## (1) Developing and implementing a health care delivery model that integrates mental and physical health care and addictions and dental health

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| AllCare | % of members who have a diagnosis of SPMI and diabetes, and have had an HbA1c and LDL-C tests. | 10% improvement over baseline | 15% improvement over baseline. |
| AllCare | Number of encounters by physical health providers done in outpatient MH setting. | 10% improvement over baseline | 15% improvement over baseline. |
| Cascade | Identify members who have a diagnosis of SPMI and diabetes who have not had HbA1c and LDL-C tests. | 80% members with conditions will receive both tests. | 80% members with conditions will receive both tests and maintain compliance with routine lab testing. |
| Columbia Pacific | Reduction in MED population from 39.66 MED. | Reduction from 39.66. | Maintain reduction. |
| Columbia Pacific | Implement First Tooth clinics. | Implementation of 2 clinics. | Implementation of 3 (minimum) clinics. |
| Columbia Pacific | Increase number of clinics receiving blended funding for co-locating behaviorists. | Co-located in minimum 3 PC clinics. | Implement clinical integration of behaviorists in all PC clinics serving more than 1,000 members. |
| EOCCO | Increase coordination of care for members through collaborative care. | Expansion of county collaborative to minimum of 4 of 12 counties. | Expansion of county collaborative to minimum of 6 of 12 counties. |
| EOCCO | Initiate collaboration using APD innovator agents, to expand communication and continuum of care. | Develop working MOU minimum 4 of 12 counties. | Develop working MOU minimum 6 of 12 counties. |
| EOCCO | Review methods for tracking referrals to APD transition. | Develop secure and effective method for tracking. | Update and monitor tracking tool. |
| EOCCO | Identify and refer members with complex needs to ICM, for services and enhanced communication with member and providers. | Full implementation of HRA process with member within 30 days. | Full implementation of HRA process with member within 30 days. |
| EOCCO | Use existing fidelity based self-assessments and TA from CCO/OSEACT, to score program measurement systems with OHA to report on specialized services. | Fidelity and or EBPs available within each SDA for submission and approval for member's holistic needs. | 6 consecutive months of self-reports and technical reviews. |
| EOCCO | Number of counties contracted with medical clinics and CMHP clinics for BH services; shared risk management; focus on shared CM with PCPCH and CMHP for high risk members, and members needing higher levels of care. | Contracts with medical clinics in 75% of counties with evidence of shared CM and risk management for members. | Contracts with medical clinics in 100% of counties with evidence of shared CM and risk management for members; 25% contracts between CMHP and PCPCH will include risk management process for members. |

**(1) Developing and implementing a health care delivery model that integrates mental and physical health care and addictions and dental health**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| EOCCO | Early adopter contract with OHA/BHS for MH residential treatment, transitions to permanent contract; during early adopter phase will create multiple community connections leading to permanent living arrangements and timely discharges from residential LOC. | Incorporated MH residential treatment into contract. | 50% of counties will have included risk management process for members. |
| EOCCO | Established UM and guidelines and preauthorization processes for MH, addictions and detox facility-based services, based on processes developed during early adoption of MH residential, on-going efforts with SUD/Detox residential community. | Established UM guidelines and preauthorization processes in place and operational for facility-based care. | Trained contracted facility-based providers reporting accurate data about UM and preauthorization requests. |
| EOCCO | Count and track number of members using facility-based services; including successful transition to lower LOC. | Established tracking method for member placement in each category of facility-based care; using data to identify and benchmark utilization. | Established process for tracking member transitions from facility-based care in all categories, specified within UM guidelines. |
| FamilyCare | P2ORTs CCO Outcome Measures and Assessment of Healthcare providers and Systems (CAHPS) for the member, practice and health plan LOC integration. | PC providers receive SBIRT training. | 100% of PCPs will be trained in SBIRT. |
| FamilyCare | Improved access (CAHPS) | Expand and enhance training of current and new P2ORT team members efficiently with use of HRA. | HRA administered to 100% appropriately identified members to create individualized care plans for ongoing CM for members with complex healthcare needs. |
| FamilyCare | Improve satisfaction of care (CAHPS) | Evaluate partnership with Asian Health and Service Center for replication in community based organizations. | Based on evaluation with Asian Health and Services Center, launch similar partnership with another cultural partner. |
| FamilyCare | Decrease ED utilization | Implement improvement strategies indicated from Provider Satisfaction Survey, including Plan of Choice indicators. | Meet or exceed CCO benchmarks and CAHPS improvements. |

**(1) Developing and implementing a health care delivery model that integrates mental and physical health care and addictions and dental health**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| FamilyCare | Decrease hospital admissions | Share individual ED utilization data with providers to improve appointment availability; improve provider training regarding accessing the P2ORT team services as needed in timely manner. | Meet or exceed CCO benchmarks and CAHPS improvements. |
| HealthShare | Increased member population, including members with SPMI, to fully integrated medical homes. | Establish improvement target for increasing membership served in integrated settings. | Increase number of members receiving services in an integrated setting. |
| HealthShare | Increased member population, including members with SPMI, to fully integrated medical homes. | Identify metrics to evaluate effectiveness of integrated models in improving outcomes, including improvement along the continuum of integration in the Four Quadrant Clinical Integration Model. | Monitor effectiveness of integrated models of care through identified metrics. |
| HealthShare | Increased member population, including members with SPMI, to fully integrated medical homes. | Establish benchmarks and targets for implementation of APMs supportive of integrated models of care. | Implement process to monitor increase in APMs used to support integrated service models. |
| IHN | Number of identified diabetic patients asked dental screening questions. | Identify diabetes patients in participating PCPCH. | Increase the baseline of dental care utilization originating from PCPCH. |
| IHN | Number of identified diabetic patients receiving a referral from PCPCH to a PC dental provider. | Identify diabetes patients in participating PCPCH. | >50% of identified diabetic patients visiting PCPCH for appointment receive an oral health screen and follow up instructions. |
| IHN | Number of patients receiving prophylactic and periodontics treatment. | Identify diabetes patients in participating PCPCH. | Lower A1c levels in identified diabetic patients receiving prophylactic or periodontics treatment as result of PCPCH referral. |
| IHN | Number of identified diabetes patients receiving referrals from PC dental providers to PCPCH. | Establish mechanisms for screening and care coordination between PCPCHs and PC dental providers. | Increase referrals between PCPCHs and PC dental providers. |
| IHN | Number of pre-post A1c measures. | Establish a data collection mechanism and test the data collection plan. | Evaluate expansion of dental integration through newly identified targeted populations or increasing newly participating PCPCH clinics. |
| IHN | Assessment of MH morbidity using industry standard assessment tools. | Develop, market, and implement low barrier, free of cost psychoeducational skills training classes for PCPCH members. | Increase MH assessments within the PCPCH setting. |

**(1) Developing and implementing a health care delivery model that integrates mental and physical health care and addictions and dental health**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| IHN | Tracking access to care from time of referral to first clinical encounter/consult. | Hold provider education presentations. | Decrease time between referral and access for MH services. |
| IHN | Pre/post measures of depression, anxiety, and social function, chart reviews, MH class attendance, physician education participation. | Quarterly reports collected. | Utilization of MH services in the PCPCH setting. |
| IHN | Monitor and measure time for follow-up visits, transfer of care back to PCPCH, total caseload, caseload turnover. | Completion of evaluation reports. | Identify best practices for MH integration in the PCPCH setting. |
| Jackson CC | 2014 7 day follow up after mental illness is 57.7%. | Increase rate for 7 day follow up after mental illness to >=61% | 2016 rate for 7 day follow up after mental illness to >=64%. |
| Jackson CC | Pain Resiliency Program will open 3/15. | 15% of members on high Opioid doses have completed the Pain Resiliency Program. | Chronic opioid usage for members at dose >120 MED decreased to <=17%. |
| Jackson CC | 24.7% members on chronic opioids at a dose of >120 morphine equivalents (MED.) | Chronic opioid usage for members at dose >120 is <=20%. | Chronic opioid usage for members at dose >120 MED decreased to <=17%. |
| Jackson CC | Birch Grove Clinic (PCC serving patients with MH and SUD) is open. | Clinical pharmacist on team to assist providers implementing best practice standards for treatment of chronic pain. | Chronic opioid usage for members at dose >120 MED decreased to <=17%. |
| Jackson CC | Identified need to establish effective policies and workflows with the 4 DCOs to coordinate care. | Minimum 75 members with high acuity chemical dependence or SPMI diagnosis will receive care at Birch Grove Clinic. | Birch Grove Clinic has developed a sustainability model to facilitate and support integrated care in PC setting for members with MH or SUD. |
| Jackson CC | Identified need to establish effective policies and workflows with the 4 DCOs to coordinate care. | Performance measures for Birch Grove Clinic are developed. | Performance measures for Birch Grove Clinic are tracked and reviewed semi-annually. |
| Jackson CC | Identified need to establish effective policies and workflows with the 4 DCOs to coordinate care. | Policies established to work effectively with 4 DCOs and a strategic plan is developed to prioritize issues. | 3 pilot projects with local DCOs implemented to enhance access/improve quality. |
| PH Josephine | Measure the number of members assigned to PCPs with BH available onsite. | Work with partners, to develop integration and co- location of services, identifying clinics that may participate as well as planning for funding and integration activities | Increase the % of members served by PCPs with co-located behavioral health to 75%. |

**(1) Developing and implementing a health care delivery model that integrates mental and physical health care and addictions and dental health**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| PacificSource Central | Establish baseline of current availablility of dental health in specialty BH or PC facilities. | Identify at least one target population for enhanced care coordination. | Implement dental care coordination model in the targeted population, increase 30% from baseline. |
| PacificSource Central | Establish baseline for average referral to treatment time. Document expedited process to include best practice access goals. | Convene local task force to develop expedited pathway model for SBIRT referrals to treatment services. | Model implemented in at least two PCPCHs. |
| PacificSource Central | Integrated, system coordinated tobacco cessation strategy. | Convene PH, dental, and PC workgroup to develop a community strategy to address tobacco use; document baseline prevalence. | 10% cessation rate. |
| PacificSource Gorge | Care coordination for children in DHS custody. | Achieve OHA's QIM 90% benchmark; build infrastructure to achieve OAR standard of physical and dental health assessments within 30 days. | Achieve 90% success of the OAR standard for <=30 days physical and dental, <=60 days MH. |
| PacificSource Gorge | Establish baseline of current availability of PC or dental in specialty BH facilities. Document increase in access to integrated services. | SPMI population will receive dental, physical and MH services as appropriate to their health status at levels equal to or better than the global CCO population. | Integrate physical health into at least one specialty BH facility that may include use of the dental van. |
| PacificSource Gorge | Develop an expedited path to SUD treatment for identified members. | Meet the best practice guidelines for access based on assessment of need, urgency, and readiness/choice of the member. | Treatment continuum for youth and adults are available with best-practice access times. |
| Trillium | Members will have access to providers that have integrated PC and BH services. | Revised model of care to be contracted with Trillium as an integrated PC home. | Mid-course review and adjustment to models of care are completed. |
| Trillium | Members will have access to providers that have integrated PC and BH services. | Revised model of care will be contrated with Trillium as a BH medical home. | APMs are refined and expanded. |
| Trillium | Members will have access to providers that have integrated PC and BH services. | TCHP will contract with selected providers for enhanced care coordination, assure appropriate and non-duplicated services. | Contracted providers that result in 60% of members assigned to an integrated clinic using APMs. |
| Trillium | Members will have access to providers that have integrated PC and BH services. | Incorporate APMs in contracts. | |
| Trillium | Members will have access to providers that have integrated PC and BH services. | 40% of members assigned to an integrated PC clinic. | |
| Trillium | Members will have access to providers that have integrated PC and BH services. | Completion of the SBIRT and other screening tools. | |

**(1) Developing and implementing a health care delivery model that integrates mental and physical health care and addictions and dental health**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| Trillium | Members will have access to providers that have integrated PC and BH services. | Four behavioral health provider contracts will incorporate APMs. | |
| Trillium | Members will have access to providers that have integrated PC and BH services. | TCHP will continue to contract with PH for prevention services including MH promotion. TCHP will contract for additional primary prevention and wellness services. | |
| Umpqua | Decrease ED utilization for members with SPMI. | Decrease ER utilization by 10% | Decrease ER utilization by 20% |
| Umpqua | Increase outpatient utilization for members with SPMI. | Increase outpatient utilization by 15% | Increase PC utilization by 30% |
| WOAH | Integration of mental and oral health care services. | Numerator will be => 70% of the value of the denominator, with no significant disparities by race or ethnicity. | Numerator will be =>80% of the value of the denominator, with no significant disparities by race or ethnicity. |
| WVCH | % of WVCH members assigned to clinics with embedded behaviorists. | 75% of members are assigned to a PCC that has an embedded behaviorist. | 85% of members are assigned to a PCC that has an embedded behaviorist. |
| Yamhill CC | Training and incorporation into patient flow in all PCPCH settings. | SBIRT training will be held in 2015/2016 for all who implement the SBIRT. | Active use of SBIRT Tool and implementation of requisite or associated work flows. |
| Yamhill CC | Training and incorporation into patient flow in both emergency departments; determine if ED coding will be captured in the OHA measure; determine whether SBIRT in MH can be captured in the OHA measure. | Yamhill CCO will provide technical assistance to hospital EDs in the development of referral pathways to treatment for positive screens. | |
| Yamhill CC | Use Non-Traditional Health Workers (NTHWs) and other outreach mechanisms to assist medical providers in successfully linking referred individuals with treatment. | | |
| Yamhill CC | Behaviorists funded, hired, trained and employed by clinics. | Proportion of encounters for mental health vs. health and behavior codes | 3% increase in the number of members served in PCPCH with embedded behaviorists. |
| Yamhill CC | Number of PCPCH qualifying at Tier 3.C.3 with behaviorists included in their team. | Number of service units per patient per 3 months, average length of sessions. | |
| Yamhill CC | Reporting fidelity measures | % of costs recouped through billings, all payers, PCP satisfaction. | |

**(1) Developing and implementing a health care delivery model that integrates mental and physical health care and addictions and dental health**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| Yamhill CC | Include options for depression screening and follow-up in PCPCH collaborative; ensure availability of evidence-based treatment (medications as first- line intervention only for serious depression in adults). | Understanding the internal referrals to behaviorist as well as external referral pathways to follow up care. | Benchmark 100% as determined by OHA. |
| Yamhill CC | Include options for depression screening and follow-up in PCPCH collaborative; ensure availability of evidence-based treatment (medications as first- line intervention only for serious depression in adults). | Data tracking system will be established to monitor and report on this measure. | Benchmark 100% as determined by OHA. |
| Yamhill CC | Total FTE of Peer Wellness Specialists | Meet target # of FTE for PWS. | PWS clients will demonstrate a PAM score improvement of 10 points by the end of service. |
| Yamhill CC | Improvement in Patient Activation Measure (PAM) scores for individuals served by PWS. | 10 point gain in average PAM score for clients served by PWS. | PWS FTE will increase if deemed necessary by data and usage. |
| Yamhill CC | Peer Wellness Specialists hired and deployed to support wellness in individuals with MH and addiction challenges. | | |
| Yamhill CC | PAM training completed and coaching underway. | | |
| Yamhill CC | Evaluate project and determine target # of PWS needed, funding mechanism, and # of members to be served. | | |
| Yamhill CC | PWS will work in collaboration with the CHW and the Community Based EMS Program to provide support to members as appropriate. | | |
| Yamhill CC | PWS will be trained on the PAM tool and Coaching for Activation tool. | | |

## (2) Implementation and development of Patient-Centered Primary Care Homes (PCPCHs)

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| AllCare | % of members assigned to recognized PCPCH providers. | 80% recognized. | 100% recognized or receive Wrap services via AllCare certification. |
| Cascade | Number of members assigned to PCPCH by tier; implement strategies to develop member engagement for certified PCPCHs. | 80% assigned to PCPCH. | 100% PC clinics certification; 100% members assigned to PCPCH. |
| Columbia Pacific | Increase number of members assigned to PCPCHs. | Develop infrastructure in 3-5 clinics. | 85-90% enrollment in tier 3 clinics. |
| Columbia Pacific | Increase number of members assigned to PCPCHs. | Complete T&TA in specified areas. | Recognized clinics or feedback on 3-5 CAP priority projects. |
| EOCCO | Number of members assigned to PCPCH by tier including 3 STAR participants. | 70% members assigned to PCPCH at any tier level, 10% members assigned to 3 STAR certified PCPCH. | 75% members assigned to PCPCH at any tier level, 20% members assigned to 3 STAR certified PCPCH. |
| EOCCO | Consistent methodology for reimbursement of community health workers employed by a PCPCH | Minimum 2 counties will be paid for community health worker services in SDA. | Provide PCPCH population health tools via secure on-line provider portal at consistent intervals; minimum 4 counties will be paid for community health worker services in SDA. |
| EOCCO | Enhanced tools available to assist PCPCH member population. | Pay for BH services in provided in minimum 4 PCPCHs. | Pay for BH services in provided in minimum 8 PCPCHs. |
| FamilyCare | 80% members assigned to PCPCH recognized locations. | Complete T&TA in specified areas. | Based on June, 2017 enrollment, 85% members assigned to PCPCH recognized locations. |
| FamilyCare | 79% members assigned to a Tier 2 or Tier 3 level provider. | Monitor progress of recognized PCPCH clinics monthly; evaluating renewals and levels of Tier recognition. | Based on June 2017 enrollment, 85% members assigned to a Tier 2 or Tier 3 level provider. |
| HealthShare | Provide TA to practices and support development of "advanced" medical home models for special populations (such as children in DHS custody, or members with SPMI.) | Review and evaluate national and local standards for evaluating medical home models for special populations. | |
| HealthShare | Provide TA to practices and support development of "advanced" medical home models for special populations (such as children in DHS custody, or members with SPMI.) | Identify opportunities to use APMs to support further development of PCPCHs, and other medical home models. | |

**(2) Implementation and development of Patient-Centered Primary Care Homes (PCPCHs)**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| HealthShare | Provide TA to practices and support development of "advanced" medical home models for special populations (such as children in DHS custody, or members with SPMI.) | Establish benchmarks and targets for implementation of APMs in PCPCHs/medical homes. | Monitor implementation of APMs supporting PCPCHs during the life of this plan. |
| IHN | Increase % of certification of clinics as PCPCH. | Submission of PCPCH application, during Q3, 2016. | Increase by 41-52 clinics. |
| IHN | Creation of Pediatric Medical Home Pilot. | Risk stratification completed, care coordination by RN. | New ICT meets regularly to evaluate process, document care plans, successful care coordination, reports quarterly. |
| IHN | Creation of Pediatric Medical Home Pilot. | MOUs established with community providers; pharmacy services medication management for risk level 3 and 4, pharmacist will spend time at clinic. | Clinic meets requirements and obtains 3 star PCPCH designation. |
| IHN | Creation of Pediatric Medical Home Pilot. | MH services with specialist and psychiatric consults on sight. | |
| IHN | Creation of Pediatric Medical Home Pilot. | 100% Level 3 patients seen every 6 months. | |
| IHN | Creation of Pediatric Medical Home Pilot. | 100% Level 4 patients seen every 3 months. | |
| Jackson CC | Regional Learning Collaborative established to support PCPCH development, system redesign to achieve and sustain Metrics. | 20 staff from PC partners have completed have completed training as Practice Coaches. | PCPCH enrollment minimum is 63%. |
| Jackson CC | Practice coach in Primary Care Transformation Training is scheduled at local venue for 7/15. | Minimum 5 critical clinical partners attend regularly at RLC. | Increased access: reduce assigned vs. seen numbers by 10% from 1/1/2015 baseline. |
| Jackson CC | Recruitment for PC Innovation Specialist (PCIS) and BH Innovation Specialist (BHIS.) | Network policy and process to allow more members to be assigned to PCPCH recognized practices. | 75% achievement of chosen clinical quality improvement targets. |
| Jackson CC | Evidence of team-based care in some clinical partner practices. | PCIS and BCIS are on board and supporting clinics. | Demonstration of a team-based care model, embedded BH staff and/or THW in place. |
| PH Josephine | Demonstrate that actionable data has been distributed to PCPs at minimum on a quarterly basis. | Use Medical Home Leadership Group to test and refine formal data distribution. | Distribution of actionable data on at least a quarterly basis from July 31, 2016- July 31, 2017. |
| PacificSource Central | Build capacity for social and BH integrated services at PCPCHs. | Outline sustainable ratio of BHC/CHW per member. | Minimum 2 PCPCH clinics participate. |

**(2) Implementation and development of Patient-Centered Primary Care Homes (PCPCHs)**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| PacificSource Central | Develop, define perinatal care continuum model that embodies PCPCH principles. | Business plan for implementing a PCPCH like medical home for the maternity population. | Implementation of 2 larger PCPCHs participation. |
| PacificSource Gorge | Change in treatment or educational services for managing acute or chronic pain. | Develop process, evaluate evidence, value of funding new treatment options or education for acute and chronic pain. | Evaluate funding options for at least two new treatment options. |
| PacificSource Gorge | Increase referrals, utilization and integration of evidence based chronic disease self-management programs. | Identify at least 3 EBPs that should be prioritized and promoted amongst CCO PCPCH clinics. | Develop integration and referral processes with at least three new PCPCH clinics. |
| Trillium | Continuing implementation and development of PCPCHs. | 65% of plan PCP's will be practicing in a recognized PCPCH. | |
| Trillium | Provider Panel will be assessed for the number PCP's practicing in a recognized PCPCH. | >85% of plan PCP's will be practicing in a recognized PCPCH. | |
| Umpqua | Increase % of members in Tier 2 and Tier 3 | 88% of members are served in Tier 2 or 3. | 90% of Members are served in Tier 2 or 3 |
| Umpqua | Increase % of members in Tier 2 and Tier 3 | Additional 2% of members are served in Tier 1 PCPCH or higher. | Additional 2% of Members are served in Tier 1 PCPCH or higher. |
| WOAH | Primary-Care Patient Centered Medical Home | Numerator >= 80% of denominator | Numerator >= 90% of denominator |
| WVCH | % of WVCH members assigned to PCPCH Tier III certified clinics. | 95% of members are enrolled in PCPCH Tier III certified clinics. | 99% of members are enrolled in PCPCH Tier III certified clinics. |
| Yamhill CC | Establish baseline for each PCP practice of what % of their newly assigned patients they see within 90 days. | Improve data tracking system established to monitor and report on this measure monthly. | 3% increase over baseline in % of new enrollees that are established with their PCPCH within 90 days of assignment. |
| Yamhill CC | Reports of patients assigned, but without a visit, sent to practices monthly. | Monitor monthly reports showing % of new enrollees that are established with their PCPCH within 90 days. | |
| Yamhill CC | Use an incentive-reward based reminder system to engage adolescents in completing their AWC visit. | Incentive-reward systems will be established with PCPCHs for adolescents completing an AWC visit. | 3% increase over baseline in percentage of AWC visits. |

**(3) Implementing consistent Alternative Payment Methodologies (APMs) that align payment with health outcomes**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| AllCare | % of available funds distributed to eligible providers. | Increase PCP achievement by 10% over baseline and expand to all 3 counties. | Increase PCP achievement by 15% over baseline and all other eligible providers to 5% over 2015 results. |
| Cascade | Reward successful PCPCH clinics via incentive program measured by PCPCH certification and continued improvement in state metrics program from 2011 baseline for assigned members in PCPCHs. | Establish negotiating committee to review payments and methods, develop payment methodologies based on metric performance and PCPCH certification; pay 2015 PCPCH metric funds to certified PCPCHs; increase certified PCPCH clinics to 5. | Develop and maintain consistent method of payment that fairly aligns payment with health outcomes in addition to incentivizing PCPCH certification. |
| Columbia Pacific | Increase number of PC clinics using APM for funding behaviorists. | Implement APMs to integrate BH into PC. | Payment models support CAP priorities. |
| Columbia Pacific | Increase number of community cost of care risk sharing models. | Develop/evaluate CAP SPM. | Minimum 2 of 3 counties, 40% membership. |
| EOCCO | Number of PC practices assuming full risk for PC services. | Minimum 1 PC practice assuming full risk for PC services. | Minimum 3 PC practices assuming full risk for PC services. |
| EOCCO | Number of in-area contracted providers and % of member population served; number of providers participating in APMs including risk assessment. | Minimum 75% in-area utilization spend to providers participating in APMs including risk assessment. | Minimum 85% in-area utilization spend to providers participating in APMs including risk assessment. |
| EOCCO | Continue modifying risk contracts to ensure majority of providers have participation opportunity. | Evaluation of additional provider categories with possibility to be included in risk contracts. | Modify risk contracts to include additional providers and provider categories. |
| EOCCO | Develop consistent methodology for sharing quality incentive funds with providers, weighted to providers with best performance. | Board approved consistent methodology for sharing quality incentive funds with providers, weighted to providers with best performance. | Sharing a portion of quality incentive funds with health care partners using methodology to reward providers performance, including ability to meet CCO incentive measures. |
| FamilyCare | Change in PCP, BH and Dental provider APMs coverage. | Implement PCP contract with incentives tied to performance on specific quality measures and PCPCH status; implement knowledge-based reimbursement methodology for BH and dental providers. | Increase in PC, BH, and dental providers contracted utilizing APMs, targeting 80% coverage for both PCPs and members. |

**(3) Implementing consistent Alternative Payment Methodologies (APMs) that align payment with health outcomes**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| FamilyCare | Change in PCP, ED and specialist utilization. | Provide provider training on current year CCO quality metrics, including correct documentation and coding. Monitor performance on quality metrics and provide feedback to providers. | Increase in PCP utilization and reduction in ED and specialist utilization. Continue to achieve quality metrics. |
| HealthShare | Increase the % of total compensation paid to providers attributed to APMs. | Conduct a current state assessment of the APMs used across managed care entities. | Implement process to track and monitor progress toward increasing the % of funding dedicated to APMs. |
| HealthShare | Increase the % of total compensation paid to providers attributed to APMs. | Establish a baseline and develop reasonable improvement targets for increased use of APMs. | Implement process to track and monitor progress toward increasing the % of funding dedicated to APMs. |
| IHN | Monthly reporting on financial performance, 3 access to care measures, 3 quality of care metrics, 6 utilization metrics identified from specific PCPCH baseline established from previous year. | Development of risk stratification model that incorporates health status and shared risk to accuracy of PMPM calculation and incentives PCPCH transformational efforts. | Comparison of risk stratified against baseline and first iteration of PMPM capitation; evaluate APM pilot from 2015 to determine if pilot should spread to additional clinics. |
| IHN | Pilots have established metrics for their own success based on pilot goals; quarterly reports on metrics; final evaluation reports. | Assessment of service types provided by pilot community service models, support outcomes not part of traditional health care that could be included in PCPCH PMPM capitation models; analyze cost reports from pilots to determine amounts to integrate into risk based PMPM capitation models; develop protocols, policies and method of payment for services. | Development, evaluation and dissemination of study, service sustainibility, cost effectiveness for service model; proposal, if applicable for moving services into the risk based PMPM capitation model. |
| Jackson CC | Eight clinics participating in Primary Care Payment Model (PCPM), self-reporting monthly performance measurements. | Quality Pool Dollar workgroup meets to develop alternative payment strategies. | Payment models developed and implemented in 13 clinics to support work of HT and continue development of capacity within PCPCHs. |
| Jackson CC | Eight clinics participating in Primary Care Payment Model (PCPM), self-reporting monthly performance measurements. | PCPM payment for recognized PCPCH clinics is increased to better support capacity and population. | |

**(3) Implementing consistent Alternative Payment Methodologies (APMs) that align payment with health outcomes**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| Jackson CC | Eight clinics participating in Primary Care Payment Model (PCPM), self-reporting monthly performance measurements. | Provide additional bonuses to eligible clinics (recognized PCPCHs) for BH visits and achieving targets on reduced use of EDs hospitalization rates or total cost of care. | MH and SUD services are incorporated into APM. |
| Jackson CC | Eight clinics participating in Primary Care Payment Model (PCPM), self-reporting monthly performance measurements. | BH Director hired to develop quality targets for MH, SUD services. | All APM recipients track and report on process or performance measures. |
| PH Josephine | Develop APMs to increase the % of quality pool targets met by PCPs by 2% each year. | Educate providers about the APM strategy being utilized. Increase the % of quality pool targets met to 57%. | Utilize the APM to increase the % of quality pool targets met by PCPs to 59%. |
| PacificSource Central | Establish baseline for APMs usage within CCO system. | Establish a prior year baseline measure. | Achieve improvement targets; progress in integrating the currently separate reimbursement mechanisms. |
| PacificSource Central | Establish baseline for APMs usage within CCO system. | Achieve endorsement from COHC on 2017 improvement targets for APM. | Achieve improvement targets; progress in integrating the currently separate reimbursement mechanisms. |
| PacificSource Central | Establish baseline for APMs usage within CCO system. | Produce an inventory tracking tool for APM contracts. | Achieve improvement targets; progress in integrating the currently separate reimbursement mechanisms. |
| PacificSource Central | Establish baseline for APMs usage within CCO system. | Report progress on APM contracts to the COHC Finance Committee. | Achieve improvement targets; progress in integrating the currently separate reimbursement mechanisms. |
| PacificSource Central | Integrating new CCO services, funding streams into CCO Global Budget. | Document process, number of contracts executed. | Evaluate and prioritize funding streams, 80% new contracts consistent with process. |
| PacificSource Central | Invest CCO shared income dollars to high impact community health strategies and initiatives. | Develop and achieve COHC endorsement of investment methodologies; progress in beginning to allocate, consistent with the approved framework. | Begin evaluations to understand the impact of community health related shared income investments. |
| PacificSource Gorge | Establish baseline for APMs use within CCO system. | Establish a prior year baseline measure. | Achieve improvement targets; progress in integrating the currently separate reimbursement mechanisms. |

**(3) Implementing consistent Alternative Payment Methodologies (APMs) that align payment with health outcomes**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| PacificSource Gorge | Establish baseline for APMs use within CCO system. | Achieve endorsement from COHC on 2017 improvement targets for APM. | Achieve improvement targets; progress in integrating the currently separate reimbursement mechanisms. |
| PacificSource Gorge | Establish baseline for APMs use within CCO system. | Produce an inventory tracking tool for APM contracts. | Achieve improvement targets; progress in integrating the currently separate reimbursement mechanisms. |
| PacificSource Gorge | Establish baseline for APMs use within CCO system. | Report progress on APM contracts to the COHC Finance Committee. | Achieve improvement targets; progress in integrating the currently separate reimbursement mechanisms. |
| PacificSource Gorge | Integrating new CCO services, funding streams into CCO Global Budget. | Document process, number of contracts executed. | Evaluate and prioritize funding streams, 80% new contracts consistent with process. |
| PacificSource Gorge | Global budget allocation, process for distributing Flexible Service funds. | Determine if % of the global budget should be allocated for Flexible Services. | Develop report system to monitor volume, type and beneficiary impact of funded services. |
| Trillium | Reduction in the PMPM amount paid to ER physicians by at least 2%, reducing visits to the ER when measured by visits/1,000 members. Baseline mutually agreed upon by OHA and Contractor. | Capitation arrangement with ER physicians. | Reduce the amount paid to and the services provided by ER physicians. |
| Trillium | PCP groups reduce the number of ER visits/1,000 Members by at least 2% will receive a bonus payment. Baseline mutually agreed upon by OHA and Contractor. | Methodology established for providing Bonus payments to PCP groups that reduce ER visits. | Reduction in the number of ER visits/1,000 Members by at least 2%. Baseline agreed upon by OHA and Contractor. |
| Trillium | Out of the 100% paid to BH providers, 30% was paid using the case rate methodology. | Case rates for BH Providers. | 30% (by dollar amount) of payments made to BH Providers will be through case rates. |
| Umpqua | Through reportable data, measure network provider performance. | Establish quality metrics, support improved health outcomes, adopt a payment formula contingent on provider performance at the established metrics. | 5% of provider payments are attributed to quality metrics. |
| Umpqua | Through reportable data, measure network provider performance. | Communicate the established quality performance-based incentive program to applicable providers. | 5% of provider payments are attributed to quality metrics. |

**(3) Implementing consistent Alternative Payment Methodologies (APMs) that align payment with health outcomes**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| Umpqua | Through reportable data, measure network provider performance. | Contractor develops and offers regular provider performance reports to applicable providers, to support achievement of established measures. | 5% of provider payments are attributed to quality metrics. |
| WOAH | APMs to address under utilization of MH visits. | Increase from 600.7 (baseline) to > 1,000 (or an alternate measure of value.) | Increase from 600.7 (baseline) to > 1,500 (or an alternate measure of value.) |
| WVCH | % of members assigned to PCCs receiving CCO incentive measure performance payments. | 95% of members are assigned to a PCC that recieves payments from the WVCH Quality Pool. | 99% of members are assigned to a PCC that recieves payments from the WVCH Quality Pool. |
| Yamhill CC | Study and establish population health and utilization baselines and desired outcomes. | Accountability language added to LOAs with primary care and prenatal care providers using APMs. | |
| Yamhill CC | Develop criteria for methodologies and incentive metrics through collaboration with stakeholders; risk corridors, delivery system readiness. | | |
| Yamhill CC | Adjust methodologies to meet desired targets and outcomes, develop accountability plan. | | |
| Yamhill CC | Implement 1 or 2 alternative methodologies that meet targeted health outcomes. | | 2% Increase number of PC and prenatal care providers enrolled in APM. |

**(4) Developing a Community Health Assessment and adopting an annual Community Health Improvement Plan**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| AllCare | Create dashboard report that designates each strategy and sub-strategy as complete, in process, or not complete. Share with board quarterly. | 50% strategies achieved. | 100% strategies achieved. |
| Cascade | Monitor timely submission of CHIP updates for contract compliance. | Semi-annual review and submission. | Early submission by June 30, 2017. |
| Columbia Pacific | Reduce adult obesity; reduce adult heavy/binge alcohol use; reduce suicide rate. | Using action steps in the CHIP. | CHIP improvements achieved. |
| EOCCO | Maintain number of LCACs and RCACs meetings | 100% of SDA counties maintained progress in conducting LCACs and Regional CACs meetings, consistent with ORS 414.627. | 100% of LCACs and Regional CACs meeting consistently in compliance with ORS 414.627. |
| EOCCO | Number of OHP members participating in LCAC activities. | 100% of LCACs increased proportion of OHP members serving on committees, continue to strive toward goal of OHP consumers representing majority. | 100% of LCACs and Regional CACs meeting consistently in compliance with ORS 414.627. |
| EOCCO | Number of LCACs that produce annual report describing implementation of local CHIP. | 100% of LCACs and RCAC produced annual report describing progress for 2015. | 100% of LCACs and Regional CACs meeting consistently in compliance with ORS 414.627. |
| EOCCO | Number of LCACS with a completed update of their CHA. | 100% LCACs will have begun an updated Community Health Assessment. | 100% of LCACs and RCACs meeting will have updated their CHA and begun compiling a CHIP. |
| EOCCO | Number of LCACs with an updated CHIP. | 100% of LCACs and RCACs meeting will have begun compiling a CHIP. | 100% of LCACs and RCACs meeting will have updated their CHA and begun compiling a CHIP. |
| EOCCO | Produce a Regional Community Health Improvement Plan. | Regional Community Health Plan reviewed and updated semi-annually. | 100% of LCACs and RCACs meeting will have updated their CHA and begun compiling a CHIP. |
| FamilyCare | Effective engagement of Transitional Age Youth (TAY) in health and healthcare based on adolescent well child visits. | Internal critical analysis of current care coordination and health delivery to transition age youth members and report findings. In at least one county served, community listening sessions with transition age youth will be held. | 10% increase in measured engagement among transition age youth served by CCO: increase in PC utilization. |

**(4) Developing a Community Health Assessment and adopting an annual Community Health Improvement Plan**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| FamilyCare | Effective engagement of Transitional Age Youth (TAY) in health and healthcare based on primary care visits. | Internal critical analysis of current care coordination and health delivery to transition age youth members and report findings. In at least one county served, community listening sessions with transition age youth will be held. | 10% increase in measured engagement among transition age youth served by CCO: increase in adolescent well care visits. |
| FamilyCare | Effective engagement of Transitional Age Youth (TAY) in health and healthcare based on emergency room visits. | Internal critical analysis of current care coordination and health delivery to transition age youth members and report findings. In at least one county served, community listening sessions with transition age youth will be held. | Decrease in ER visits. |
| FamilyCare | Partner with Healthy Columbia Willamette Collaborative to develop and complete community needs assessment report and CHIP. | Completion of CHIP. | Community health needs assessment/health improvement plan is presented to CAC, and used to prioritize health indicators and community needs, adopted by Board of Directors. |
| HealthShare | CHNA and CHIP plans will be completed on time and accepted by the CAC and board of directors. The CHNA and CHIP final documents are created in partnership with the CAC. | Present CHIP and CHNA drafts to CAC. | Submit additional CHP report to OHA to include details on top priority health needs and progress on disparity, addressing how each are being addressed. |
| HealthShare | CHNA and CHIP plans will be completed on time and accepted by the CAC and board of directors. The CHNA and CHIP final documents are created in partnership with the CAC. | Report to OHA on progress accomplishing CHIP strategies. | Submit additional CHP report to OHA to include details on top priority health needs and progress on disparity, addressing how each are being addressed. |
| IHN | Assessment of pilot projects to determine CHIP health impact area. | Identify gaps in current pilots, inform future focus areas; process created and implemented to use CHIP in evaluation of new grants and funding opportunities. | Transformation pilots address 1 or more of 4 CHIP impact areas; external funding aligns with 1 or more CHIP health impact areas. |
| IHN | Pre/post survey of CAC members to determine their knowledge of how the CHIP is used to influence the work of CCO and transform health care. | Survey tool developed and baseline data collected from CAC members; final survey scheduled for completion. | CAC members report an increased knowledge of how the CHIP is being used to transform health care. |

**(4) Developing a Community Health Assessment and adopting an annual Community Health Improvement Plan**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| Jackson CC | Current CHA/CHIP is complete with implementation in progress. | Actively engage CAC in assessment of current CHIP progress and reports to OHA when appropriate. | Plan for future CHA/CHIP cycle complete with partners identified. |
| Jackson CC | Current CHA/CHIP is complete with implementation in progress. | Conduct outreach to hospitals, PH and other organizations obligated to complete similar work to ensure efficient use of CHA and CHIP to broader community. | Plan for future CHA/CHIP cycle complete with partners identified. |
| PH Josephine | Minimum 1 priority strategy of the Phase II CHIP will be implemented, develop measurement strategy and clear description of outcome. | Support early learning/reading efforts by distributing books to school age children. | Minimum 1 measurable/reportable CHIP priority implemented. |
| PH Josephine | Minimum 1 priority strategy of the Phase II CHIP will be implemented, develop measurement strategy and clear description of outcome. | Sponsor/support ongoing learning opportunities for the CAC. | Minimum 1 measurable/reportable CHIP priority implemented. |
| PH Josephine | Minimum 1 priority strategy of the Phase II CHIP will be implemented, develop measurement strategy and clear description of outcome. | Provide ongoing learning opportunities for community providers. | Minimum 1 measurable/reportable CHIP priority implemented. |
| PacificSource Central | Formulating strategies to bring services closer to high need/ opportunity areas. | Develop capability to report on cost, quality and utilization patterns by geography; reports completed and presented to COHC. | Implements at least one initiative targeted to areas of high need or opportunity as identified by analytics. |
| PacificSource Central | Bridging Health Care and Housing for Better Outcomes. | Secure funding for a pilot program. | Pilot program implemented, early findings provided to COHC and CAC. |
| PacificSource Central | Alignment with the Early Learning Hub. | Adopt at least one early learning goal in addition to developmental screening rates. | Adopt at least one additional EL Hub metric. |
| PacificSource Gorge | Provider contracts require participation and response to focus areas outlined in CHIP, contribute input to CHA. | Establish tracking tool, report bi-annually to CCO Governance, establish a 2017 improvement target. | Achieve improvement target established for 2016 milestone. |
| PacificSource Gorge | Develop process to establish partnerships, measure progress to advance CHIP priorities. | 2 or more CHIP topics in partnership with CGHC, Metrics integrated into CHA ,reviewed at least bi-annually. | 4 or more CHIP topics in partnership with CGHC, metrics integrated into CHA , reviewed at least bi-annually. |

**(4) Developing a Community Health Assessment and adopting an annual Community Health Improvement Plan**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| PacificSource Gorge | Participation in a regional, collaborative CHA and CHIP process. | Evaluate the ability to include the following: ACEs prevlance; data from EHR across region; data from CAHPS surveys. | Coordination, participation in regional collaborative CHIP, meets or exceeds 2014 CHIP. |
| Trillium | Adoption and distribution of CHA and CHIP by Contractor. | Adoption of collaborative CHA/CHIP. | Adoption of collaborative CHA/CHIP. |
| Umpqua | CHIP action plans completed. | Evaluate results of initial CHIP action plans. | Contractor completes subsequent CHIP action plans. |
| Umpqua | CHIP action plans completed. | Determine subsequent action plans to support the prioritized focus areas of the CHIP. | Contractor completes subsequent CHIP action plans. |
| Umpqua | CHIP action plans completed. | Publish progress report of initial CHIP action plans. | Contractor completes subsequent CHIP action plans. |
| WOAH | CACs will each submit a time-framed and measurable outcome objective. | Compliant and updated 2016-2017 CHAs to be available by both counties. | Each CAC will attain its CHIP objective at the 80th percentile level-of-confidence. |
| WOAH | CACs will each submit a time-framed and measurable outcome objective. | Compliant and updated 2016-2017 CHIPs to be available for both counties. | Each CAC will attain its CHIP objective at the 80th percentile level-of-confidence. |
| WOAH | CACs will each submit a time-framed and measurable outcome objective. | Proposals including SMART objectives and evaluation plans to be available by CACs for both counties. | Each CAC will attain its CHIP objective at the 80th percentile level-of-confidence. |
| WVCH | Reduce tobacco prevalence as indicated in the CHIP. | Contractor reduces tobacco prevelance by 5% from 2014 CAHPS baseline. | Reduce tobacco prevelance by 10% from 2014 CAHPS baseline. |
| Yamhill CC | The CAC will utilize a modified MAPP process for the CHA, development of an annual CHIP. | CAC members will track and monitor CHIP metrics and produce an Annual Update to be submitted to OHA as required each year. | |
| Yamhill CC | The CAC will utilize a modified MAPP process for the CHA, development of an annual CHIP. | Annual Updates will be provided to consumer. | |
| Yamhill CC | At the CHIP year end, the CAC will compile a report for the CCO regarding the progress of the specific measures that were to be addressed as a result of the CHA/CHIP process. | | Annual update will be written in English and Spanish. |
| Yamhill CC | The MAPP process will be followed so that a CHA is performed every five years by the CAC, with annually reported updates. | | Annual updates will be submitted to OHA as required each year. |

**(5) Developing a plan for encouraging Electronic Health Records (EHRs), Health Information Exchange (HIE), and Meaningful Use**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| AllCare | Number of contracted providers who have capacity to submit data electronically, and of those, who shared information through JHIE. | 35% of EP's use JHIE. | 50% of EP's use JHIE. |
| Cascade | JHIE utilization by providers, successful implementation and reporting using Jefferson HIE. | 80% utilization of JHIE daily. | >40% Cascade clients assigned to JHIE PCP. |
| Columbia Pacific | Increase number of clinics using pre-manage as communication tool across PC and with BH partners. | Inventory clinics by MU stage, develop work plans. | Integrate clinical and claims data for analysis. |
| EOCCO | Number of members assigned to PC practices which incorporate EHR. | 50% population management and outreach tailored to member's cultural and linguistic needs. | 75% population management and outreach tailored to member's cultural and linguistic needs. |
| EOCCO | Number of PC practices and EHRs reporting accurate clinical quality data. | 100% healthcare materials will be assessed and modified with health literacy tool. | 25% enrollment and website material will be assessed with the health literacy tool. |
| EOCCO | Number of PC practices assessing quality, utilization and member roster via secure on-line member portal. | 3 interventions will use the teach back. | 6 interventions will use the teach back; minimum 50% of LCAC meetings will have a consumer in attendance. |
| EOCCO | Number of members accessing real-time health information using an on-line member portal. | Consistent methodology for demographic data provided to CACs and providers. | CCO will list demographic data in clinic-level reports quarterly. |
| FamilyCare | % of members whose clinical information is electronically shared between contractor and provider networks at the end of each calendar year. | Collecting patient level data in accordance with OHA CCO Technology plan. | Collection of patient level data with providers totaling 65% or more of member population. |
| FamilyCare | % of PCPs receiving ED and/or inpatient visit notifications through EDIE pre-manage. | 20% of PCPs will receive electronic ED and/or outpatient data through EDIE pre-manage. | 40% of PCPs will receive electronic ED and/or inpatient visit notifications through EDIE pre-manage. |
| HealthShare | Data from the clinical quality measures will be incorporated into the data warehouse, providing enhanced reporting to support integrated models of care and to identify and address disparities. | Select and begin implementation of business analytics user interface to completment the current data warehouse. | Expand use of analytics user interface. |

**(5) Developing a plan for encouraging Electronic Health Records (EHRs), Health Information Exchange (HIE), and Meaningful Use**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| HealthShare | Data from the clinical quality measures will be incorporated into the data warehouse, providing enhanced reporting to support integrated models of care and to identify and address disparities. | Convene partners to understand/analytic systems to avoid duplication while adding value. | Clinical quality measures at the member level in data to facilitate analysis across member demographics. |
| HealthShare | Data from the clinical quality measures will be incorporated into the data warehouse, providing enhanced reporting to support integrated models of care and to identify and address disparities. | Pilot use of interface with a small number of providers to evaluate effectiveness and benefit of interface for specific populations management. | Clinical quality measures at the member level in data to facilitate analysis across member demographics. |
| IHN | Increase site visits to clinics, individual health providers, care coordinators, month after month. | Evaluate RHIC expansion opportunity to include/provide training to additional providers, inquire using data to promote health of members. | Increase RHIC to minimum 10 partner sites using Care Team Link viewer for patient care; RHIC expansion to include 3 new data sources. |
| IHN | Increase frequency of repeat users to clinics, individual health providers, care coordinators, month after month. | Increase value of RHIC by enhancing dataset and adoptability. | 20% increase (Q2-2016 to Q2-2017) Care Team Link use. |
| IHN | Increase members inquired upon month after month; decrease duplicate lab or test results; count page visits on existing labs, count if new labs ordered. | RHIC data used to improve care coordination at collaborative level. | New labs will be <50% of labs inquired upon when last lab was <=30 days of date of inquiry. |
| Jackson CC | 68% of providers in service area meet EHR adoption requirements. | EHR adoption included in financial and TA strategies. | Minimum 40% members are empaneled to PCPs utilizing JHIE. |
| Jackson CC | 305 local providers enrolled in JHIE. | JHIE's CHR is routinely utilized in management. | >=72% of providers in service region meet EHR requirements. |
| Jackson CC | JHIEs CHR is not available. | JHIE's CHR is routinely utilized in management. | Plan for interface between JHIE and community connected network developed. |
| PH Josephine | % of PCPs utilizing secure, real-time information transfer. | % of PCPs utilizing secure, real-time information transfer. | 10% increase from baseline. |
| PH Josephine | Expand % of PCPs utilizing secure, real-time information transfer. | Establish benchmark of Phase I PCP clinics ready to expand. | 5% increase from baseline. |

**(5) Developing a plan for encouraging Electronic Health Records (EHRs), Health Information Exchange (HIE), and Meaningful Use**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| PacificSource Central | Continue development and implementation of HIT/HIE roadmap. | Establish a baseline for high ED utilization, establish improvement target for baseline, submit to OHA. | Achieve improvement target. |
| PacificSource Central | Impact quality and patient outcomes through improved health analytics and provider information exchange. | Integrate 2016 CCO claims information into PS Enterprise HEDIS. | Pilot quarterly delivery of “Patient Profiles” to at least 1 provider partner. |
| PacificSource Gorge | Continue development, implementation of HIT/HIE to support Triple Aim outcomes in region. | Establish baseline for high ED utilization. | |
| PacificSource Gorge | Continue development, implementation of HIT/HIE to support Triple Aim outcomes in region. | Establish improvement target based on baseline, submit to OHA. | Achieve improvement target. |
| PacificSource Gorge | Continue development, implementation of HIT/HIE to support Triple Aim outcomes in region. | Access to 100% OHP CCDs in JHIE. | Meet benchmark, improvement target. |
| PacificSource Gorge | Continue development, implementation of HIT/HIE to support Triple Aim outcomes in region. | 50% PCP providers have access to CCDs in JHIE. | Meet benchmark, improvement target. |
| PacificSource Gorge | Continue development, implementation of HIT/HIE to support Triple Aim outcomes in region. | Submit 2017 benchmark to OHA. | |
| PacificSource Gorge | Impact quality and patient outcomes through improved health analytics and provider information exchange. | Integrate 2016 CCO claims information into PS Enterprise HEDIS. | Pilot quarterly delivery of “Patient Profiles” to at least 1 provider partner. |
| PacificSource Gorge | Facilitate automated capture and reporting of Clinical Quality Measures. | Test feasibility to receive CQM data elements from at least one provider partner via JHIE. Requires automated generation of CCD from partner EHR at the close of each encounter. | Scale functionality achieved in 2016. |
| Trillium | Develop a plan for EHR; establish baseline, benchmark. | Shared care plan system links >90% Contractor, contracted PCPCHs and BH Providers. | Shared care plan system links >95% Contractor, contracted PCPCHs and BH Providers and >90%, specialists, community health workers, and selected social service agencies. |

**(5) Developing a plan for encouraging Electronic Health Records (EHRs), Health Information Exchange (HIE), and Meaningful Use**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| Umpqua | Members assigned to a PCPCH that met EHR meaningful use standards. | 88% of Members are assigned to PCPCH that meets EHR meaningful use standards. | 92% of Members are assigned to PCPCH that meets EHR meaningful use standards. |
| WOAH | Health Information Technology | Reduce ACS Ratio to < 2.00 in Coos County | Reduce ACS Ratio to < 1.50 in Coos County |
| WVCH | Increase % of WVCH providers who have *ever* received an EHR incentive payment. | 75% of WVCH providers who have *eve* r received an EHR incentive payment. | 80% of WVCH providers who have *ever* received an EHR incentive payment. |
| Yamhill CC | Assessment of communication platforms that will align multiple systems, including medical, behavioral, dental and early learning systems, which would allow for valid data exchanges and storage between systems. | System & software assessments completed. | |
| Yamhill CC | Assessment of communication platforms that will align multiple systems, including medical, behavioral, dental and early learning systems, which would allow for valid data exchanges and storage between systems. | Program licenses purchased. | Program licenses for partners purchased. |
| Yamhill CC | Assessment of communication platforms that will align multiple systems, including medical, behavioral, dental and early learning systems, which would allow for valid data exchanges and storage between systems. | Training plan developed and implemented for Yamhill CCO staff. | Training plan developed. |
| Yamhill CC | Assessment of communication platforms that will align multiple systems, including medical, behavioral, dental and early learning systems, which would allow for valid data exchanges and storage between systems. | Training plan developed for partner organizations. | Communication platforms implemented and in use. |

**(6) Assuring communications, outreach, member engagement and services are tailored to cultural, health literacy, and linguistic needs**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| AllCare | % of CCO staff who participate in cultural diversity training. | 100% of staff trained annually. | 100% of new hires receive diversity training within 3 months of hire. |
| Cascade | 100% of member materials available in Spanish for delivery to non-English speaking members. | 50% of Spanish speaking members receive materials in their language. | 85% of Spanish speaking members receive materials in their language. |
| Columbia Pacific | Number of cultural competence policies that utilize community defined benchmarks. | Update policies/procedures using community definitions, review language access and translation services to address consumer complaints. | Completed clinic-specific level of assessment of capacity/culturally responsive services, identify 2-3 clinics for TA and supports. |
| Columbia Pacific | Number of clinics trained in trauma; number of non-clinical settings trained in trauma. | Conduct trauma training, including ACEs in 5 clinic and 3 non-clinic settings. | Complete trauma/resilience training across service area, all major clinics and key community settings (schools, etc.) |
| EOCCO | Track vendor outreach with members who are chronically ill or have psychological issues; tailored outreach will be addressed. | 50% population management outreach tailored to member's cultural competency. | 75% population management outreach tailored to member's cultural competency. |
| EOCCO | Number of consumer materials assessed and modified using a health literacy assessment tool. | 3 interventions will utilize the teach back consumer feedback method. | Utilize health literacy tool to assess 25% of enrollment website and consumer material. |
| EOCCO | Number of LCAC meetings with consumer attendance. | Create consistent methodology for disseminating demographic data to providers and CACs. | 50% LCAC meetings will have a minimum of one consumer in attendance. |
| EOCCO | Number of interventions with integrated consumer feedback. | | 6 interventions will use the teach back consumer feedback method. |
| EOCCO | Number of demographic data reports completed and disseminated to providers and staff. | | List demographic data in clinic-level report disseminated quarterly. |
| FamilyCare | Written communication with members and providers based on OAR 410-141-3300. | Create Medicaid members materials catalog/matrix to ensure readability; cultural and linguistic appropriate for all written communication. | Annually review and revise as needed, the catalog/matrix process to ensure all written materials comply. |
| FamilyCare | Diversity of the P2ORTs multidisciplinary teams reflect member population served. | Hiring practices are guided by CLAS in health and healthcare. | Annually review the ratio of member to P2ORTs and other staff diversity to assess the effectiveness of hiring practices and revise as indicated in gaps in ratio. |

**(6) Assuring communications, outreach, member engagement and services are tailored to cultural, health literacy, and linguistic needs**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| FamilyCare | CAHPS improvements based on OHA 2013 Final report. | P2ORTs teams and staff receive new employee orientation and ongoing education and training in cultural and linguistically appropriate service delivery. | Human resources records of pre-and-post training survey results demonstrate ongoing education is appropriated. CAHPS access to care and overall members satisfaction improvement met or exceeded current CCO benchmark. |
| HealthShare | Develop, implement and report annual improvement plans, using Cultural Competency and Health Equity Workgroup objectives. | Report to OHA documenting improvement strategies and progress on improvement measures. | Assure all affiliate organizations have implemented strategies and reached minimum standards in identified areas. |
| HealthShare | Adopt consistent minimum standard for policies, practices and procedures, using Cultural Competency and Health Equity Workgroup objectives. | Report to OHA documenting improvement strategies and progress on improvement measures. | Assure all affiliate organizations have implemented strategies and reached minimum standards in identified areas. |
| HealthShare | Adopt standard practice to test translated materials to improve written materials, using Cultural Competency and Health Equity Workgroup objectives. | Report to OHA documenting improvement strategies and progress on improvement measures. | Assure all affiliate organizations have implemented strategies and reached minimum standards in identified areas. |
| HealthShare | Evaluate disparity in non-English speaking members filing complaints, grievances and appeals, using Cultural Competency and Health Equity Workgroup objectives. | Report to OHA documenting improvement strategies and progress on improvement measures. | Assure all affiliate organizations have implemented strategies and reached minimum standards in identified areas. |
| IHN | Develop measurement based on using input from workgroup, members, community partners, consultants. | Evaluation and gap identification of current web based communications; workgroup formed to provide oversight and input; launch stand-alone website. | Website improves communication and engagement is considered valuable tool. |
| IHN | Establish baseline measurement for website by assessment of: plain language/reading level, Federal Section 508 requirements for accessibility, availability of English and Spanish versions. | Evaluation and gap identification of current web based communications; workgroup formed to provide oversight and input; launch stand-alone website, 100% of all linked documents and website pages will meet federal standards for requirements for accessibility. | 100% all linked documents will be a maximum of 6th grade reading level, or summary document at same reading level will be provided, 30% increase from baseline of Spanish version documents. |

**(6) Assuring communications, outreach, member engagement and services are tailored to cultural, health literacy, and linguistic needs**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| Jackson CC | All member communications are available in English and Spanish. | One Board Literacy conference held and partners encouraged to attend. | Literacy, linguistic materials of key partners in community engagement tailored to meet members unique needs. |
| Jackson CC | All literacy materials for said materials are at 6th grade reading level. | 2 community partners collaborate to ensure all member communication materials are available at appropriate language and literacy levels. | Hiring of bilingual and bicultural staff to focus on engagement and empowerment of Latino populations. |
| Jackson CC | All member outreach events are attended by a certified interpreter. | 3 outreach events held to target the Latino population for engagement and assistance with interpreter, materials, and staff available to assist in English or Spanish. | Outreach to said population and sub-population to be informed by CHA and CHIP findings in addition to claims data and quality metrics. |
| PH Josephine | Review and develop cultural competency targets. | Completion of delegate oversight review. | Demonstration of provided, consistent oversight. |
| PacificSource Central | Applying learnings from Transformation Projects for enhanced member engagement. | Establish baseline reaching diverse members, measure overall impact of activities. | Improve outreach to specific membership by 30% over baseline. |
| PacificSource Central | Cultural and linguistically appropriate Grievance and Appeals processes. | Identify at least one area for improvement. | Implement at least one improvement to ensure G&A processes are culturally and linguistically appropriate. |
| PacificSource Central | Culturally and linguistically appropriate services within provider network across disciplines. | Make available education to providers in at least 2 annual workshops. | Documented improvement in at least 2 major areas. |
| PacificSource Gorge | Ensure use of, assist community partners with, plain language in all member communications, in English, Spanish. | Update at least one of key member materials, plain language training for at least 2 appropriate employees. | Provide community partners with relevant examples of, and resources for, training in plain language. |
| PacificSource Gorge | Develop, test strategies designed to educate, engage Hispanic/Latino and Native American members experiencing disparities in primary and preventive care access. | Engagement approaches to reduce disparities in access to primary or preventive care through cultural competency. | Identify and address at least one additional population experiencing disparities. |
| PacificSource Gorge | Inform members how to access language assistance services in their preferred language. | Develop a system to measure the utilization of language assistance services, establish a baseline relative to the # of members who indicate a language preference other than English. | Increase from baseline by 10%. |

**(6) Assuring communications, outreach, member engagement and services are tailored to cultural, health literacy, and linguistic needs**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| Trillium | % of member materials and outreach efforts are available in formats for whom English is not their primary language. | Assess materials continually for improvement, achieve benchmark. | 90% materials available are culturally appropriate. |
| Umpqua | Communications, outreach and services are available in alternative formats to meet member needs. | Evaluate current member race, ethnicity, cultural data. | Implement plan to ensure communication, outreach and services that addresses identified gaps. |
| Umpqua | Communications, outreach and services are available in alternative formats to meet member needs. | Assess and identify gaps in availability of alternative format. | Implement plan to ensure communication, outreach and services that addresses identified gaps. |
| Umpqua | Communications, outreach and services are available in alternative formats to meet member needs. | Develop plan to address identified gaps. | Implement plan to ensure communication, outreach and services that addresses identified gaps. |
| WOAH | Meeting cultural, linguistic, and health literacy needs. | 5% improvement over baseline, with minimum score of 85%. | Minimum score of 90% |
| WVCH | % member materials and outreach efforts available in appropriate formats for whom English is not their primary language. | Complete a CAC-led review of member materials and outreach to assess language and literacy. | Conduct a CAC-led outreach effort aimed at eliminating cultural and linguistic disparities. |
| Yamhill CC | Enrollment data will be reviewed and assessed to determine the cultural composition of our members as well as literacy levels as a baseline measurement. | | |
| Yamhill CC | The CAC will review enrollment data and assess the preferred spoken and written languages of members, persons eligible for Medicaid, or underserved populations. | Develop a procedure for review of member materials including multiple language options, cultural appropriateness, health equity. | |
| Yamhill CC | The CAC will research best practices when determining a method to use for assessing the literacy levels of our members with the possibility of engaging members in a focus group or in-person interviews. | Demographic data will be assessed for cultural composition. | |

**(6) Assuring communications, outreach, member engagement and services are tailored to cultural, health literacy, and linguistic needs**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| Yamhill CC | Recommendations from that assessment will be sent to the Yamhill CCO Board and CAP. | Focus groups will be considered for disparate populations to determine needs regarding written materials, including Member Handbook, website and social media. | |
| Yamhill CC | Recommendations from that assessment will be sent to the Yamhill CCO Board and CAP. | Health Literacy training for members, providers, clinic staff, CCO staff. | |
| Yamhill CC | Implementation of the review process for member materials will ensure they are culturally and linguistically appropriate for the member population. | | Implement the review process for member materials. |

**(7) 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 worker composition reflects member diversity)**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| AllCare | % of staff and contracted providers and their staff who meet the definition for a "diverse workforce." | Development and implementation of workforce diversity policies and procedures. | Demonstrated improvement in workforce diversity. |
| Cascade | Perform a baseline survey (by 7/1/2015) and subsequent surveys (1/31/2016, 7/1/2016) to measure CC diversity training program participation numbers. | 30% improvement. | 50% improvement. |
| Columbia Pacific | Increase number of members engaged with HRS (health resilience specialists.) | 100-120 members engaged. | 200-240 members engaged. |
| Columbia Pacific | Increase number of clinical pharmacists deployed in PC clinics. | Hire, train, embed 1 clinical pharmacist in PC clinic. | Completed evaluation of DCTR (drug therapy coordination risk) scores over rolling 12-months for members who receive clinical pharmacy intervention. |
| EOCCO | Number of educational events; informational materials provided to providers and staff. | 2 educational opportunities for providers and staff. | Implement annual cultural competency educational opportunities. |
| EOCCO | CHW services funded by contractor will be delivered using culturally competent tools. | Develop process with CHW to develop report process addressing cultural needs. | CHW staff will establish a methodology for reporting service delivery methods to contractor. |
| EOCCO | Build partnerships with community organizations that use culturally diverse materials. | Participation in 2 community-based events and/or work to improve meeting the needs of culturally diverse members. | Participation in 4 community-based events and/or work to improve meeting the needs of culturally diverse members. |
| EOCCO | Implement Trauma Informed Care recommendations. | Identify 1 clinic with capacity and willingness to adopt a Trauma Informed Care policy. | Implement 1 Trauma Informed Care clinic level pilot based on recommendations from the TICLCC. |
| FamilyCare | Diversified small to medium contracted provider network includes culturally unique, neighborhood centered practices. | Based on new member assignments, need for additional diversified small to medium practices (particularly small), culturally unique in contracted provider network. | PESP includes regular review process based on Provider Satisfaction Survey. |

**(7) 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 worker composition reflects member diversity)**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| FamilyCare | Grant funded community based projects to address population health issues. | Initial on-boarding and ongoing provider education and support, including TA, relevant member data to address cultural diversity and disparate health needs is provided by provider education services, based on PORT assignment. | On individual basis, effectiveness of community-based projects, including those utilizing CHWs and THWs will be evaluated based on program outcomes. |
| FamilyCare | CAHPS improvements based on OHA 2013 final report; access to care, 81.2%, satisfaction with care, 84.3%. | Broad spectrum of community-based projects implemented to address specific population health needs. | Meet or exceed current CCO benchmark with CAHPS access to care, and overall member satisfaction. |
| HealthShare | Address health disparities in membership using strategic investments in culturally specific Traditonal Health Workers to improve member services and outcomes. | Number of Traditional Health Workers FTE supported by CCO and partners. | % increase in relationships between CCO, CBO and the community, using Traditional Health Workers. |
| HealthShare | Address health disparities in membership using strategic investments in culturally specific Traditonal Health Workers to improve member services and outcomes. | Develop evaluation framework for measuring outcomes. | Implement Traditional Health Worker evaluation and framework. |
| HealthShare | Target resources to improve staff competence regarding equity and inclusion. | Number of equity and inclusion trainings offered and % of staff who report increased knowledge and understanding; establish improvement target. | Increase number of staff self-reporting increased knowledge and understanding of issues related to equity and inclusion. |
| IHN | Establish baseline with data collection on number of staff that have attended an ACEs or trauma informed training. | Trainings identified, training platform/schedule developed. | ACEs or trauma informed trainings provided to CCO staff; identifies actions and opportunities to promote tools with community partners and members. |
| IHN | 100% of staff participate in ACEs or trauma informed training; of those participating report increased knowledge of impact of ACEs on members. | Pre and post training survey created. | Trauma informed organizational self-assessment completed. |
| IHN | A trauma informed organizational self-assessment tool is used. | A trauma informed organizational self-assessment tool identified. | Staff recognizes trauma response behaviors, triggers, early warning signs, and crisis responses, staff is trauma informed. |

**(7) 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 worker composition reflects member diversity)**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| Jackson CC | Regional health disparities report concluded. | Health Literacy Conference held. | Minimum 2 community partners have policy changes in hiring due to work described in milestones. |
| Jackson CC | Staff represented on Regional Health Equity Steering Committee. | Minimum 2 presentations designed to inform business and all health areas, social service communities, of the effects of social detriment to health and regional health disparities. | 10 partner organizations completed 18 month learning collaborative in Trauma Informed Care. |
| Jackson CC | Community engagement program activities are informed by disparities report, CHA and CHIP findings, and staffed by appropriate peers who are bilingual. | Oregon Regional Health Equity Coalition: Health Equity 101 training developed and conducted for 3 organizations, addressing best practices in hiring policies to produce diverse workforce. | 5 local presentations offered on Health Equity 101 and regional disparities. |
| Jackson CC | Community engagement program activities are informed by disparities report, CHA and CHIP findings, and staffed by appropriate peers who are bilingual. | Trauma informed Care learning collaborative established engaging all partners in learning/action plan, to integrate findings into practice for SDA population. | Internal hiring policy reviewed for adherence to current best practice standards in hiring diverse workforce. |
| PH Josephine | Number of education/training opportunities provided. | Specific plan on which education/trainings shall be facilitated. | Provide OHA with a report regarding types/number of trainings facilitated. |
| PacificSource Central | Developing Workforce Diversity. | Complete baseline assessment on health care workforce. | Program plan developed, begin implementation. |
| PacificSource Central | Increasing access to in-person qualified or certified interpreters. | Establish support protocols to increase the number of clinics who train staff to become qualified or certified interpreters. | Increase the number of qualified or certified interpreters by 20%. |
| PacificSource Gorge | Increasing access to in-person qualified or certified interpreters. | Capture a baseline of clinics that employ qualified or certified interpreters. | Increase the number of qualified or certified interpreters by 20%. |
| PacificSource Gorge | Developing Workforce Diversity. | Complete baseline assessment on health care workforce and specific focus on Hispanic, Native American members. | Program plan developed, begin implementation. |
| Trillium | % of members who report satisfaction with how their cultural values, language, and literacy needs were met. | | Increase the % of members who report satisfaction, literacy needs were met. |

**(7) 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 worker composition reflects member diversity)**

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| Trillium | % of over/under representation of gender and cultural/language diversity of staff. | | Reduce % of under-representation of gender and cultural/language diversity of staff at the CCO, provider and front-office role by 25%. |
| Umpqua | % of contractor and ancillary staff who receive diversity training. | Identify appropriate diversity training, offer at least one training. | 30% of contractor and ancillary staff receive diversity training. |
| WOAH | Assuring culturally diverse needs of members are met. | 10% improvement over 2014 baseline. | 20% aggregate improvement over 2014 baseline. |
| WVCH | The annual provision of provider cultural and linguistic competency training. | Annual centralized cultural competency training offered to all providers. | If providers do not attend training, request they submit attestation declaring that they have received training from an alternative source. |
| Yamhill CC | By following the MAPP process for Community Health Assessment (CHA), baseline population data will be provided to the CAP and Yamhill CCO in order to determine the culturally diverse needs of the Members. | Demographic data of members is assessed for cultural composition. | |
| Yamhill CC | Cultural diversity training will be provided to Yamhill CCO staff and contracted providers on an annual basis. | At least one Cultural Diversity, Health Equity training will be provided for network providers and staff. | |
| Yamhill CC | Member data will be assessed to determine any shifts in cultural makeup of the member population. | | Demographic data of Yamhill CCO members assessed for cultural composition and compared to baseline. |
| Yamhill CC | 100% of staff will have participated in at least one formal cultural competency training. | | 100% of staff will have participated in at least one formal cultural competency training. |
| Yamhill CC | 50% of contracted providers will have participated in at least one formal cultural competency training. | | 50% of contracted providers will have participated in at least one formal cultural competency training. |
| Yamhill CC | % of providers and NTHW cultural composition will closely match the cultural composition of the member population as is feasible for Yamhill County. | | % of providers and NTHW cultural composition will closely match the cultural composition of the Member population as is feasible for Yamhill County. |

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

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| AllCare | Number and % of members within a contracted DCO who receive dental services. | | Identify, increase 5% over 2014 baseline for dental exams, preventive and/or restorative care by DCO, by age and ethnicity. |
| Cascade | Reduce identified disparities in ACA conditions: specific HbA1c and LDL-C testing in SPMI members; timeliness of prenatal care for high risk members. | Completed analysis and identification of disparities and development of priority improvement plans. | 20% sustained increase of care for identified disparities. |
| Columbia Pacific | 12.6% of members receiving timely prenatal care are Latino. | Retrospective claim analysis with clinical data to identify true baseline screening, for Latino membership vs entire member population. | Reduce health outcome disparities related to racial/ethnic/linguistic status. |
| Columbia Pacific | 34% of members receiving CRC are Latino. | Retrospective claim analysis with clinical data to identify true baseline screening, for Latino membership vs entire member population. | Equality of screening and timeliness across all races/ethnicities. |
| EOCCO | Track pre and post-Intensive CM intervention for members with special needs/high utilization history. | Develop claims analysis and process to identify and track members enrolled in ICM. | ICM will improve services based on analysis of impact, as defined by pre-and-post program utilization. |
| EOCCO | Develop process to identify health disparities and gaps using the annual OHA report on reading language and ethnicity. | Completed analysis of 2015 CAHPS data for access to care and satisfaction to care. | Implement intervention based on 2015 CAHPS data access to care and satisfaction with care. |
| FamilyCare | Analyze quality measures and metrics by race, ethnicity and language. | Identify disparities and develop a plan to reduce them, including community based initiative and metrics. | Evidence in reduction of disparities based on implementation of plan. |
| HealthShare | Convene a REaL data analysis group to develop and implement strategic disparities analysis framework. | Develop plan for addressing disparities using rapid cycle improvement, including input and involvement from impacted counties. | Implement milestone activities, reporting the process and outcome measures established in the improvement plans. |
| HealthShare | Analyze grievance and appeal clinical care category by race, ethnicity and language to identify disparities. | Develop plan for addressing disparities using rapid cycle improvement, including input and involvement from impacted counties. | Implement milestone activities, reporting the process and outcome measures established in the improvement plans. |
| HealthShare | Provide quarterly reports and analysis to Quality Management Council. | Develop plan for addressing disparities using rapid cycle improvement, including input and involvement from impacted counties. | Implement milestone activities, reporting the process and outcome measures established in the improvement plans. |

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

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| IHN | Develop 3 Pilot programs utilizing CHWs/THWs. | Development of 'Hub" model for hiring, training, supervising CHWs for PCPCH settings. | Completed pilot evaluations provide important information for program replication and expansion, best practices. |
| IHN | Develop 3 Pilot programs utilizing CHWs/THWs. | Increase number of OHA registered CHWs/THWs providing care coordination, self management services. | Completed pilot evaluations provide important information for program replication and expansion, best practices. |
| IHN | Develop 3 Pilot programs utilizing CHWs/THWs. | Develop targeted outreach, coordination and support services offered by school based bilingual and bicultural THWs. | Completed pilot evaluations provide important information for program replication and expansion, best practices. |
| IHN | Develop strategic plan: using a variety of data collection tools, measurements are developed based on input from workgroup, members and partners. | Workgroup meets on regular basis, disparities identify disparities and root causes. | Strategic plan implemented to address disparities. |
| Jackson CC | Access to recently completed Regional Health Disparities Report and CCO metrics to identify greatest areas of disparities. | Contractors QI plan to be updated annually. | QI plan incorporates strategies to understand and reduce disparities of health outcomes. |
| Jackson CC | Contractor has a QI plan and strategies to monitor health disparities. | Where available, information about racial and other ethnic disparities on CCO quality metrics reported to partners annually. | QI plan incorporates strategies to understand and reduce disparities of health outcomes. |
| Jackson CC | Contractor has a plan to offer QI tools and data to core clinical partners. | QI tools and data provided monthly through PC3 learning collaborative. | QI plan incorporates strategies to understand and reduce disparities of health outcomes. |
| Jackson CC | Contractor has a plan to offer QI tools and data to core clinical partners. | Results of Regional Health Disparities report presented to staff, CAP, CAC and local rotary. | QI plan incorporates strategies to understand and reduce disparities of health outcomes. |
| Jackson CC | Contractor has a plan to offer QI tools and data to core clinical partners. | Partner with SORHEC to provide minimum 2 awareness-building efforts improving cultural agility. | QI plan incorporates strategies to understand and reduce disparities of health outcomes. |
| PH Josephine | CAP will review and act on data at least twice annually. | *I* dentify 3 outcome measures on which to focus and monitor for racial and ethnic disparities. | Monitor outcome measures minimum of twice annually. |
| Pacific Source Central | Promote engagement in Spanish-language and/or AI/AN diabetes self management programs. | Establish baseline and develop workflow. | Increase referrals and participation of specified populations by at least 20%. |

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

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| Pacific Source Central | Reporting clinical quality data by race/ethnicity. | Contractor, stakeholders report feasibility clinical quality measures data by race/ethnicity. | At least one clinic establishes feasibility, reports CQM by race/ethnicity. |
| Pacific Source Gorge | QI project to reduce disparities in access to medical and/or dental preventive care. | Establish baseline, identify and address at least one additional population experiencing disparities. | Achieve target, identify and address at least one additional population experiencing disparities. |
| Pacific Source Gorge | Reporting clinical quality data by race/ethnicity. | Contractor, stakeholders report feasibility clinical quality measures data by race/ethnicity. | At least one clinic establishes feasibility, reports CQM by race/ethnicity. |
| Pacific Source Gorge | QI initiatives to reduce diabetes disparities. | Establish baseline of AI/AN and Hispanic members participating in culturally responsive diabetes self-management programs, identify strategies. | Meets program goal and target. |
| Trillium | Reduction of identified racial/ethnic disparities in ACA conditions. Method of calculation to be agreed upon by OHA and Contractor. | Complete re-analysis and identification of disparities related to ACA conditions and development of priority improvement plans. | Reduction by 30% of disparities identified as priority for improvement. Method of calculation mutually agreed upon by OHA and Contractor. |
| Umpqua | Eliminate member disparities that impede appropriate care being delivered in the appropriate setting. | Evaluate current member ER and outpatient utilization patterns filtered by race, ethnicity, or residence. | Decrease ER utilization by 15%, increase outpatient utilization by 20% for members with disparities. |
| Umpqua | Eliminate member disparities that impede appropriate care being delivered in the appropriate setting. | Identify disparities in ER and outpatient utilization related to member race, ethnicity, or residence. | Decrease ER utilization by 15%, increase outpatient utilization by 20% for members with disparities. |
| Umpqua | Eliminate member disparities that impede appropriate care being delivered in the appropriate setting. | Develop QI plan to address identified disparities that influence member ER and outpatient utilization. | Decrease ER utilization by 15%, increase outpatient utilization by 20% for members with disparities. |
| WOAH | Attaining a score => the mean score for all Oregon children on the Kindergarten Readiness Assessment tool. | | 10% increase over baseline, calculated by school district, for each of 3 variables: approach to learning, early math, early literacy. |

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

*Benchmark measurement: Baseline to July 31, 2017*

| CCO | Measure | July 1, 2016 | July 1, 2017 |
|---|---|---|---|
| WVCH | Incentive measure performance stratified by race/ethnicity. | 25% reduction in absolute disparity between white/non-white members across a minimum of two claims-based measures. | 50% reduction in absolute disparity between white/non-white members across a minimum of 2 claims-based measures. |
| Yamhill CC | Results of 2014 CAHPS survey reviewed by Board and CAP, CAC and improvement targets will be established. | Improvement targets established by the CAC, CAP and Board. | |
| Yamhill CC | Improvement of established targets on the CAHPS Survey. | | Improvements in specific targets identified will be demonstrated by the most current CAHPS Survey results. |
| Yamhill CC | Baseline rate of these preventive measures for this group can be set this year, 2015. | Systems will be in place to collect and report data on these specific measures for this specific population. | |
| Yamhill CC | Rates for these measures of quality improve to the benchmark set after analysis of 2015 baseline data, if available. | | Number of preventative services provided for this group will have increased by 3% over baseline. |