allow for continual feedback on the appropriateness of community based connections, specialty care availability, and development needs for members.</li> </ul>
<p>Milestone(s) to be achieved as of July 31, 2016</p>	<ul style="list-style-type: none"> <li>• Expand the county collaboratives to at least four of the 12 counties included in the EOCCO to achieve optimal member outcomes, e.g. coordinating care between medical, behavioral health and dental through intensive case management, dental case management, and behavioral health providers, members, and the county collaborative representatives. .</li> <li>• Develop working MOU for at least four of the 12 counties included in the EOCCO to ensure member confidentiality in communication between the collaborative participants.</li> <li>• Develop secure and effective method for tracking referrals to APD transition coordinators.</li> <li>• Health risk assessment (HRA) review process will be fully implemented with review of HRAs completed within 30 days of receipt including identifying members in need of referral to medical, dental, and/or behavioral health programs as appropriate.</li> <li>• Fidelity and/or evidence based programs within each service delivery area will create a sustainability plan, and submit either or both a self-assessment and/or OSEACT/EASA/Wrap-around evaluation, that will be submitted and approved by EOCCO as appropriate to the</li> </ul>

	<p>members holistic needs for each community.</p> <ul style="list-style-type: none"> <li>• Contracts with medical clinics in at least 75% of counties that show evidence of shared care management and risk sharing responsibilities for EOCCO enrolled members.</li> <li>• 25% of the contracts between CMHP and PCPCH will include a risk management process for EOCCO members.</li> <li>• EOCCO will have incorporated mental health residential treatment into its' OHA contract.</li> <li>• EOCCO will have established UM guidelines and pre-authorization processes in place and operational for facility based care.</li> <li>• EOCCO will have an established tracking method for tracking member placement in each category of facility based care (i.e. MH, SUD, and Detox) for the purposes of identifying and benchmarking utilization and evaluating systematic interventions to prevent, retain, and to effectively transition EOCCO members back into their communities.</li> </ul>
<p>Benchmark to be achieved as of July 31, 2017</p>	<ul style="list-style-type: none"> <li>• Expand the county collaboratives to at least six of the 12 counties included in the EOCCO to achieve optimal member outcomes, e.g. coordinating care between medical, behavioral health and dental through intensive case management, dental case management, and behavioral health providers, members, and the county collaborative representatives.</li> <li>• Develop working MOU for at least six of the 12 counties included in the EOCCO to ensure member confidentiality in communication between the collaborative participants.</li> <li>• Monitor and update as necessary the tool developed for tracking referrals to APD to ensure appropriate identification of members with potential long term care needs.</li> <li>• Complete all new HRA reviews within 30 days of receipt including identifying members in need of referral to medical, dental, and/or behavioral health programs as appropriate.</li> <li>• Sustainability for each fidelity and/or evidenced based program will be achieved as evidenced by six consecutive months of self-reports and technical reviews by EOCCO.</li> <li>• Contracts with medical clinics in 100% of counties that address shared care management and risk sharing for EOCCO members.</li> <li>• 50% of the counties will have included within them a risk management process for EOCCO members.</li> <li>• All contracted facility based care providers will have been trained and will be accurately reporting data to EOCCO regarding UM and pre-authorization requests.</li> <li>• EOCCO will have an established process for tracking member transitions from facility based care in all</li> </ul>

	categories specified within the established UM guidelines.
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**(2) Area of Transformation:** Continuing implementation and development of Patient-Centered Primary Care Home (PCPCH).

Benchmark 2	
How Benchmark will be measured (Baseline to July 31, 2017)	<ul style="list-style-type: none"> <li>• EOCCO will continue to measure the number of members assigned to a certified PCPCH at each tier level including 3 STAR participants.</li> <li>• EOCCO will have a consistent methodology to reimburse for community health workers employed by PCPCH's.</li> <li>• EOCCO will have enhanced tools available to assist PCPCH's with population health.</li> <li>• EOCCO will have a consistent methodology to reimburse for behavioral health services provided within PCPCH's.</li> </ul>
Milestone(s) to be achieved as of July 31, 2016	<ul style="list-style-type: none"> <li>• At least 70% of EOCCO members will be assigned to a certified PCPCH at any tier level.</li> <li>• At least 10% of EOCCO members will be assigned to a 3 STAR certified PCPCH.</li> <li>• EOCCO will pay for community health worker services in at least two EOCCO counties.</li> <li>• EOCCO will provide integrated medical and behavioral health utilization data to PCPCH's to assist in managing member health conditions.</li> <li>• EOCCO will pay for behavioral health services provided in at least four PCPCH's.</li> </ul>
Benchmark to be achieved as of July 31, 2017	<ul style="list-style-type: none"> <li>• At least 75% of members will be assigned to a certified PCPCH at any tier level.</li> <li>• At least 20% of EOCCO members will be assigned to a 3 STAR certified PCPCH.</li> <li>• EOCCO will pay for employed community health worker services in at least four EOCCO counties.</li> <li>• EOCCO will provide PCPCHs population health tools via a secure on-line provider portal at consistent intervals that will provide PCPCHs with the information necessary to focus on the most high cost/high risk members within their practice.</li> <li>• EOCCO will pay for behavioral health services provided in at least eight PCPCH's.</li> </ul>

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

Benchmark 3	
How Benchmark will be measured (Baseline to July 31, 2017)	<ul style="list-style-type: none"> <li>• EOCCO will measure the number of primary care practices assuming full risk for primary care services.</li> <li>• EOCCO will measure the number of in-area contracted providers and the percentage of the member population being served by in-area contracted providers participating</li> </ul>

	<p>in alternative payment methodologies including risk contracts.</p> <ul style="list-style-type: none"> <li>• EOCCO will continue modifying risk contracts to ensure the majority of healthcare providers have an opportunity for participation.</li> <li>• EOCCO will develop a consistent methodology for sharing quality incentive funds with providers that is weighted toward those providers with the best performance.</li> </ul>
Milestone(s) to be achieved as of July 31, 2016	<ul style="list-style-type: none"> <li>• At least one primary care practice is taking full risk for primary care services.</li> <li>• At least 75% of in-area utilization spend is to providers participating in alternative payment methodologies and risk contracts.</li> <li>• EOCCO will evaluate additional provider categories that could be included in risk contracts.</li> <li>• The EOCCO board will approve a methodology for sharing quality incentive funds with providers that is weighted toward those providers with the best performance.</li> </ul>
Benchmark to be achieved as of July 31, 2017	<ul style="list-style-type: none"> <li>• At least three primary care practices are taking full risk for primary care services.</li> <li>• At least 85% of in-area utilization spend is to providers participating in alternative payment methodologies and risk contracts.</li> <li>• EOCCO will modify risk contracts to include additional providers and provider categories within the healthcare system.</li> <li>• EOCCO will share a portion of quality incentive funds with hospitals, primary care providers, specialists, GOBHI, DCO's and the local community advisory councils using a methodology that rewards providers based on their performance including their ability to meet the CCO incentive measures.</li> </ul>

**(4) Area of Transformation:** Preparing a strategy for developing Contractor's Community Health Assessment and adopting an annual Community Health Improvement Plan consistent with ORS 414.627.

Benchmark 4	
How Benchmark will be measured (Baseline to July 31, 2017)	<ul style="list-style-type: none"> <li>• EOCCO will maintain the number of Local Community Advisory Councils (LCACs) and Regional CAC (RCAC) meetings already established.</li> <li>• EOCCO will measure the number of OHP members participating in LCAC activities.</li> <li>• EOCCO will measure the number of LCACs that produce an annual report describing implementation of the local CHIP.</li> <li>• EOCCO will measure the number of LCACs with a completed update of their Community Health Assessment.</li> </ul>

	<ul style="list-style-type: none"> <li>• EOCCO will measure the number of LCACs with an updated Community Health Improvement Plan.</li> <li>• EOCCO will produce a Regional Community Health Improvement Plan.</li> </ul>
Milestone(s) to be achieved as of July 31, 2016	<ul style="list-style-type: none"> <li>• 100% of EOCCO's counties will have maintained progress in conducting LCAC and RCAC meetings consistent with ORS 414.627.</li> <li>• 100% of LCACs will have increased the proportion of OHP members serving on the committees and will continue to strive toward meeting the goal of OHP consumers representing the majority of the committees. In June of each year the LCAC meeting invitation list will be compared to the official list of LCAC members provided by the county commission/court that appoints them. The percentage of membership who are OHP plan members will be determined and compared to the prior year.</li> <li>• 100% of LCACs and the RCAC will have produced an annual report describing progress for 2015.</li> <li>• 100% of LCACs will have begun an updated Community Health Assessment.</li> <li>• 100% of LCACs will have begun to compile a Community Health Improvement Plan.</li> <li>• The RCAC Community Health Improvement Plan will have been reviewed and updated on a semi annual basis.</li> </ul>
Benchmark to be achieved as of July 31, 2017	<ul style="list-style-type: none"> <li>• 100% of LCACs and the RCAC will be meeting consistently in compliance with ORS 414.627.</li> <li>• 100% of LCACs and the RCAC will have updated their Community Health Assessment and produced an updated Community Health Improvement Plan.</li> <li>• 100% of LCACs and RCAC will have produced annual progress reports on their Community Health Improvement Plans.</li> </ul>

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

Benchmark 5	
How Benchmark will be measured (Baseline to July 31, 2017)	<ul style="list-style-type: none"> <li>• EOCCO will measure the number of members assigned to primary care practices which incorporate Electronic Health Records (EHRs).</li> <li>• EOCCO will measure the number of primary care practices and EHRs reporting accurate clinical quality measure data.</li> <li>• EOCCO will measure the number of primary care practices accessing quality, utilization and member roster data via a secure on-line provider portal.</li> <li>• EOCCO will measure the number of members accessing</li> </ul>

	real time health information using an on-line member portal.
Milestone(s) to be achieved as of July 31, 2016	<ul style="list-style-type: none"> <li>• EOCCO’s vendor will have installed data connectors, extracted clinical quality measure data and performed quality/completeness analysis of incoming clinical data with 15 key hospital/clinic systems.</li> <li>• EOCCO will be able to store clinical quality measure data within it’s data store for 15 key hospital/clinic systems.</li> <li>• EOCCO will provide primary care practices with quality, utilization and member roster data via a secure on-line provider portal</li> <li>• EOCCO will have launched the on-line member portal.</li> </ul>
Benchmark to be achieved as of July 31, 2017	<ul style="list-style-type: none"> <li>• 15 key hospital/clinic systems will be able to submit accurate clinical quality measure data to EOCCO via a secure connector regardless of the EHR being used at any given clinic.</li> <li>• EOCCO will be able to access clinical quality measure data from 15 key hospital/clinic systems on demand.</li> <li>• 90% of EOCCO primary care practices will access quality, utilization and member roster data via a secure on-line provider portal on a monthly basis.</li> <li>• 20% of EOCCO members will have signed up for the on-line member portal.</li> </ul>

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

Benchmark 6	
How Benchmark will be measured (Baseline to July 31, 2017)	<ul style="list-style-type: none"> <li>• EOCCO will track vendor outreach with members identified as chronically ill with psychosocial issues. Tailored communication outreach to be addressed include social gaps, consciousness raising, cognitive reframing, agenda mapping, patient education, and provider support.</li> <li>• EOCCO will measure the number of consumer materials assessed and modified using a health literacy assessment tool.</li> <li>• EOCCO will measure the number of LCAC meetings with consumer attendance.</li> <li>• EOCCO will measure the number of interventions with integrated consumer feedback.</li> <li>• EOCCO will continue to measure the number of demographics data reports completed and disseminated to EOCCO health care providers and staff.</li> </ul>
Milestone(s) to be achieved as of July 31, 2016	<ul style="list-style-type: none"> <li>• 50% of population management outreach and communication will be tailored to member’s cultural and linguistic needs.</li> <li>• 100% of EOCCO healthcare service department member</li> </ul>

	<p>material will be assessed and modified with a health literacy assessment tool.</p> <ul style="list-style-type: none"> <li>• EOCCO will utilize the teach back consumer feedback method on at least three interventions.</li> <li>• EOCCO will create a consistent methodology for disseminating demographic data to providers and CACs.</li> </ul>
Benchmark to be achieved as of July 31, 2017	<ul style="list-style-type: none"> <li>• 75% of population management outreach and communication will be tailored to member's cultural and linguistic needs.</li> <li>• EOCCO will utilize the health literacy tool to assess at least 25% of EOCCO enrollment and website consumer material.</li> <li>• At least 50% of LCAC meetings will have a minimum of one consumer in attendance.</li> <li>• EOCCO will utilize the teach back consumer feedback method on at least six interventions.</li> <li>• EOCCO will list demographic data in clinic-level reports disseminated quarterly.</li> </ul>

(7) **Area of Transformation:** Assuring that the culturally diverse needs of Members are met (cultural competence training, provider composition reflects Member diversity, Certified Traditional Health Workers and Traditional Health Workers composition reflects Member diversity).

Benchmark 7	
How Benchmark will be measured (Baseline to July 31, 2017)	<ul style="list-style-type: none"> <li>• EOCCO will measure the number of educational events and informational material on cultural competency and health disparities provided to EOCCO providers and staff.</li> <li>• CHW services funded by EOCCO will be delivered using culturally competent models and tools.</li> <li>• EOCCO will build partnerships with community organizations that advocate, educate, and/or work to improve meeting the needs of culturally diverse members.</li> <li>• EOCCO will implement Trauma Informed Care Learning Community recommendations.</li> </ul>
Milestone(s) to be achieved as of July 31, 2016	<ul style="list-style-type: none"> <li>• EOCCO will provide at least two educational opportunities to EOCCO providers and staff.</li> <li>• CHW staff and EOCCO will develop a process to report methods to meet the needs of culturally diverse members.</li> <li>• EOCCO will actively participate in two community based events that advocate, educate, and/or work to improve meeting the needs of culturally diverse members.</li> <li>• EOCCO will identify one clinic with capacity, and willingness to adopt a Trauma Informed Care policy.</li> </ul>
Benchmark to be achieved as of July 31, 2017	<ul style="list-style-type: none"> <li>• EOCCO will implement annual cultural competency educational opportunities.</li> <li>• CHW staff will establish a methodology for reporting</li> </ul>

	<p>service delivery methods to EOCCO.</p> <ul style="list-style-type: none"> <li>• EOCCO will actively participate in four community-based events that advocate, educate, and/or work to improve meeting the needs of culturally diverse members.</li> <li>• EOCCO will implement one Trauma Informed Care clinic level pilot based on recommendations of the Trauma Informed Care Learning Community committee.</li> </ul>
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**(8) Area of Transformation:** Developing a quality improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes.

<b>Benchmark 8</b>	
How Benchmark will be measured (Baseline to July 31, 2017)	<ul style="list-style-type: none"> <li>• EOCCO will track utilization pre- and post- Intensive Case Management intervention for members with special health care needs and high utilization history.</li> <li>• EOCCO will develop a process to identify health disparities and gaps in care using the annual Oregon Health Authority report on reading language and ethnicity.</li> </ul>
Milestone(s) to be achieved as of July 31, 2016	<ul style="list-style-type: none"> <li>• EOCCO will develop a claims analysis process to identify and track members enrolled in ICM.</li> <li>• EOCCO will complete an analysis of 2015 CAHPS data for access to care and satisfaction with care.</li> </ul>
Benchmark to be achieved as of July 31, 2017	<ul style="list-style-type: none"> <li>• Intensive Case Management will improve services based on analysis of impact as defined by pre-and-post program utilization.</li> <li>• EOCCO will implement an intervention based on the 2015 CAHPS data access to care and satisfaction with care.</li> </ul>