Columbia Pacific CCO Transformation Plan

Submitted to Oregon Health Authority

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By:
Mimi Haley
Regional Executive, Columbia Pacific CCO
Email: haleym@careoregon.org
Desk: 503-416-3679
Cell: 503-319-8218

Columbia Pacific CCO
Background Narrative for Transformation Plan 2013-15

Columbia Pacific Coordinated Care Organization ("Columbia Pacific") is a wholly owned LLC of CareOregon. It was formed as a partnership between CareOregon and Greater Oregon Behavioral Health, Inc (GOBHI), which are delegated to share the financial risk for physical and behavioral health, respectively. Prior to CCO implementation, CareOregon was the state's largest Medicaid managed care organization (MCO); CareOregon also offers two Medicare Advantage plans to Medicare beneficiaries in Clatsop and Columbia Counties, with plans to expand into Tillamook and Douglas Counties in 2014. GOBHI is the largest managed mental health organization (MHO) to operate in rural Oregon, providing a network of mental health providers in 16 counties. While a wholly-owned subsidiary of CareOregon now, the intent is for Columbia Pacific to become an independent 501(c)(3) organization in the future.

Columbia Pacific Operations and Governance
Columbia Pacific includes all zip codes in Clatsop, Columbia and Tillamook Counties, and 5 zip codes in the non-contiguous area of Reedsport. The latter was included in Columbia Pacific's service area at the request of the largest primary care clinic there, which felt affinity with CareOregon rather than Douglas County IPA. Each area of the Columbia Pacific CCO has its own community patterns of care, some of which are out of the geographic boundaries of Columbia Pacific.

Columbia Pacific CCO represents the first time a substantial number of OHP residents in that area will receive both managed physical and mental health services. From September to November, 2012, approximately 7,000 of the Columbia Pacific members were receiving both physical and mental health services under the capitated CCO contract with OHA, with another approximately 7,000 receiving MHO services, but with open card status for physical health. Columbia Pacific currently has approximately 14,000 members; it grew by about 80% with the November 1, 2012 conversion. This presents a challenge, as these open card patients have little to no experience with managed care and are familiar with seeking medical services on a random and uncoordinated basis, often outside the service area. This is most true for patients in the Columbia County area; of the 5,000 FFS patients enrolled on November 1st, 30% have been receiving care in the greater Portland area or in Longview, Washington. The care patterns are also into Lincoln City from southern Tillamook and from south Reedsport into North Bend. All these situations will present a management challenge for care coordination and operating within a single global budget for Columbia Pacific.

Columbia Pacific entered into a management services agreement with CareOregon to provide staffing support for finance, information services, customer service, governance and other CCO operations. CareOregon uniquely funded the restricted reserves required of CCOs by OHA. Both CareOregon and GOBHI put equal amounts into a $500,000 Transformation Fund, formed to seed innovation and investments in clinical practices, infrastructure or other support systems to transform care and improve health outcomes for Columbia Pacific enrollees. The CCO is managed by a Regional Executive employed through CareOregon, with strong leadership support and services from executive staff at GOBHI. In addition, CareOregon operations and medical leaders provide strategic guidance and key operations infrastructure for Columbia Pacific.

The governing Board of Columbia Pacific currently consists of 19 leaders from the following organizations:

- CareOregon
- GOBHI

- Coastal Family Medicine Clinic
- Columbia Community Mental Health
- Columbia Memorial Hospital
- Columbia County Commission on Children and Families
- Community Action Team
- Dunes Family Medicine Clinic
- Lower Umpqua Hospital
- OHSU Family Medicine - Scappoose
- Providence Seaside Hospital and Clinics
- Rinehart Clinic
- Tillamook Adventist Hospital and Clinics
- Tillamook Health and Human Services
- Tillamook Family Counseling Center

The Board also includes County Commissioners from Clatsop and Columbia Counties and an independent physician with a large panel of OHP clients in Astoria. The Community Advisory Councils are just forming, as noted below, as is the CCO's Clinical Advisory Panel; both the CACs and the CAP are currently focused on broadening their membership. Columbia Pacific also has formed a Finance Committee. All have had initial meetings, but have not yet developed their 2013 work plans to help achieve the milestones and benchmarks outlined in the CCO Transformation Plan.

The disparate geography of Columbia Pacific has created unique challenges with governance of the CCO, including difficulty even convening meetings of the Board of Directors, its committees, and the Clinical Advisory Panel. In addition, the diverse communities require Columbia Pacific to organize and staff 4 separate Community Advisory Councils, with 4 community health needs assessments, to ensure local community needs are represented and addressed. Columbia Pacific will be developing a meta-analysis and single community health improvement plan for the CCO as a whole.

Baseline Information on Columbia Pacific Providers and Members

Prior to founding the Columbia Pacific CCO, the area already suffered from access problems for both physical and mental health in selected locations: northern Columbia County and Reedsport being the primary areas with limited access. Chronic underfunding of the community mental health system has created access problems within clinics across the service area; these access issues will be exacerbated by the diversion of limited resources required to comply with the assessment, data collection and reporting requirements of the USDOJ settlement with the state of Oregon. Columbia Pacific will need to focus on improving access to both primary care and mental health services concurrent with transformation innovations in its local communities.

Columbia Pacific has 24 contracted primary care clinic sites, 10 mental health/addictions sites and 4 hospitals within its 4 county service area. All the hospitals are critical access hospitals; all operate with 25 available beds or less, with average annual occupancy rates varying between 17-70%. Most of the physical medicine clinics are licensed FQHCs or RHCs; two are certified as Tier 2 and four are Tier 3 PCPCHs; while only 25% of Columbia Pacific clinics are state certified, these clinics account for 58% of empaneled members. There are both large clinics that still need to seek state certification, as well as small independent practices scattered throughout the Columbia Pacific service area that will have difficulty achieving PCPCH status based on size and available resources. The latter includes school-based health centers that provide much-needed access but cannot even qualify as PCPCHs.

All the physical health providers are paid on a fee-for-service basis, with a cost-based reimbursement structure dictated by statute for the CCO's licensed FQHCs and RHCs. This will create a challenge for development and implementation of alternative payment methodologies and cost-trend improvements required of CCOs by the state. The mental health providers that are part of the GOBHI network have all been paid on a capitated basis 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 exported to physical medicine providers over time. The majority of primary care providers are on some version of Epic's EMR; most use OCHIN Epic as their electronic platform. There is no consistent digital platform for the mental health/addictions providers in Columbia Pacific's network.

Claims data for physical health indicates a demographic distribution of a disproportionate number of OHP adults relative to the OHP population in the state as a whole: 37% of Columbia Pacific's members are adults, with 63% under 18. There is a marked problem of chronic pain and drug dependence in the adult population; six of the top seven prescriptions for adults are for opioids/narcotics. After drug dependence, the top diagnosis for adults is diabetes. For members under 18, the diagnoses and prescriptions are more appropriate for the age cohort: well child visits, asthma, ear infections and ADHD. There is, however, indication that the adolescent population has a problem with drug dependence as well. There also appears to be an opportunity to improve prescribing of antibiotics for children.

The majority ethnic group in the Columbia Pacific service area is Caucasian, with Hispanic a distant second; the percent of the Hispanic population varies from a low of <5% to a high of 17% depending on the city and county. Columbia Pacific's work to improve health equity will focus on member definitions of cultural competence and access rather than more traditional markers of race, ethnicity and language; the culture of poverty and health literacy are likely to emerge as priority focus areas for the CCO.

Transformation Plan Development

Columbia Pacific's Transformation Plan reflects the CCO's planning and visioning efforts over the past four months, and was informed by current state activities, initiatives and innovations in isolated clinical practices across the service area. The Plan was developed through the leadership of Columbia Pacific, CareOregon and GOBHI staff. The Board of Directors as a whole, as well as ad hoc sub-committees and the nascent CAP provided direction on, and prioritization of, the Plan's goals and strategies. The Transformation Plan was drafted with the critical knowledge that it will need to change and evolve in order allow for the CACs' work to conduct community health needs assessments and improvement plans, as well as the work of other committees, workgroups and organizations to catch up and inform the transformational priorities of the CCO. The CACs, due to their emerging formation, have not had a chance to review, inform or otherwise assist in the development of this draft Transformation Plan.

Columbia Pacific's Clinical Advisory Panel reviewed and agreed to the proposed Performance Improvement Projects for Columbia Pacific.

The two PIPs for Columbia Pacific include:

1) Best practices in the treatment of chronic pain syndromes with opioids.
2) Improving timeliness of prenatal care and behavioral health screening, including screening for substance abuse and clinical depression.

The Improvement project is:

> Increasing rates of developmental screening for children under 36 months, with the use of a standardized screening tool in pediatric and primary care clinics.

These topics were selected based on three criteria: a known opportunity for improvement based on baseline claims and clinical data for the CCO members provided by CareOregon; alignment with the state's incentive measures; and opportunity for cost trend improvements through early and upstream interventions to offset acute or ED utilization. The CAP will set overall direction and monitor the impacts for the CCO's PIPs .

Monitoring and Metrics

Columbia Pacific is using CareOregon's historical claims data and health analytics tools and staff to inform decisions and to measure progress. Already the Columbia Pacific Board and staff have begun looking at some of the aggregated data of Columbia Pacific's membership, including demographics, cost trends, risk scores, claims trends, utilization across varying provider types and systems, prescribing patterns and top diagnosis codes.

In addition to providing administrative support and medical management services for Columbia Pacific, CareOregon is providing similar services for four other CCOs (Jackson Care Connect, PrimaryHealth of Josephine County, Yamhill County Care Organization, and Health Share of Oregon). Developing production reports to assist Columbia Pacific has taken CareOregon time to code and separate existing data into the five CCO service areas, develop mechanisms to allocate costs, and reorganize staff and processes to support five separate organizations. While critical to ongoing and future CCO operations, this work has not yet allowed for immediate, on-demand delivery of data and reports.

Until such work is completed, Columbia Pacific cannot identify baseline measures for some of the benchmarks required by OHA in Attachment 1. The first quarter of 2013 will be spent trying to determine baseline performance for the Columbia Pacific CCO, and to confirm realistic stretch targets for each of the Transformation Plan elements with clinical benchmarks. The baseline data will need to be further disaggregated to county-level data for Columbia Pacific in order to allow for development of relevant local interventions to improve performance. The development of baseline data for Columbia Pacific will be hindered by the lack of cost data from the state for the former open card patients who transitioned to Columbia Pacific in November 2012.

CareOregon has committed to bring its resources to bear to build the analytic capability to ensure that each of the CCOs has the data needed to make fully informed decisions and to monitor performance toward achievement of the stated goals. Equally important is using this data to let the community and local stakeholders know how the CCO is performing and where there may be opportunities for collaborative problem solving and collective impact.

CCO Plan and Strategies	Milestones/Benchmarks	Due Dates
Transformation Element 1: 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. January 2013 Baseline: From September to November, 2012, approximately 7,000 of the Columbia Pacific members were receiving both physical and mental health services under the capitated CCO contract with OHA, with another approximately 7,000 receiving MHO services, but with open card status for physical health. Columbia Pacific currently has approximately 14,000 members; it grew by about 80% with the November 1, 2012 conversion. No baseline is yet known for the number of Columbia Pacific members with severe and persistent mental illness.		
Columbia Pacific CCO will use the Clinical Advisory Panel to provide advice and global direction to the integration work described in this Element as well as supporting the community health teams who will provide integrated care management services in the communities. The CAP, or a sub-committee if determined appropriate, will evaluate current active initiatives aimed at facilitating integration of behavioral and physical health and research the applicability of additional models from other communities. This team will be broadly representative, including mental and addictions providers and advocates, representatives of the developmentally disabled, anti-poverty and other social support systems, as well as primary care, pharmacy, non-traditional health care workers, dentists and others. Numerous projects currently underway which may be evaluated for applicability of spread throughout the CCO include: - Formalizing and supporting "hot spotting" processes that are joint efforts between behavioral health and primary care providers throughout the region. - Co-locating behavioral health (addictions and mental health) providers with primary care providers. - Integrating behavioral health care workers (including peer and parent specialists and advocates) into the community care teams (CCT) that will be coordinating care in CCO communities. As part of this, the CCO will explore creating a "shared flex fund" for use by the CCT. See the description of this possible alternative payment model in Element 3. - Creating a Pain Management model that utilizes behavioral health technology and alternative approaches to assist primary care providers in caring for	Develop baseline data on super-users and members with severe and persistent mental illness, including diagnoses, sites of care, utilization/cost profiles, for appropriate intervention. Form CAP and develop work plan to evaluate current and new integration models for evidence of improvement and applicability to local CCO communities. Evaluate and recommend a limited number of high value priority integration models for spread to at least three clinics, and potentially other communities, in the CCO in 2014. Develop an alternative pain management model for patients with complex co-morbid conditions including addictions.	Mar 2013 Mar 2013 Dec 2013 Dec 2013

CCO Plan and Strategies	Milestones/Benchmarks	Due Dates
members with chronic pain conditions. This may include developing a telephonic psychiatric consultation service for prescribing assistance to PCPs. - Formalizing a model for bi-directional development of PCPHM's. This will include providing support and technical assistance to Community Mental Health Providers (CMHPs) to attain Tier 1-2 certification based on clients who identify the CMHP as their primary point of service and care coordination. This work will be pursued as part of Element 2 as well.		
As part of Element 8's PIPs, the CCO will develop and implement outreach, training and tools to assist primary care providers improve: - Best practices in the treatment of chronic pain syndromes with opioids; - Prenatal and maternal care through consistent screening for behavioral health and addictions screening; and - Developmental screening for children under 36 months.	Design, implement and evaluate PIPs as required by OHA. Include partnerships with schools and other community resources to focus on addictions screening for adolescents.	Dec 2013
The CCO will begin integration work through two specific initiatives in 2013: 1) Integrating the mental health and addictions benefits under one capitated contract with each mental health clinic in the CCO. See a description of this in Element 3, as well.	Complete contracts with mental health clinics.	Jul 2013
2) Begin planning and outreach to create a dental network for CCO members.	Complete contracting plan.	Dec 2013
As a first step towards integration, the CCO may convene a learning collaborative of primary care and behavioral health providers to introduce the guiding principles of the Triple Aim, and the clinical implications of managing in care teams and with a primary focus on primary prevention.	Convene at least one learning collaborative and develop process for continued cross-training and learning.	Sep 2013
Additional integration and new care models that could be reviewed to pilot, evaluate and/or adapt to the Columbia Pacific CCO, include: - Replicating an integrated "resilience model" that includes participants from all communities and providers in the Columbia Pacific region, and that is designed to prevent and mitigate the effects of adverse childhood events. The current model, "Resilience Trumps ACEs" will be evaluated as a prototype. - Identifying the service and coordination needs of the developmentally	Identify new models for possible testing in the Columbia Pacific region starting in 2014.	2014

CCO Plan and Strategies	Milestones/Benchmarks	Due Dates
disabled members, with a special focus on those in crisis. - Deploying a dental health professional into a primary care medical home or into the community to pilot the opportunities for dental prophylaxis, health and nutrition education to reduce ED visits and medical complications of oral disease/sepsis. - Placing a navigator in the ED to redirect patients presenting with dental pain to a CCO participating dentist. - Deploying EMT/first responders into local communities as an alternative model to identify 'hot-spots' of opportunity for focused intervention. To the greatest extent possible, Columbia Pacific Board of Directors, CAC(s), CAP and staff will incorporate and integrate the Element 1 work with initiatives and priorities – including use of non-traditional workers – developed through the early childhood education and social/criminal justice reforms adopted by Oregon legislature and relevant state, municipal and local agencies. The CCO will include future focused efforts to engage with the school-based and criminal justice settings to integrate screening and services targeted to members with substance abuse and multi-dimensional mental health needs. All of the work identified in the Element 1 will be informed and potentially modified by the results of the CCO Community Health Needs Assessment meta-analysis, CAC and community gap identification and prioritization process, and Community Health Improvement Plan. This work may also identify opportunities to expand coverage beyond the OHP benefit package, where cost reduction offsets warrant the flexibility.		
Transformation Element 2: Continuing implementation and development of Patient-Centered Primary Care Home (PCPCH). January 2013 Baseline: Columbia Pacific has 24 contracted primary care clinic sites, 10 mental health/addictions sites and 4 hospitals within its 4 county service area. Most of the physical medicine clinics are licensed FQHCs or RHCs; two are certified as Tier 2 and four are Tier 3 PCPCHs. While only 25% of Columbia Pacific clinics are state certified PCPCHs, these clinics account for 58% of empaneled members as follows: 0% in Tier 1, 5% in Tier 2, 53% in Tier 3, with 39% not recognized.		
Currently, 58% of Columbia Pacific members are enrolled in Tier 2 and 3 PCPCHs. In	Goal: increase to 75-80% of CCO	2015

CCO Plan and Strategies	Milestones/Benchmarks	Due Dates
consultation with the Clinical Advisory Panel, the CCO will: 1) Assess the current status of PCPCHs in the CCO service area to increase the percentage of members paneled with T1-3 PCPCHs; 2) Form a learning collaborative of clinics willing to commit staff time and resources to further capacity building of the PCPCH; 3) Develop a roll-out plan to train participating clinics on four major topics for increasing capabilities to achieve Tier 3 status: Leadership, Data Systems, Team Based Care and Clinical Support Systems; 4) Identify, train and deploy on-site practice coaches to assist clinics with the transfer of curriculum into clinical practice. The clinics involved in the CCO Primary Care Collaborative will be encouraged to link to the resources available through the PCPCI. Columbia Pacific will also develop standard and ad hoc reports on utilization and service costs for the CAP to identify and prioritize promising integration, interventions and other improvements. Columbia Pacific's CAP will explore the opportunities to use Transformation Investment Funds, Q Corp PCPCH grant funding and other available capacity building funds for the above work, as well as for data extraction from the clinic EMR, and/or funding of a Quality Improvement coordinator or other relevant clinic staff to help PCPCH's implement standard work to identify, outreach to and manage hi-risk, complex members, or other interventions identified as high priority for improvement and transformation. As noted in Element 1, Columbia Pacific CCO will evaluate formalizing a model for bi-directional development of PCPCH's. This work will include providing support and technical assistance to Community Mental Health Providers (CMHP) to attain Tier 1-2 certification for those clients who identify the CMHP as their primary point of service and the setting of their choice.	members paneled to PCPCH by end of 2015. This would break down to: 65-70% enrolled in Tier 3 clinics, 10-15% enrolled in Tier 2 clinics, with 20% not recognized. Secure Transformation Investment Funds to launch PCPCH collaborative. Select 7-9 clinics willing to commit resources to participate in learning collaborative and PCPCH training and capacity development program. Mental health and school-based health practices will be included as invitees to the learning collaborative. Identify, fund, hire and train 1-3 part-time Practice Coaches. Complete schedule and implement training. Develop reports and discuss and/or deploy by the CAP. Identify funding criteria and sources and approve applicants.	 Jan 2013 Mar 2013 May 2013 Dec 2013 Mar 2013 Jun 2013
Transformation Element 3: Implementing consistent alternative payment methodologies that align payment with health outcomes.		

CCO Plan and Strategies	Milestones/Benchmarks	Due Dates
January 2013 Baseline: Columbia Pacific has 24 contracted primary care clinic sites, 10 mental health/addictions sites and 4 hospitals within its 4 county service area. All the hospitals are critical access hospitals; all operate with 25 available beds or less, with average annual occupancy rates varying between 17-70%; as CAHs, all of the hospitals are paid on a cost-based reimbursement structure. 100% of the physical health providers are paid on a fee-for-service basis, with a cost-based reimbursement structure dictated by statute for the FQHC/RHC clinics. 100% of the mental health providers that are part of the GOBHI network have all been paid on a capitated basis for over a decade.		
Columbia Pacific CCO will charter the Board Finance Committee and the CAP, with expertise from the Innovator Agent, CareOregon and GOBHI staff and other knowledgeable individuals and organizations, to research existing payment methodologies that align payment with health outcomes, to incent integration of mental and behavioral health services including addictions screening and treatment, and, when appropriate, dental health. Payment models to be considered include those already developed and in practice by MHOs and CCOs across Oregon, OPCA, Primary Care Renewal/PCPCH incentive payments, Pay for Performance, payment bundling, risk sharing and withhold pools. As noted in Element 1, the CCO will: - integrate the separate funding streams for mental health and addictions treatment into one consolidated pool that can be sub-capitated to providers in a shared risk contract. This will prepare the system for the integration of residential addictions funding and detox services in 2013. - Implement quality incentive payments for all PCPCHs. The integrated payment model described above will improve outcomes by allowing providers to more effectively manage co-morbid conditions. The current silo'ed and inconsistent funding streams for Columbia Pacific behavioral health providers who provide both mental health and addictions services, the former on a capitated and the latter on a fee-based system, creates inefficiencies and difficulties in providing integrated treatment. In addition, the CCO may develop an alternative payment model(s) based on improvement in key quality metrics as well as possibly for access and utilization improvements for practices that are certified at any Tier in the PCPCH Program.	Finance sub-committee and Clinical Advisory Panel select 1-2 payment methodology models to evaluate for the CCO. Select one primary care clinic to deploy an alternative payment model in 2014. Complete contracts with mental health clinics. Complete contracts for quality incentive payments. Identify appropriate clinics/practices to implement possible additional incentive payment model(s) for	Apr 2013 2014 Jul 2013 Dec 2013 2014

CCO Plan and Strategies	Milestones/Benchmarks	Due Dates
Clinical practices would develop an improvement plan indicating measures for improvement specific to their patients. Funding for incentive payments would come from the CCO global budget, but may also take into consideration multi-payer models and opportunities. Such alternative models could include creating a "shared flex fund" for use by Community Care Teams (CCT) for coordination of care, disposition, placement and support for those members whose needs cut across tradition lines of clinical responsibility. This ties to the integration model described in Element 1 of integrating behavioral health care workers (including peer and parent specialists and advocates), into the CCT. Assess and adjust any payment models as needed to accommodate additional populations to be covered by CCOs, including Medicare, PEBB, OEBB and other populations, as needed.	primary care practices certified under the PCPCH program as well as participating CMHPs. An APM pilot for clinic-level quality improvements developed by CareOregon for Health Share may be adopted by the CCO: this pilot incents primary care clinics to report on a set of metrics from their systems to be able to take action for improvements. Upgrade and enhance payment models for multiple populations and payers.	 2014
Transformation Element 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. January 2013 Baseline: The 4-county geographic composition of Columbia Pacific requires the CCO to organize and staff 4 separate Community Advisory Councils, with 4 community health needs assessments, to ensure local community needs are represented and addressed. Columbia Pacific will be developing a meta-analysis and single community health improvement plan for the CCO as a whole. All 4 CACs have met once and are in the process of finalizing charters and membership for each.		
Columbia Pacific will establish a consistent Community Advisory Council (CAC) meeting schedule with robust governance structure; ensure sufficient representation by OHP members (≥ 51%) with demographics reflective of OHP membership in CCO communities, as well as the diversity of the CCO communities including, race and ethnicity, age, gender identity, sexual orientation, disability, and geographic location. The CAC(s) will develop a meta-analysis of existing clinical and community health data with an emphasis placed on local assessments already conducted in mental and	CAC(s) fully formed and staffed, meeting at a frequency determined by the CAC members and working on identified priority projects and deliverables. Draft meta-analysis of existing community health needs assessments.	Mar 2013 Oct 2013

CCO Plan and Strategies	Milestones/Benchmarks	Due Dates
behavioral health, public health, hospital community benefit reporting, and other assessments from agency or community-based organizations that help address socio-economic issues such as housing, domestic violence, employment and food insecurity. As noted in Element 6, the CAC(s) will work closely with Office of Equity and Inclusion (OEI) experts, OHA Innovator Agent and others to develop and implement plans for gathering additional information and performing analyses on health disparities in the CCO service area. This could include assessment of the health literacy of the local populations, existing Patient Activation Measures or other indicators of barriers to access for sub-populations of the CCO's members. When possible, the community health assessment will follow the MAPP process. The CAC(s) will prioritize community health needs that meet the Triple Aim and create a framework for addressing health equity and the elimination of health disparities. This will include a focus on CCO members whose serious mental health challenges create significant reductions in life expectancy. As part of the above, the CAC(s) will solicit community feedback on prioritized health needs and will generate community ideas for strategies of at least 3 health or related needs with a focus on identification of underlying health inequities. A final CCO-wide Community Health Needs Assessment will be completed that incorporates all findings, stories, priorities and strategies for addressing gaps that result in health disparities and health inequity in the CCO's communities. The CAC(s) and Board of Directors will develop a plan for future CHAs that align or are coordinated with other required community assessments when appropriate, such as the MAPP process for Public Health, and which begin to address social determinants leading to poor community health outcomes. This work will align with the CAP's identified improvement measures and include aggregating existing data to identify patterns of over-, under- and mis-utilization of clinical services. The intent will be to also conduct gap analysis to identify missing data points critical to understanding adequacy of network capacity, health disparities that create barriers for individuals	Schedule joint and public Board and CACs meetings to prioritize gaps and opportunities identified in meta-analysis. Prioritize community health needs with a health equity framework, and identify at least 3 areas for strategy development. Convene focus groups, stakeholder meeting(s) and other data-gathering and community conversations in order to finalize prioritized community health needs. Complete a comprehensive CCO-wide Community health Needs Assessment. Create a plan for collecting primary data in 2014. This will be developed in close partnership with County Public Health, OEI and other stakeholders already conducting required community assessments.	Dec 2013 2014 2014 Dec 2013 2014

CCO Plan and Strategies	Milestones/Benchmarks	Due Dates
accessing care, and community health status/needs. The CCO will work with County Public Health and other stakeholders to develop a plan for collecting primary data in 2014 based on this analysis. The CAC(s) and Columbia Pacific Board of Directors will draft and begin to implement an iterative process to develop, adapt and adopt the final Community Health Improvement Plan by mid-2014.	Complete a working draft of the Community Health Improvement Plan. Finalize the Community Health Improvement Plan.	Feb 2014 May 2014
Transformation Element 5: Developing a plan for encouraging electronic health records; health information exchange; and meaningful use. January 2013 Baseline: No baseline is yet known for the number of Columbia Pacific providers using EMRs. No baseline is yet known for the opportunity to adopt any form of health information exchange. This work will be exacerbated by the large number of Columbia Pacific members receiving care from providers outside the CCO service area. Most of the physical medicine providers known to be using an EMR use OCHIN Epic. There is no baseline of consistent EMR use among the mental health providers.		
Columbia Pacific CCO will assess and inventory the percent of participating providers regarding capabilities to meet Stage 1 meaningful use objectives, to determine existing ability to share medical information electronically, and to assess opportunities for technical assistance to implement and upgrade electronic health records. This work will be tied to the transformation work to enhance and spread PCPCH capabilities identified in Element 2. As part of this inventory, Columbia Pacific will do an inventory of EHR use by CCO clinics, engage the Board in prioritizing the adoption of EHR, and make appropriate investments in resources to increase the number of clinics using electronic records. Columbia Pacific CCO will assess the current status of participating provider capability and/or adoption of Care Everywhere, and - Provide policies for integration of CE into existing EHRs - Provide technical assistance and support for adoption of CE into CCO clinics - Encourage and seek technical support and training from appropriate state agency staff to deploy OHA's CareAccord across the participating provider network and with key specialty providers outside the CCO service area.	Complete inventory and identify next steps for provide technical assistance to specific providers and clinics. Support adoption of policies and practices to integrate CE into CCO EMRs.	Jun 2013 Dec 2013

CCO Plan and Strategies	Milestones/Benchmarks	Due Dates
Columbia Pacific CCO may also explore opportunities to adapt any existing models of community wide event notification for members accessing primary care services through local EDs and urgent care settings.	Charter the CAP to review models and opportunities for information exchanges and event notifications.	Dec 2013
Columbia Pacific CCO will work collaboratively with Innovator Agents, partner organizations and appropriate state agency staff to develop state-led initiatives to allow better coordination and interface of physical and mental health EMRs and care plans. This will include exploring existing models that integrate clinical data with social services, schools and other community-based providers into 'health care neighborhoods.' Columbia Pacific CCO 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, the CCO will designate appropriate executive and staff representatives to be 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, Columbia Pacific will update this HIE component of its transformation plan at the next update cycle. The CCO will also work to improve existing AMH requirements for medical chart documentation, patient management and billing requirements so that barriers to integration across the medical behavioral spectrum are removed to begin use of a single comprehensive and unified care plan for each patient.	Work with OHA and other appropriate agency staff to prioritize necessary supports, strategies and agency deliverables to support transformation efforts required by contract and included in the CCO Transformation Plans.	On-going
Transformation Element 6: Assuring communications, outreach, Member engagement, and services are tailored to cultural, health literacy, and linguistic needs. January 2013 Baseline: The majority ethnic group for the general population in the Columbia Pacific service area is Caucasian, with Hispanic a distant second; the percent of the Hispanic population varies from a low of <5% to a high of 17% depending on the city and county. No baseline is yet known for the race, ethnic or language needs of the Columbia Pacific CCO members, by community. All Columbia Pacific written materials are produced in English and Spanish, with translation to other languages on request. Columbia Pacific CCO will launch a website in late January		

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2013 that allows all web content to be translated via Google Translators. Columbia Pacific CCO providers and members are able to access Passport to Languages for telephonic interpretative services. **Transformation Element 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).** January 2013 Baseline: No baseline is yet known for capabilities of Columbia Pacific CCO providers to offer culturally competent services, including use of non-traditional health workers.		
In collaboration with key leaders and staff from OEI, Columbia Pacific CCO will begin the work to identify and address health disparities that are specific to the four different counties, and communities within those counties, of the Columbia Pacific CCO. This will work will be guided by principles of community collaboration, patient experience, inclusion and openness. As noted in Element 4, the CCO work will include the following: • Developing a standardized method to collect racial, ethnic and language data for the populations served by the CCO; • Working with the CAC, community-based organizations, and other constituent groups, such as those representing the disabled, to identify inequities in access, communications or service delivery that may not otherwise emerge from the data; • Developing a process to regularly ask patients and their families to assess the quality of the translation and interpretation services provided by the CCO, advise on ways to revise the language in the CCO's 'vital documents' for members, and recommend alternative or preferred communications, outreach or other methods or media to engage members in their health; • Collecting narrative stories from members on what cultural competence, health, well-being or other attributes for engagement means to them, and incorporating the learnings from those stories into the CCO's ongoing plan to reduce health disparities. In addition, as noted in Element 1, the CCO will work through the CAC or local	Develop and communicate baseline information on race, ethnicity and language needs of CCO members by community. This will include assessment of existing provider capabilities regarding culturally competent services. Develop a cultural competence policy, including standards, and registry of member documents required to meet those standards. Create a standard process for collecting and utilizing member input into definitions and delivery of culturally competent care and services, as well as obtaining advice on the quality of written materials, outreach and other communications. Non-traditional health workers	Sep 2013 Dec 2013 2013-2014 2013-2014

CCO Plan and Strategies	Milestones/Benchmarks	Due Dates
community-based organizations to help identify and spread the use of various types of non-traditional health workers to impact service utilization and total PMPM cost of care, including peer support counselors, navigators, community care workers or others, into care teams within primary care and community mental health teams. This could include working on recruitment strategies, job descriptions and training programs for non-traditional health workers who can help identify and reduce barriers to care that result in inequity.	deployed in identified clinical practices within the CCO service area as part of identified super-user interventions noted in Element 1.	
The CCO will begin planning for a program, competencies and training curriculum required for CCO providers to create an environment where reductions in health disparities through culturally competent practices and workers is a norm. This will be accomplished through an approach that: • Creates a common definition and understanding of cultural competence; • Requires ongoing training for the achievement of sustainable skills; • Standardizes recruitment practices and team composition that include non-traditional health workers; • Engages patients and families in planning and evaluating the quality of the services, outreach, communications and care they receive. The CCO will also develop training for providers on how PCPCHs should amend clinical practices to help identify and treat children exposed to violence. This work will be guided by a sub-group of the CAC that includes members, providers, CAP representatives, leaders from local community-based organizations, and other interested individuals. The work for Elements 6 and 7 will be informed by the results of the CCO Community Health Needs Assessment, CAC prioritization process and Community Health Improvement Plan as well as by claims and clinical data on diagnosis, utilization and outcomes, and satisfaction, complaint and other indicators of the quality and sufficiency of access and care.	Develop training plan, benchmarks and program. All clinics invited to attend and training delivered to at least 50% of CCO primary care and mental health providers. Convene an ongoing and high-functioning workgroup to guide strategies for health disparities reduction.	Sep 2013 2014 Sep 2013
Transformation Element 8: Developing a quality improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes.		

CCO Plan and Strategies	Milestones/Benchmarks	Due Dates
January 2013 Baseline: The Columbia Pacific Board and Committees have begun looking at some of the aggregate data of Columbia Pacific's membership, including demographics, cost trends, risk scores, claims trends, utilization across varying provider types and systems, prescribing patterns and top diagnosis codes. No baseline is yet known for clinical outcomes, quality, utilization and satisfaction of the Columbia Pacific CCO members by county. The development of baseline data for Columbia Pacific will be hindered by the lack of cost data from the state for the former open card patients who transitioned to Columbia Pacific in November 2012.		
The Columbia Pacific CCO CAP will establish a quality improvement plan that capitalizes on existing data sources to evaluate clinical outcomes and patient experience. The plan will include the CCO's identified Performance Improvement Projects and improvement opportunities, findings from the Community Health Assessment meta-analysis, and will be tailored based on final CHNA and CHIP products. The quality improvement planning will, to the extent possible, include methods to assess and incorporate metrics for health improvements based on social determinants and health disparities, drawing on expertise from community organizations that work to mitigate transience, violence, criminal behavior, food insecurity etc. with a focus on families and youth. The plan will utilize quality standards and metrics developed by OHA. The CAC(s) will provide input on customer satisfaction metrics, strategies for using racial, ethnic and language data to inform progress, and possible data collection methods. As part of Element 8's PIPs, the CCO will develop and implement outreach, training and tools to assist primary care providers improve: - Best practices in the treatment of chronic pain syndromes with opioids; - Prenatal and maternal care through consistent screening for behavioral health and addictions screening; and - Developmental screening for children under 36 months. These PIPs were chosen through a review of 12 month prior claims experience of CCO members; data revealed low rates of screenings in these areas along with a prevalence of drug dependence and chronic pain diagnoses. The PIPs will include creating more specific outcomes reports by geography and clinic and include member demographics and, as available, race, ethnicity or language.	Create baseline measures and dashboard to track improvements in quality outcomes over time. Develop a comprehensive Quality Improvement Plan with input from CAP, CAC, agency and other relevant experts, and approved by the CCO Board of Directors. As part of this plan, identify at least two priority areas for disparities reduction over the next 2 years across the CCO. Design, implement and evaluate PIPs as required by OHA.	May 2013 Sep 2013 Dec 2013

CCO Plan and Strategies	Milestones/Benchmarks	Due Dates
Columbia Pacific may sponsor a clinic/provider learning collaborative regarding requirements and infrastructure for outcomes reporting in the integrated care model of CCOs, as part of the learning collaborative work mentioned in Element 1. This will incorporate findings and recommendations from the CCO CAP to improve CCO metrics and required performance improvement projects, as well as identified best practices for reaching performance targets.	Convene at least 1 clinic/provider learning collaborative on measuring outcomes.	2013-14
Representatives from the CCO CAP, Board of Directors, and other interested providers will engage in ongoing discussions and learning opportunities, such as the Care Oregon Quality Improvement Forum, to build collective understanding of how to evaluate quality in the CCO setting.	Columbia Pacific stakeholders participate in ongoing quality improvement planning and discussions.	Ongoing

Columbia Pacific Coordinated Care Organization
Glossary of Terms

ACA	Affordable Care Act
ACE	Adverse Childhood Event
AMH	Addictions and Mental Health Services Agency
APM	Alternative Payment Methodology
CAC	Community Advisory Council
CAH	Critical Access Hospital
CAHPS	Consumer Assessment of Health Plans
CAP	Clinical Advisory Panel
CCO	Coordinated Care Organization
CCT	Community Care Team
CE	Care Everywhere
CHIP	Community Health Improvement Plan
CHNA	Community Health Needs Assessment
CMHP	Community Mental Health Provider
DCO	Dental Care Organization
ED	Emergency Department
HER	Electronic Health Record (see also EMR)
EMR	Electronic Medical Record (see also EHR)
EMT	Emergency Medical Technician
FQHC	Federally Qualified Health Center
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
IA	Innovator Agent
MAPP	Mobilizing for Action through Planning and Partnership
MCO	Managed Care Organization OEBB: Oregon Educators Benefit Board
MHO	Mental Health Organization
OEI	Office of Equity and Inclusion
OHA	Oregon Health Authority
OHP	Oregon Health Plan
OPCA	Oregon Primary Care Association
PCMH	Primary Care Medical Home (see also PCPCH)
PCPCH	Patient-Centered Primary Care Home (see also PCMH)
PEBB	Public Employees Benefit Board
PH	Public Health
PIP	Performance Improvement Project
QIP	Quality Improvement Plan
RHC	Rural Health Center
SBHC	School-Based Health Center
SBIRT	Screening, Brief Intervention and Referral to Treatment
SPMI	Serious and Persistent Mental Illness
TP	Transformation Plan
NEMT	Non-Emergent Medical Transportation