

# Columbia Pacific CCO Strategic Plan 2019 – 2021

## Mission

Partnering for healthy members and community well-being.

## Vision

Helping those in need reach their highest potential by providing services that support their social, emotional and physical health.

## Values

Transparency  
Honesty  
Accountability  
Respect  
Commitment

## Organization Goals

1. SDoH, Prevention and Health Promotion	2. Equity	3. Health Integration	4. Clinical Excellence	5. Value-Based Payments
<b>Defined:</b> CPCCO invests in interventions to address Social Determinants of Health consistent with member-identified priorities in the CHIP.	<b>Defined:</b> CPCCO reduces health disparities by building culturally-responsive networks and services within and across our communities.	<b>Defined:</b> CPCCO builds and supports a team of health providers working with patients, families and communities to provide holistic services for defined populations.	<b>Defined:</b> CPCCO provides actionable data, emerging evidence, leadership and learning collaboratives to advance clinical excellence across the health system.	<b>Defined:</b> CPCCO ensures financial stewardship of its scarce resources by sharing risk with and aligning provider incentives for prevention and evidence-based clinical outcomes.

## Strategies

Empower and continue to professionalize CACs in their advisory role to the Board, and as liaisons between CPCCO and broader community health initiatives.	Direct CCO staff to investigate specific populations likely to suffer health disparities and inequities including, but not limited to, chronically mentally ill adults and disabled children.	Identify and import best practices for service integration between clinical and community supports (e.g. child welfare).	Monitor and invest in access improvements for specific clinical services. Specific services (e.g. SUD/MAT, dental, specialty, primary care) will be prioritized by county, community, CCO needs.	Review/approve ROI on NEMT re-investment opportunities.
Invest in community prevention, including strategies such as community health workers, nutrition supports or nurse home visiting. Invest in key stakeholders and organizational partners that demonstrate readiness, leverage and capability.	Establish a new Board of Directors Equity Committee to: build out the CPCCO Equity Plan, BOD/staff trainings, and CCO point of contact for equity.	Approve CPCCO pilot or model in 2019 for greater accountability of the Behavioral Health benefit.	Make necessary investments to achieve annual 100% quality payout.	Approve community risk share model for each county for 2020.
Invest in community-identified priorities included in the 2020-24 CHIP.	Require CAP and CACs to integrate culturally responsive workforce initiatives into their respective annual work plans.	Prioritize funding to enhance health navigators and/or integrated regional care teams within the region.	Support CAP and clinics to build and/or retain workforce, including emerging workforce (such as CHWs) to address rising clinical needs.	Approve APMs for non-claims based care models/providers (e.g. peer supports, CHWs).
Request staff to create a plan for investing in community-based innovations to address SDoH.	Require new CAC membership demographic and reporting requirements be included in CAC 2019 workplan.	Propose pilot or model to the state in 2019 to get ahead of new requirements, such as taking on risk for state hospitalization	Invest in expanding Behavioral Health access across the continuum of care within the region.	Further incentivize hospital systems to prioritize ambulatory and primary care.
Board designate priority investment focus areas, in synergy with non-CCO investments in SDoH.	Require BOD Nominating Committee to address OHP representation on CPCCO Board.		Invest in CAP-identified clinical initiatives, evidence-based and population health programs (e.g. palliative care).	Support and allocate resources to explore community-based alternatives to Oregon State Hospital.

## Measures

1. PMPY total investment	1. % increase in interpreted visits	1. Cost of care by RAE	1. Access and engagement/penetration targets	1. NEMT PMPM actual to budget
2. CAC Best Practices implemented	2. Baseline disparities data and improvement targets set for identified priority populations	2. BOD quarterly dashboard, including MBR by RAE	2. % metrics achieved	2. County total cost of care targets
3. Shared community health investment priorities identified		3. #/% members touched by care models	3. BH/SUD penetration rate	