

TRANSFORMING HEALTH CARE IN OREGON: CCO STRATEGY, ACTIVITY, AND PROGRESS

A DOCUMENT ANALYSIS

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TRANSFORMING HEALTH CARE

EXECUTIVE SUMMARY

BACKGROUND AND PURPOSE

Coordinated Care Organizations (CCOs) are distinct health entities tailored to the needs of the Medicaid eligible population in particular geographic areas. They govern care and are ultimately responsible for health outcomes, including physical, mental, and dental health. There are 16 distinct CCOs in Oregon and each one approached transformation in their own way, though there are some similarities and trends seen within particular transformation areas. Each CCO was expected to report details of their transformation endeavors routinely to the state. CCO transformation efforts are numerous, complex, and difficult to track in a succinct way using raw documents. This report is intended to provide a systems-level overview of where transformation efforts are focused, capturing a snapshot of progress both broadly across the state and within each distinct CCO.

METHODS

Using CCO transformation documents and a framework designed by Oregon Health Authority (OHA), CCOs' narrative descriptions of their efforts were aggregated into broader categories so they could be compared across and within organizations. We used summative content and framework analysis, as well as descriptive statistical analyses to paint a picture of CCO transformation.

1. TRANSFORMATION EFFORTS ARE NUMEROUS AND BROAD-REACHING.

CCOs reported over 2,600 distinct transformation activities, underscoring 1) the sheer amount of work required for success of CCOs and 2) the authentic response to the call for visionary change: CCOs wanted to achieve system-level change. *Planned activities* (activities incorporated into Transformation Plan amendment contracts and become part of the CCOs' contractual requirements; these activities could be also found in Community Health Improvement Plans, Transformation Fund Grant proposals, or Performance Improvement Plans) numbered over 370 across all 16 CCOs, and were mostly broad-reaching activities that touch most or all of the CCO's service area rather than narrowly focused pilots.

3. INTEGRATION AND WORKFORCE DEVELOPMENT WERE KEY FOCUS AREAS ACROSS THE STATE.

Over a fifth of all planned activities were associated with the transformation area of integration, significantly more than other transformation areas. Additionally, 80 transformation activities across the state were related to workforce development, suggesting a widespread effort to create and train a new workforce for the future.

5. INTEGRATION WAS A PRIORITY FOR A REASON

The push toward integration might have been a relic of the fact that many CCOs appeared to choose to tackle integration first, and the chronology of choice continued to define their transformation strategy over time. This might have taken priority because most CCOs are operated by health systems that had necessary infrastructure and integration has cost benefits associated with it.

2. MOST CCOs HAD GOOD SUCCESS MEETING THEIR TRANSFORMATION GOALS.

Overall, half (8 of 16) of all CCOs achieved at least 75% of all planned activities. Generally, CCOs were more successful at meeting *milestones* (an identified incremental outcome that is both a short-term target and a logical step that moves the CCO toward achieving its benchmark) than *benchmarks* (an objectively identifiable and measurable standard that the CCO will report to measure its progress). Specifically, 12 CCOs met at least 75% of their milestones and eight met benchmarks. CCOs struggled the most in the areas of Meeting Members Culturally Diverse Needs and Eliminating Health Disparities.

4. TRANSFORMATION WORK IS COMPLEX AND MULTI-DIMENSIONAL.

CCOs engaged in broad efforts that cut across multiple transformation priorities. Activities such as contracting or planning cut across domains and transformation areas, speaking to the complexity of transformation and the many types of administrative work required to accomplish diverse goals.

6. THERE WAS LITTLE FOCUS ON ALTERNATIVE PAYMENT METHODOLOGY AND HEALTH IT TRANSFORMATION

We postulate that 1) they are interrelated and 2) improvement in HIT requires a significant financial investment, which CCOs might have been hesitant to make early on. This, in turn, could have precluded a focus on APM, because models like paying for performance require outcomes data.

TRANSFORMING HEALTH CARE

BACKGROUND & INTRODUCTION

PURPOSE OF THIS REPORT

This report is designed to bring together all the narrative reporting of Oregon’s CCO transformation efforts and provide a single, integrated snapshot of transformation progress. CCO transformation efforts are numerous, complex and difficult to track in a succinct way. By employing standardized document analysis techniques we are able to produce a systems-level overview of where transformation efforts are at that captures a snapshot of progress both broadly across the state and within distinct CCOs.

BACKGROUND

Oregon has mobilized state and federal resources to activate the *Coordinated Care Model*, a massive reconstruction of the Medicaid delivery system. At the heart of the Coordinated Care Model are Oregon’s Coordinated Care Organizations (CCOs), which unify payment and delivery for physical, behavioral, and dental health care services within regional collaboratives. CCOs are encouraged to use the flexibility within their global budget to find innovative ways to control costs and improve care. This flexibility allows for nimble, geographic-specific, and market-appropriate responses to healthcare challenges, but this inherent variability makes it difficult to track CCO transformation activities.

The Oregon Health Authority (OHA) has been tracking CCO activities through a series of detailed transformation documents that are qualitative in nature. This reporting strategy allows CCOs to describe their efforts narratively, thus providing the kind of intricate information that allows for the comprehensive oversight required for regulating these organizations. These documents also contain a complete record of all CCO efforts to transform their delivery systems in the wake of reform. In addition to keeping CCOs accountable to the mission, the detail in these reports offers a wealth of knowledge on the various strategies around reform.

The vast amount of text in the documents made it difficult to observe patterns and trends of activities both within and across CCOs at a glance, which led to the partnership between OHA and the Center for Outcomes Research and Education (CORE). CORE worked to synthesize the content and extrapolate succinct and digestible information relating to on-the-ground transformation efforts.

OVERVIEW OF REPORT

This document summarizes the findings of a content analysis study of CCOs’ transformation documentation on behalf of the Oregon Health Authority (OHA). CORE collected and coded narrative data submitted by the state’s CCOs, collapsed that data into discrete elements, entered those elements into OHA’s data tracking system, and then analyzed the data to identify key themes on what transformation activities CCOs are undertaking and how successful they have been at achieving their goals. We outline our specific methodology, highlight state-wide patterns of transformation, and provide activity profiles of each CCO.

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FROM NARRATIVE TO NUMBERS: THE CODING FRAMEWORK

APPLYING THE FRAMEWORK

In order to provide a system-wide overview of what transformation efforts look like across the state, we classified and aggregated each CCO's narrative descriptions of their efforts into broader categories to be compared.

To do this, we reviewed each document and identified discrete **activities** each CCO indicated it planned to undertake. Each distinct activity was categorized along 7 dimensions: *Type, Transformation Area, Domain, Scope, Contractual Status, Milestone, and Benchmark*. Figure 1 explicates these dimensions in detail.

FIGURE 1. Coding Framework: Seven Dimensions of Transformation Activities

<p>ACTIVITIES</p>	<p>We read through the transformation document, then identified and summarized activities. Activities were broadly defined as an action or set of actions the CCO says it will take.</p>
<p>EACH ACTIVITY WAS CATEGORIZED IN THE FOLLOWING WAY:</p>	
<p>TYPE</p>	<p>Each activity was categorized into eight types: Contracting, Hiring, Implementing, Planning, Training, Research, Outreach, & Other. Activities could only be categorized into one type. Types of activities are thoroughly defined in Appendix A.</p>
<p>TRANSFORMATION AREA</p>	<p>In Transformation Plan reports, each activity was assigned to a transformation area by the CCO. This was used as the primary Transformation Area indicator. CORE coders applied secondary flags for activities that crossed multiple areas; therefore an activity could be categorized as belonging to more than one area. A majority of the analysis using the primary indicator for reference. Transformation areas were identified by OHA as the 8 key components of transformation CCOs should be focused on. Transformation areas are defined on the next page and in Appendix A.</p>
<p>DOMAIN</p>	<p>Domains are topic areas of special interest to health transformation in Oregon as identified by OHA. Each activity was also assigned a topical area(s) related to specific health conditions or aspects of the delivery system. Each activity could be categorized as pertaining to as many as five domains. In addition, an activity could be categorized as not pertaining to any domain. OHA identified 68 unique domains which are included as Appendix A.</p>
<p>SCOPE</p>	<p>Each activity was categorized by scope or reach. Scope had two subcategories: population and geography. We flagged each activity to indicate the intended <i>population</i>: broad (all or most of the CCO's population) or targeted (a specific group or community). We also flagged each activity based on the <i>geographic</i> reach: broad (most or all of the CCO's service area) or targeted (a specific town or neighborhood within the CCO's service area). Oftentimes activities did not specify the scope; in these cases, "unknown" was indicated.</p>
<p>CONTRACTUAL STATUS</p>	<p>Some activities were incorporated into CCO contracts and became part of CCOs' contractual requirements ("<i>planned</i>" activities). Other activities were described as planned, but were not formally incorporated into CCO contracts. <i>Planned</i> activities could cross multiple reports. The analysis included in this report focuses around <i>planned</i> activities.</p>
<p>MILESTONE</p>	<p>A milestone is a <i>planned</i> activity, meaning it is found in the Transformation Plan 2013-2015 amendment. These activities are explicitly defined and intended to signify progress toward an outlined transformation benchmark. For activities that were incorporated into CCO contracts, a milestone with a date to be achieved was included in the contract. We reported both on milestones that were completed generally, and on those that were completed on time.</p>
<p>BENCHMARK</p>	<p>A benchmark is a <i>planned</i> activity, meaning it is found in the Transformation Plan 2013-2015 amendment. These activities are a measurable indication of success of Transformation Plan execution. For activities that were incorporated into CCO contracts, a benchmark with a date to be achieved was included in the contract.</p>

FROM NARRATIVE TO NUMBERS: TRANSFORMATION AREAS

DEFINING TRANSFORMATION AREAS

For many of the reports, CCOs were required to submit to OHA focused activities around eight key components, referred to in this report as “Transformation Areas.” OHA offers technical assistance to guide CCOs on these areas to ensure that each is addressed throughout the reports.

These eight areas often overlap with other metrics set by the State and many are primary goals of Health Systems Transformation, and are therefore our highest level of activity organization.

A full definition of each Transformation Area is listed in Figure 2 below.

FIGURE 2. Definitions of Transformation Areas

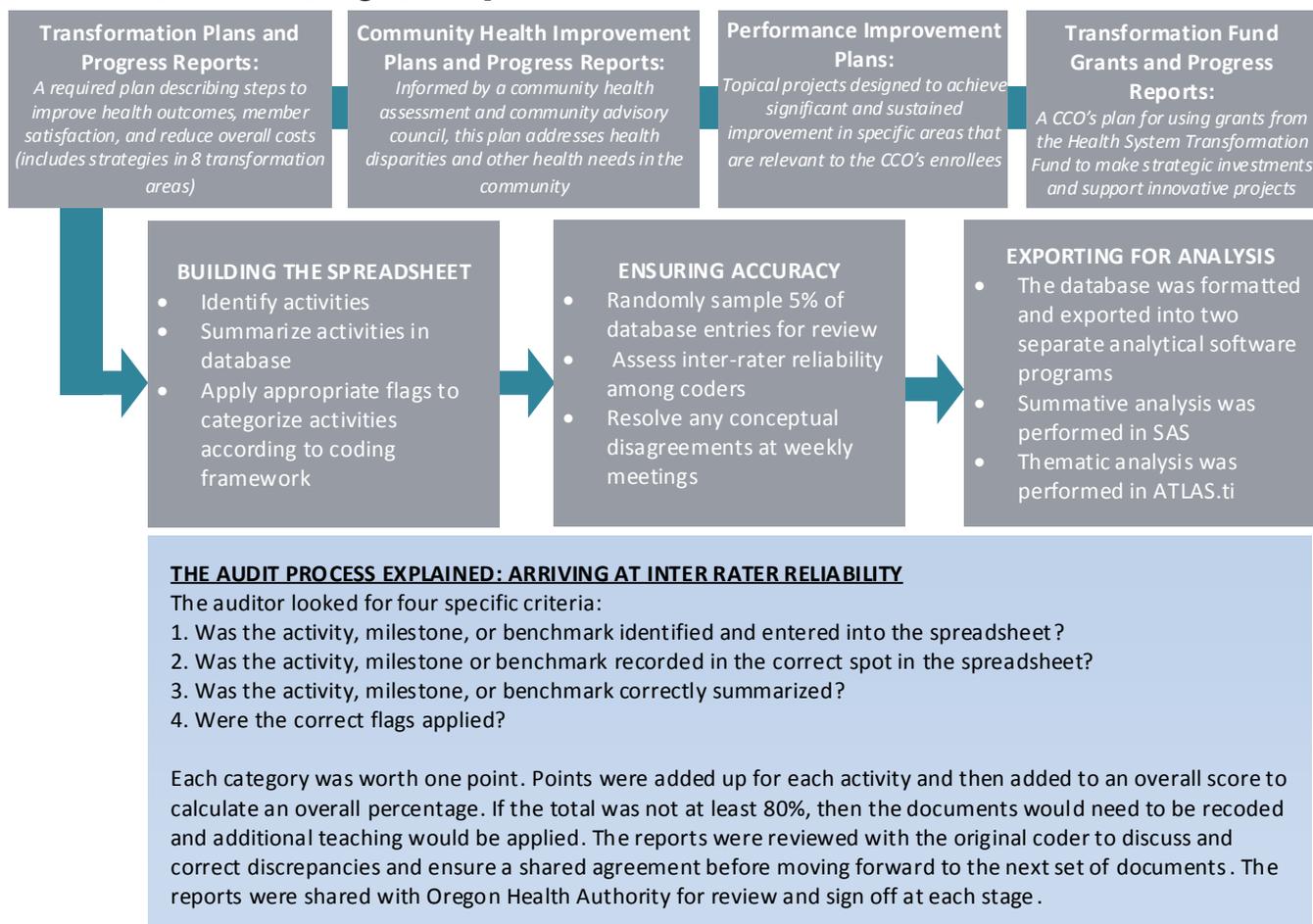
TRANSFORMATION AREA	DEFINITION
INTEGRATION	Developing and implementing a health care delivery model that integrates mental health and physical health care and addictions and dental health, when dental services are included. This area of transformation must specifically address the needs of individuals with severe and persistent mental illness.
PATIENT-CENTERED PRIMARY CARE HOMES	Continuing implementation and development of Patient-Centered Primary Care Home (PCPCH).
ALTERNATIVE PAYMENT METHODOLOGIES	Implementing consistent Alternative Payment Methodologies that align payment with health outcomes.
COMMUNITY HEALTH ASSESSMENT & COMMUNITY HEALTH PLAN	Preparing a strategy for developing Contractor’s Community Health Assessment and adopting an annual Community Health Improvement Plan consistent with SB 1580 (2012), Section 13.
HEALTH INFORMATION EXCHANGE	Developing a plan for encouraging Electronic Health Records, health information exchange, and meaningful use.
COMMUNICATIONS, OUTREACH, MEMBER ENGAGEMENT	Assuring Communications, Outreach, Member Engagement, and Services are tailored to cultural, health literacy, and linguistic needs.
MEETING MEMBERS CULTURALLY DIVERSE NEEDS	Assuring that the culturally diverse needs of Members are met (Cultural Competence training, provider composition reflects member diversity, non-traditional health care workers composition reflects member diversity).
ELIMINATING HEALTH DISPARITIES	Developing a Quality Improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes.

FROM NARRATIVE TO NUMBERS: THE CODING PROCESS

WHAT DOCUMENTS DID WE CODE AND HOW DID WE CODE THEM?

Using the framework described on the previous page, text-based CCO documents were synthesized into a single spreadsheet that includes numeric flags for simplified sorting and querying and parsimonious descriptions of activities and their associated efforts. This process is detailed in Figure 3 below.

FIGURE 3. Workflow: A Coding Roadmap



HOW DID WE PERFORM THE ANALYSIS FOR THIS REPORT?

CRUNCHING THE NUMBERS: Summative content analysis (counting, comparison, and interpretation of coded text) was done using Statistical Analysis System (SAS). SAS allowed us to write code to apply different lenses and layers to the data. We analyzed the patterns of activities both across and within CCOs.

TRACKING THE THEMES: Weekly team meetings were held to discuss emergent themes. To maximize the effectiveness of this process, coding was divided amongst coders by CCO so that within- and across-organizational patterns were observable. Detailed notes were recorded during meetings and once coding was complete, these notes were organized and entered into ATLAS.ti for analysis. Additionally, the spreadsheet with text-heavy columns were entered into ATLAS.ti for analysis. In particular, barriers to transformation efforts were reviewed and coded for high-level themes we observed and feel might be of use to help guide future CCO effort within Oregon and beyond.

STATEWIDE EFFORTS: TRANSFORMATION ACROSS THE STATE

MEASURING TRANSFORMATION

To provide an overview of statewide transformation efforts represented in the documents, we relied on a combination of codes that identified what types of transformation areas CCO activities were directed toward: transformation areas; and domains. We focused specifically on *planned* activities specifically stated in Transformation Plan amendments, and some of these activities could also be found in Community Health Improvement Plans, Transformation Fund Grant reports, or Performance Improvement Plans. To measure transformation, we:

- Counted the number of planned activities across all CCOS (n=374).
- Categorized and counted the activities across the 8 transformation areas and across the 68 domains identified by OHA.

HOW IS THE EFFORT SPREAD ACROSS TYPES?

The table to the right represents the spread of planned activities across transformation areas.

- Activities are spread fairly evenly across 6 of 8 transformation areas.
- Of all Transformation Area activities, Integration and Communication, Outreach, and Member Engagement were the most commonly planned activities.
- PCPCH and CHA & CHIP was the least commonly planned transformation area.

Statewide Planned Activities by Transformation Area

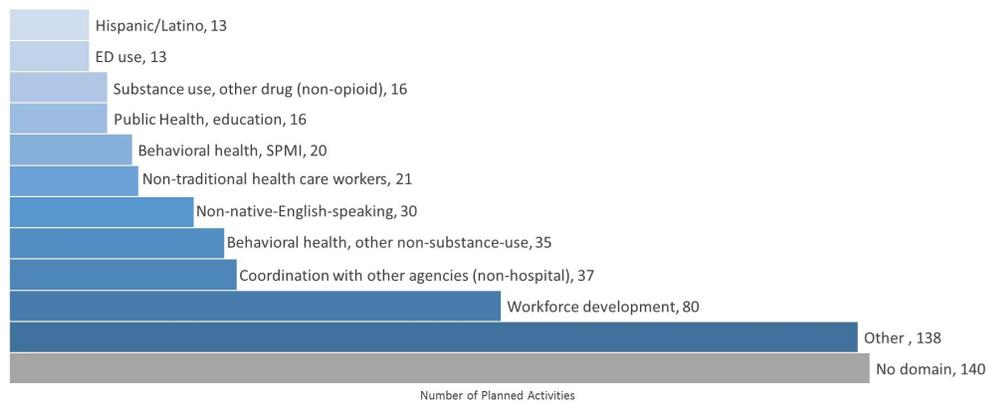
Transformation Area	# of Planned Activities
Integration	79
Communications, Outreach, and Member Engagement	53
APM	44
Meeting Members Culturally Diverse Needs	42
HIT	42
Eliminating Health Disparities	39
CHA and CHIP	38
PCPCH	37

DOMAINS ACROSS THE STATE

We conducted an identical analysis for Domains across activities and the 10 most common domains for planned activities are indicated below:

- There were 80 Workforce development associated activities (which represents almost a fifth of all planned activities across the state).
- Coordination with non-hospital organizations represented 10% of all planned activities.
- There were 13 domains that only had one associated planned activity (these were combined into the “Other” category with 138 activities). These domains were primarily related to public health, social determinants of health, tele-health, flexible services, and specific populations (rural and LGBTQ).
- 140 activities did not have an associated domain. These activities were typically focused on less direct-care and more technically oriented, like APM or HIT.

Top 10 Most Common Domains for Planned Activities



KEY TAKEAWAYS: There appears to be a fairly even spread of activities across most transformation areas. Integration is the most prominent transformation area. Document analysis leads us to believe that after formation, CCOs tackled integration first, before taking on another transformation areas, perhaps explaining why so many activities are concentrated there. The prevalence of workforce development activities indicates that health care transformation requires new staff and new skillsets. CCOs are focusing their attention on developing a new workforce, suggesting that CCOs are attempting to do things differently—an authentically transformative effort. The 13 domains with only one planned activity for each may speak to either difficulty in addressing that specific domain or regionalized focus areas for specific CCOs.

INDIVIDUAL VISION & EFFORT OF COORDINATED CARE ORGANIZATIONS

MEASURING OVERALL EFFORT

In total, *we coded 2,659 distinct activities* across all 16 Oregon CCOs. To assess overall CCO vision versus CCO concrete activities we compared non-planned and planned activities by counting:

- The number of activities each CCO indicated they planned on engaging in.
- The average number of activities associated with any given transformation area.
- The average number of activities associated with any given domain.
- The number and percentage of activities that were planned as identified in the Transformation Plan reports.

WHAT WE FOUND

- CCOs varied widely in the number of activities presented across all reports.
- There was variation in the percentage of activities that were incorporated into CCO's contracts. As an example, while one CCO legally contracted just under half of their activities, others contracted less than 5% of all activities.
- On average, each activity was related to one transformation area and domain. More detail on cross-cutting activities can be found in the following pages.

TABLE 1. Activities, Domains, and Transformation Areas Within Each CCO

COORDINATED CARE ORGANIZATION	CCO Activities (Overall #)	Activities that were planned (#)	Proportion of activities planned (%)	Transformation Areas Per Activity, based on all activities	Domains Per Activity, based on all activities (Mean)
AllCare Health Plan	173	8	5%	1.23	0.88
Cascade Health Alliance	112	19	17%	1.27	1.14
Columbia Pacific CCO	123	20	16%	1.15	1.41
Eastern Oregon CCO	175	40	23%	1.22	1.05
FamilyCare, Inc.	84	26	31%	1.19	1.15
Health Share of Oregon	125	19	15%	1.78	1.17
Intercommunity Health Network CCO	131	19	15%	1.25	1.08
Jackson Care Connect	137	62	45%	1.21	1.37
PacificSource Community Solutions: CO	488	17	3%	1.21	0.98
PacificSource Community Solutions: CG	201	15	7%	0.98	0.84
PrimaryHealth of Josephine County	122	28	23%	1.22	0.93
Trillium Community Health Plan	182	11	6%	1.25	1.13
Umpqua Health Alliance	63	24	38%	1.14	0.97
Western Oregon Advanced Health	258	10	4%	1.04	0.97
Willamette Valley Community Health	78	10	13%	1.13	1.09
Yamhill Community Care Organization	197	46	23%	1.61	1.64

KEY TAKEAWAYS: It is clear from the large number of overall activities listed that some CCOs have a large, transformative vision for their organization. However, the proportion of activities that were planned (legally contracted) demonstrates how challenging it can be to operationalize that kind of transformation. We explore the type, success, and breadth of planned activities in more detail in the following pages.

SCOPE OF ACTIVITIES ACROSS CCO POPULATIONS

MEASURING SCOPE OF ACTIVITIES

We wanted to know how far transformation activities are actually reaching: In general, are activities wide-reaching or targeting a specific area or population? We organized planned activities by the target population they were intended to impact. When applicable, activities were subject to two levels of categorization:

- Population - Did the activity target the CCO's entire population or a specific subset, such as diabetics or high-utilizers?
- Geography - Did the activity target the CCO's entire service area or a smaller geography?

To accomplish this, we first counted the number of planned activities within each transformation area, and then within each area, we aggregated activities by scope (population and geography).

WHAT WE FOUND

- As seen in the below, CCOs often did not specify the scope of their activity, thus there are a high number of Unknown for both scopes especially for APM, CHA & CHIP, and HIT. Our suspicion is that these activities refer to broad populations and regional geographic scopes, which suggests that the split between broad and targeted are even greater than what is reflected in the table.
- Broad initiatives outweigh targeted ones across almost all transformation areas.
- The majority of planned activities related to PCPCH and Eliminating Health Disparities had a broad population and regional geographic scope, while about half of Integration activities had defined population scope.
- Overall, about half of all transformation area activities fell into regional geographic scope, depicting the wide-angle view of many contracted activities.

TABLE 2. Scope of Activities Across All CCOs

SCOPE:		Transformation Areas								
								Communications, Outreach, Member Engagement	Meeting Members Culturally Diverse Needs	Eliminating Health Disparities
Population	All Planned Activities	Integration (n=79)	PCPCH (n=37)	APM (n=44)	CHA & CHIP (n=38)	HIT (n=42)				
Broad Population Scope (%)	20%	19%	49%	18%	8%	12%	21%	7%	49%	
Defined Population Scope (%)	25%	48%	8%	5%	0%	5%	32%	26%	8%	
Unknown Population Scope (%)	55%	33%	43%	77%	92%	83%	47%	67%	43%	
Geographic										
Regional Geographic Scope (%)	54%	54%	68%	41%	50%	60%	58%	45%	56%	
Targeted Geographic Scope (%)	14%	23%	32%	11%	0%	10%	8%	5%	21%	
Unknown Geographic Scope (%)	32%	23%	0%	48%	50%	31%	34%	50%	23%	

KEY TAKEAWAYS: Overall, CCOs tended to engage in activities that have a broad reach throughout their service area. It is likely that CCOs focused the majority of activities on the larger populations, both demographically and geographically. There were many times that CCOs did not specify the scope of their contracted activities.

CROSS CUTTING ACTIVITIES ACROSS TRANSFORMATION AREAS

MEASURING BREADTH OF ACTIVITIES

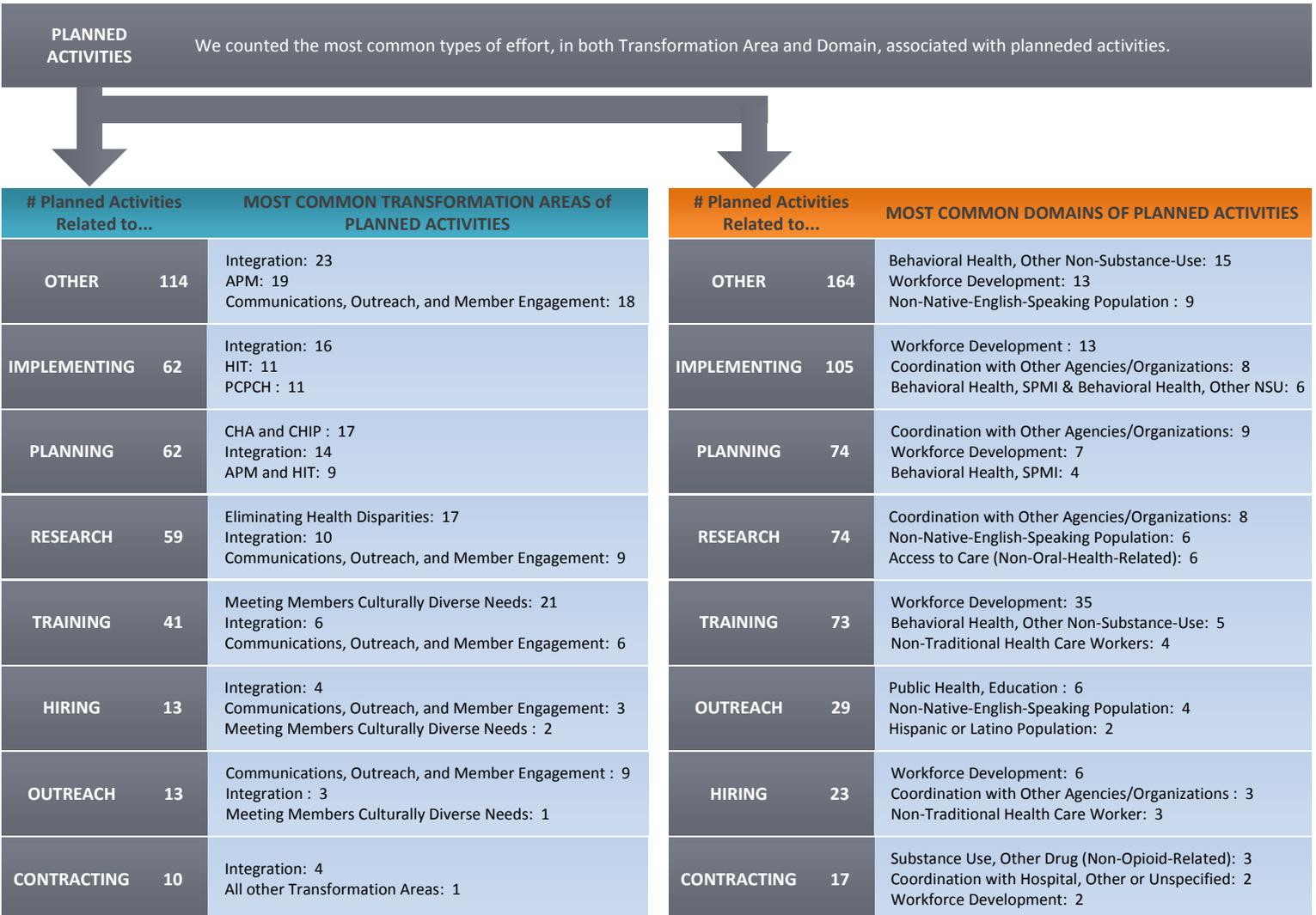
We wanted to understand how CCOs were operationalizing transformation within specific domains or transformation areas. To do this we:

- Counted the number of domains and transformation areas associated with a given activity type for planned (legally contracted) activities.
- Identified the top 3 most common domains and transformation areas associated with an activity type.

WHAT WE FOUND

- Across almost all transformation areas, CCOs engaged in a breadth of activities (with the exception of outreach, which was only cited as an activity within 3 transformation areas shown).
- Implementation, Planning, and Research were the most commonly contracted activities (62, 62, 59, respectively).
- There were many activities that did not have an associated activity type for both Transformation Areas and Domains (114 and 164 respectively). These were generally too vague to define or too technical to be captured by the activity types.

FIGURE 4. Activities and Domains Across Transformation Areas



KEY TAKEAWAYS: CCOs needed a wide range of activities to tackle a wide range of transformation. This might have implications for how CCOs hire and support staff to carry out transformation activities.

ACHIEVEMENTS BY MILESTONES & BENCHMARKS

MEASURING SUCCESS OF ACTIVITIES

Among all documented activities across all CCOs, 333 had explicit milestones and 207 had benchmarks that were part of CCO contracts. We wanted to know how successful CCOs were at achieving activities devoted to certain areas of transformation.

To do this, we analyzed contracted activities that had associated measures of progress (meeting a milestone) and eventual success (meeting a benchmark). In other words, we:

- Counted the number of milestones associated with a given transformation area.
- Calculated the percentage of milestones that were met within that area.
- Counted the number of benchmarks associated with a given transformation area.
- Calculated the percentage of benchmarks that were met within that area.

WHAT WE FOUND

- 273 of 334 milestone activities were achieved among all transformation areas.
- 135 of 209 benchmark activities were achieved among all transformation areas.
- CHA & CHIP had highest success rates for completion of milestones and benchmarks.
- Meeting Members Culturally Diverse Needs and Eliminating Health Disparities has the lowest success rate with less than half benchmarks being met.
- Top domains across contracted milestones and benchmarks are relatively similar.

TABLE 3. Milestone and Benchmark Achievement by Transformation Area

Transformation Area	Planned Milestones (#)	Milestones Met by Milestone Report (%)	Milestones Met by Benchmark Report (%)	Planned Benchmarks (#)	Benchmarks Met by Benchmark Report (%)
CHA & CHIP	31	84%	100%	22	91%
HIT	37	78%	92%	21	81%
Communications, Outreach, Member Engagement	50	60%	74%	26	65%
PCPCH	36	83%	89%	21	71%
Integration	71	52%	80%	44	66%
APM	38	45%	74%	26	65%
Eliminating Health Disparities	35	46%	74%	28	46%
Meeting Members Culturally Diverse Needs	36	61%	78%	21	33%

KEY TAKEAWAYS: Meeting Members Culturally Diverse Needs and Eliminating Health Disparities are not mutually exclusive constructs and it is therefore not surprising that they appear on the bottom rungs together. This indicates that there might be an opportunity for OHA to better support CCOs in catering to a more diverse member population. Further, more milestones were met than benchmarks. That benchmarks appear to be more challenging to achieve could be attributable to a number of factors, but it is possible that standards need recalibration.

ACHIEVEMENTS BY MILESTONES & BENCHMARKS

MILESTONE ACTIVITIES CATEGORIZED BY DOMAIN

Workforce Development had the most (72) associated milestones. However, Black or African American Population and Trauma-Informed Care had the most success, but with the fewest number of associated activities. With five planned milestones, the Adolescent domain saw the least successful completion with only 40% of related milestones being met. There were 78 milestones that were not met by the milestone report, but then completed by the benchmark report, and 56 uncompleted milestones.

TABLE 4. Milestone Achievement by Domain

TOP DOMAINS FOR MILESTONES		Milestone Activities (#)	Milestones Met by Milestone Report (%)	Milestones Met by Benchmark Report (%)
1	Workforce Development	72	71%	83%
2	Coordination with Other Agencies or Organizations	34	50%	79%
3	Behavioral Health, Other-Non-Substance-Use	29	72%	83%
4	Non-Native-English Speaking Population	28	61%	93%
5	Non-Traditional Health Care Workers	19	68%	84%
BOTTOM DOMAINS FOR MILESTONES				
16	Coordination with Hospital, Other or Unspecified	5	60%	60%
17	Coordination with Hospital, Overall Goals and Strategy	5	80%	80%
18	Adolescents	5	20%	40%
19	Black or African American Population	5	80%	100%
20	Trauma-Informed Care or Trauma-Informed Services	4	100%	100%

BENCHMARK ACTIVITIES CATEGORIZED BY DOMAIN

As seen for milestones, Workforce Development had the most associated planned benchmarks. However, Public Health Education, Coordination with Hospital (other), and American Indian or Alaska Native Population had the most success (all completed benchmark activities). Oral Health (other) domain presented the greatest challenges, completing only one-third of contracted benchmarks.

TABLE 5. Benchmark Achievement by Domain

TOP DOMAINS FOR BENCHMARKS		Benchmark Activities (#)	Benchmark Activities Met (%)
1	Workforce Development	33	67%
2	Coordination with Other Agencies or Organizations	18	72%
3	Behavioral Health, Other-Non-Substance-Use	16	75%
4	Non-Native-English Speaking Population	16	94%
5	Public Health, Education	9	100%
BOTTOM DOMAINS FOR BENCHMARKS			
16	Coordination with Hospital, Other or Unspecified	3	100%
17	Coordination with Hospital, Overall Goals and Strategy	3	67%
18	Oral Health, Other	3	33%
19	Behavioral Health, Depression	3	67%
20	American Indian or Alaska Native Population	3	100%

KEY TAKEAWAYS: Top domains across planned milestones and benchmarks are relatively similar. When broken down by domain, CCOs appear more successful at meeting both milestones and benchmarks. This suggests that there were successes within transformation areas that were obscured by the broadness of the transformation area definitions. Overall, there is success across transformation areas, however, it is not uniform.

IDENTIFYING MAJOR BARRIERS: A THEMATIC ANALYSIS

UNDERSTANDING CHALLENGES

In addition to implementing the OHA coding framework, we reviewed the barriers section of each document that we coded to analyze it for common themes around challenges across all activities, domains, and transformation areas. All activities were included in this analysis. Our analysis revealed the following patterns of obstacles to success:

1. PROVIDER AND OTHER WORKFORCE CAPACITY: Unsurprisingly, a consistent barrier was the capacity of the current workforce to take on activities. CCOs cited general understaffing (particularly associated with the increased patient load due to expansion), reporting burden, and turnover as barriers to a variety of different efforts.

What remains unclear is whether or not CCOs are currently self-correcting— as our previous results indicate that most work is going into workforce development. It remains to be seen if this focus on workforce development might be a reaction to provider/other workforce constraints, or if the workforce constraints might be persisting in spite of the focus on workforce.

“Shortage of primary care physicians and psychiatrists. Assignment to PCP is difficult for 32,000 new members. Workload is intensive, monitoring outcomes is difficult, Cost of change exceeds payment, and telemedicine approaches have yet to be developed.”

2. WORKING WITH THE MEDICAID POPULATION: CCOs appear to have become increasingly aware of the all-around complexities in working with the Medicaid population that stretches beyond medical conditions. Issues around low take-up of programs, appointment compliance, and being able to effectively outreach cut across activities, domains, and transformation areas.

New patients seem to have “limited patient motivation to participate. High cancellation rate. Majority patients lack pre-existing relationship with pharmacy provider.”

3. DATA: CCOs struggled with data—claims fell short in helping CCOs identify subpopulations for a targeted program, or it was difficult to tell whether or not their efforts were having any impact. CCOs felt that was a gatekeeper for some population-level data, particularly data regarding basic demographics of the CCO service area.

“Population data on the Medicaid population is limited. Difficult to draw reliable conclusions about health disparities. Also, race/ethnicity data, in particular, was not collected consistently prior to the implementation of the CCO.”

4. FUNDING: Funding constraints were a common barrier for many CCOs. They cited this for a variety of activities including PCPCH certification, staff training, member outreach, provider and staff hiring, etc.

“Transformation requires practices to make financial investments that in many cases are beyond their abilities. “

5. LACK OF GUIDANCE: CCOs felt adrift at times, unsure of how to approach the task of transformation. However, this challenge was mitigated by the fact that many CCOs made use of their innovator agents.

“We need additional guidance from OHA so that we can appropriately implement the alternate payment methodology for hospitals moving off of cost base reimbursement.”

6. COLLABORATION: Collaborating with other organizations was also a commonly cited barrier: things like the time it takes to build inter-organizational trust and getting stakeholder buy-in were key issues. Yet that these issues presented at all suggests that CCOs are making deliberate attempts to move beyond their own walls to more effectively deliver care.

“Six months of startup time was needed to build relationships with partners” and “recruiting was more difficult without established program in place. Three distinct and complex partners made meetings and communication challenging.”

CONNECTING TRANSFORMATION DATA: THE SIM EVALUATION

STATE INNOVATION MODEL (SIM) EVALUATION REFRESHER

This past fall, using a tool developed in partnership with CORE, OHA, and key stakeholders, we assessed Oregon’s status across 11 key domains of health care transformation, both in total and for distinct types of health care organizations. We compared CCOs with other payers and provider organizations to determine how transformation efforts are spreading. Another round of SIM data collection is scheduled for Spring 2016.

The Transformation Domains used to evaluate spread in SIM are similar to Transformation Areas used in the report. We looked for crossover between the datasets to see if additional information from either could help explain findings in the other.

Below are our SIM findings and associated Transformation Areas from this report.

WHAT WE FOUND

- CCOs led the way in community engagement, but not necessarily in integrated care—health plans and providers have also been working hard to create integrated care, and their efforts are apparent in their scores.
- CCOS scored lower on financial domains than other payers and providers

SIM Domain	SIM Statewide Score* (N = 103)	Transformation Area of Planned Activities	% of Planned Activities (N = 374)
Integrated Care Models	7.4	Integration	21
		Communications, Outreach, and Member Engagement	14
Ownership of Risk	5.0	Alternative Payment Models (APMs)	12
Integrated Risk	4.6		
Aligning Incentive and Value	4.4		
Integrated and Shared Health Care Data	6.2	Health Information Technology (HIT)	11
Data for Population Health Management	4.0		
Workforce Transformation	4.0	Meeting Members' Culturally Diverse Needs	11
Better Care Coordination	7.2	Patient Centered Primary Care Home (PCPCH)	10
Prevention and SDH-Informed Care	5.2	Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP)	10
		Eliminating Health Disparities	10

*Scores (0-10, 10=most transformed)

CONNECTING THE DOTS

Findings from the document analysis provides some answers and raises some questions. Consider:

- The document analysis revealed that CCOs did not make any huge pushes around APM, which implies their lag behind other organizations is not necessarily a failure, but that they did not make it a priority and focused on other aspects of transformation instead. Data for population health management was a challenge in the SIM Evaluation similarly to the Transformation Activities, and data is closely tied to APMs, which may have been a contributing factor leading to lower APM transformation scores.
- CCOs were initiating more transformation than other types of organizations on community engagement, but document analysis underscored that there were difficulties meeting milestones and benchmarks related to culturally diverse populations. We suspect that there is still significant room for improvement in this domain.
- Further, CCOs had a fairly low score (4.0) in the workforce transformation domain, but workforce development is one of the most common activities in these documents for most of the organizations. Thus, we should consider this a domain of interest for the next round of surveys now that we know they are investing a lot of resources in this area.

ALLCARE TRANSFORMATION PROFILE

SUMMARY

AllCare CCO's origin is rooted in an Independent Physician Association (IPA) in Josephine and Jackson County. The CCO has since expanded to include Curry and Southern Douglas Counties and serves more than 27,000 Medicaid and Medicare eligible members. AllCare used transformation funds to focus on developing and implementing innovative payment models, funding mental health and addictions staff, establishing stakeholder committees, training community health workers, increasing the number of state recognized PCPCHs within the CCO region, and measuring patient satisfaction.

TRANSFORMATION AREAS & DOMAINS

AllCare Transformation Areas

Transformation Area	# of Planned Activities
Communications, Outreach, and Member Engagement	1
HIT	1
Integration	1
PCPCH	1
APM	1
Eliminating Health Disparities	1
CHA and CHIP	1
Meeting Members Culturally Diverse Needs	1

TRANSFORMATION AREAS: ALLCARE'S EVEN SPREAD

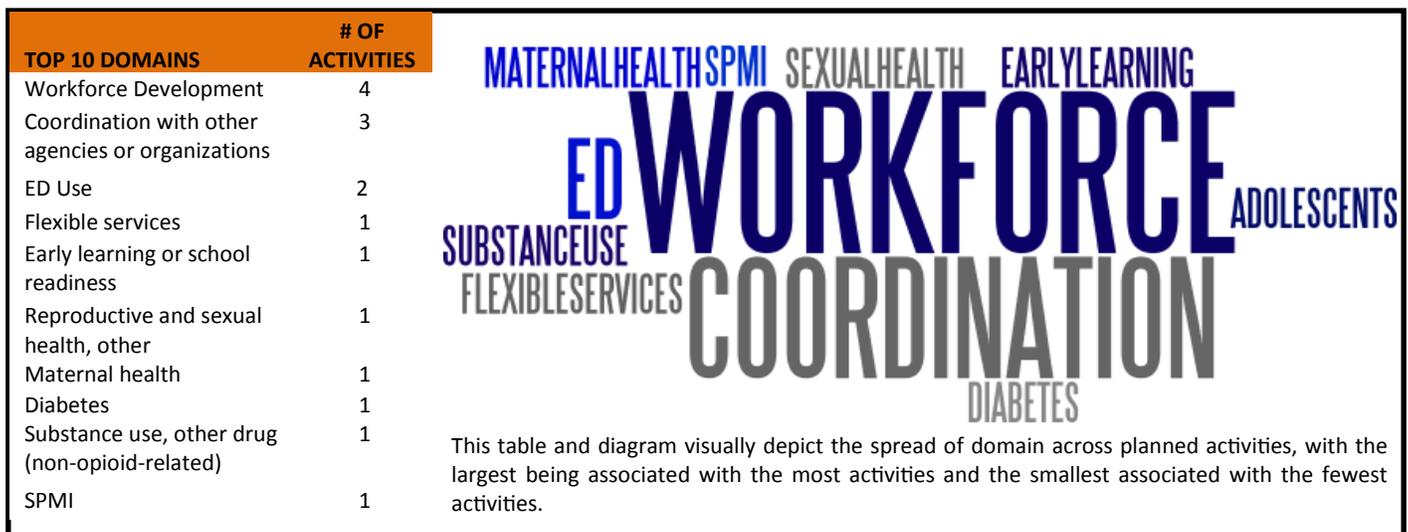
AllCare's planned activities across each transformation area were aggregated using summative content analysis to determine where efforts were focused. The table to the left displays the spread of planned activities across transformation areas.

- AllCare had 8 total planned activities (either a milestone or a benchmark).
- AllCare spread activities evenly over all transformation areas—they had one planned activity for each transformation area.

DOMAIN AREAS: EMPHASIZING DEVELOPMENT & COORDINATION

Domains associated with each activity were counted utilizing summative analysis. There was a clear pattern of focus on certain areas, depicted in the figure below. AllCare's transformation efforts were focused mainly on workforce development and coordination with CBOs and other organizations (non-hospital). Other domains of interest, but not limited to, included emergency department use (ED use), flexible services, and early learning or school readiness. AllCare did have one activity without an associated domain.

The table and diagram visually depict the spread of domain across planned activities, with the largest being associated with the most activities and the smallest associated with the fewest activities.



GOAL ACHIEVEMENT & BARRIERS TO SUCCESS

Transformation Plan Reports

AllCare met nearly all of its contracted transformation goals and activities. They achieved particular success with Integration, PCPCH, APM, CHA and CHIP, HIT, and Eliminating Disparities. A select few are described below:

- **APM:** Implemented pilot projects providing shared savings incentives tied to access, utilization, and quality measures. Participating physicians received shared savings from reduced emergency department (ED) use resulting from improved primary care access, utilization, and quality measures. The cost of ED use was reduced from \$11.17 per member per month (PMPM) to \$10.58 PMPM which amounted to \$0.59 PMPM savings.
- **Integration:** Identified 75 members who were diagnosed with both SPMI and diabetes. Utilizing recently hired care coordinators, 54 (72%) of the 75 identified members received both LDL and HbA1C screening.
- **PCPCH:** As of the Benchmark report, AllCare increased the number of members engaged with a PCPCH, to 74%, an improvement of 14% since 2013.

Other Reports

AllCare completed a Community Health Improvement Project (CHIP), which was divided into three areas: Healthy Beginnings, Healthy Living, and Health Equity.

- **Healthy Beginnings** included activities related to Early Learning Hubs, awareness of adverse childhood events (ACEs), healthy food and physical activity, gardening, oral screenings and dental sealants. To achieve their goals they collaborated with community organizations including YMCA, community gardens, farms, Oregon State University, and Boys and Girls Club.
- **Healthy Living** focused on proper opioid prescribing, mental health integration, and projects relating to built environment. This project area led to the development of an aquatic center in Brookings, OR.
- **Health Equity** projects included a youth summit on homelessness, a grant for housing programs, food bank support, Veggie Rx, Farmer's market vouchers, medical interpretation, scholarships for community health worker education, data collection related to health disparities, non-emergent transportation resources, and expansion of oral health service in Curry County.

Barriers Across All Reports

AllCare demonstrated difficulty in meeting milestones and benchmarks related to Communications, Outreach, and Member Engagement and Meeting Members Culturally Diverse Needs. The CCO cited staffing issues, brief timelines, physician time, and lack of user-friendly training resources as major barriers to being able to provide culturally competent training.

OTHER OBSERVATIONS & CONCLUSIONS

The transformation reports AllCare submitted were often inconsistent when indicating outcome and percentages (particularly with APM data), and varied across reports. There was also a lack of consistency relating to activities noted in the proposal versus subsequent progress reports. It is interesting to note that AllCare demonstrated the same activity/milestone/benchmark as Cascade Health Alliance CCO for TA #1, Integration.

In a general sense, AllCare CCO included a high level of detail pertaining to their activities and the resulting outcomes, and succeeded in meeting many of their goals.

MILESTONES MET

75%

6 of 8

BENCHMARKS MET

75%

6 of 8

CASCADE

TRANSFORMATION PROFILE

SUMMARY

Cascade Health Alliance (CHA) serves members in Klamath County, the fourth largest county (geographically) in Oregon. The CCO faced many challenges, some pertaining to geographical size as well as staffing. CHA has not submitted all transformation documents, and the information in this report is limited to the narrative, milestone and second progress reports. CHA successfully made progress on transformation activities relating to shared savings payment methodology, developing and maintaining a Community Advisory Council (CAC), completing a Community Health Improvement Project (CHIP), increasing use of the regional Health Information Exchange, and developing a Spanish version of member materials.

TRANSFORMATION AREAS & DOMAINS

Cascade Transformation Areas

Transformation Area	# of Planned Activities
Communications, Outreach, and Member Engagement	6
CHA and CHIP	4
Eliminating Health Disparities	3
APM	2
HIT	1
Integration	1
PCPCH	1
Meeting Members Culturally Diverse Needs	1

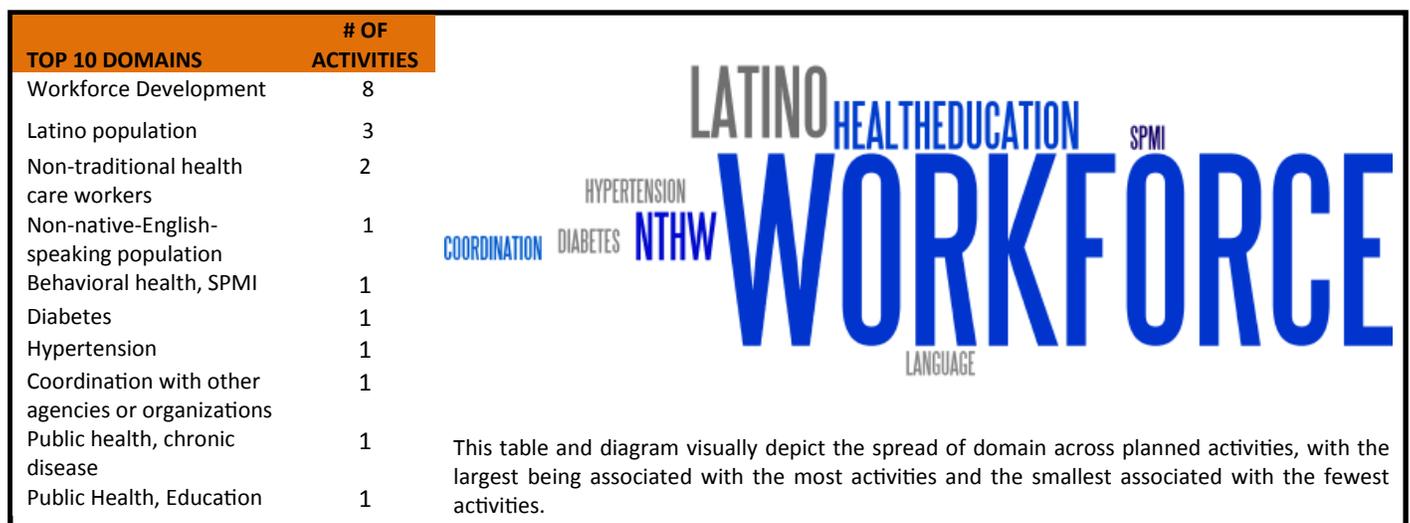
TRANSFORMATION AREAS: MEMBER-CENTERED

Cascade’s planned activities across each transformation area were aggregated using summative content analysis to determine where efforts and resources were focused. The table to the left displays the spread of planned activities across transformation areas.

- Cascade had a total of had 19 total planned activities (either a milestone or a benchmark).
- Cascade focused almost two-thirds of their efforts on member-focused areas: Communications, Outreach, and Member Engagement (32%), CHA and CHIP (21%), and Eliminating Health Disparities (16%).
- There was a lesser focus on more technical areas: HIT (5%), Integration (5%), and PCPCH (5%).

DOMAIN AREAS: EMPHASIZING DEVELOPMENT & HISPANIC/LATINO POPULATION

We also utilized summative analysis to count the types of domains associated with each activity. This time, there was a clear pattern of focus on certain areas, depicted in the figure below. Cascade’s transformation efforts were overwhelmingly targeted to workforce development. Further, they made significant investment in their Hispanic or Latino population and non-traditional health workers. Public health areas and coordination activities were of lesser focus. Cascade had seven activities without an associated domain.



GOAL ACHIEVEMENT & BARRIERS TO SUCCESS

Transformation Plan Reports

CHA met seven of their 16 planned benchmarks, leaving nine benchmarks unmet. A few of the successful benchmark activities were:

- **Communications, Outreach, and Member Engagement:** Spanish translation of member materials, development of cultural competency training for all CHA staff, and launching of the “Healthy Klamath” website.
- **CHIP:** Completion of a Community health Assessment Plan and established a Community Advisory Council (CAC) that meets regularly.

Milestones Met

54%

7 of 13

Other Reports

The Community Health Improvement Plan (CHIP) focused on three main areas of improvement: 1) healthy eating and active living, 2) social and mental well-being, and 3) transportation. A few of the major outcomes of the CHIP were:

- Distribution of YMCA punch cards.
- Tobacco cessation specialist training.
- Non-traditional health worker (NTHW) and case manager hired.
- Purchase of a case management program (Essette).
- Assembled adolescent residential program and respite care, made possible through a collaboration with Klamath basin.

Benchmarks Met

44%

7 of 16

Transformation grant funds (TFG) were applied to various unrelated projects.

- The first project aimed at implementing an **HIE** in which 495 providers and 91 clinics are currently enrolled.
- A program director and three community health workers were hired for targeted public health intervention. Over 100 members have been enrolled in this program.
- A mobile crisis team was established and in the first three months responded to 256 calls. The crisis team has assisted in averting crisis ED visits, which were reduced from 61 to 25 visits in three months.
- Lastly, In conjunction with the CHIP, a 12-bed local residential youth program was developed for youth in custody of DHS who have debilitating psychosocial, emotional, and behavioral disorders in an effort to keep them from being transported out of the area.

Barriers Across All Reports

The most frequently mentioned barriers throughout all reports were lack of staffing support and limited funding sources. Possibly due to the large geographical area and low population density, CHA struggled with staffing issues in many transformation areas. The CCO unsuccessfully attempted to hire and maintain additional bilingual staff, translators, quality improvement specialists, NTHWs, as well as member recruitment for the CAC. Financial barriers were identified in PCPCH, APM, CHIP, and Integration activities.

OTHER OBSERVATIONS & CONCLUSIONS

CHA struggled to meet milestones and benchmarks within most of the transformation areas. Multiple reports were not submitted, and there was a lack of consistency and clarity within and between each transformation report. Progress toward non-contracted activities listed in the narrative was not discussed in successive reports. Some transformation areas had duplicated milestones and benchmarks (PCPCH & APM), neither of which were met.

The CHIP, written by members of the CAC, was the most informative, organized, and precise document produced by CHA. The CHIP, in addition to TFG activities, resulted in producing tangible outcomes, indicated earlier in this report.

Overall, CHA met very few of their transformation plan contracted milestones and benchmarks and were missing multiple reports. In spite of these losses, CHA made significant progress with CHIP goals.

COLUMBIA PACIFIC

TRANSFORMATION PROFILE

SUMMARY

Columbia Pacific CCO (CPC) serves the four-county region of Clatsop, Columbia, Tillamook, and Douglas counties, with over 14,000 enrolled members. The CCO is contracted with 24 primary care clinics, 10 mental health and addiction sites, and four critical access hospitals within the area. Transformation activities were informed by claims data, indicating that opportunities for intervention included chronic pain and opioid dependence, diabetes, pediatric primary care, and health equity among the Hispanic population in addition to members with low-income.

TRANSFORMATION AREAS & DOMAINS

Columbia Pacific Transformation Areas

Transformation Area	# of Planned Activities
PCPCH	4
Communications, Outreach, and Member Engagement	3
HIT	3
Integration	3
Meeting Members Culturally Diverse Needs	3
APM	2
Eliminating Health Disparities	1
CHA and CHIP	1

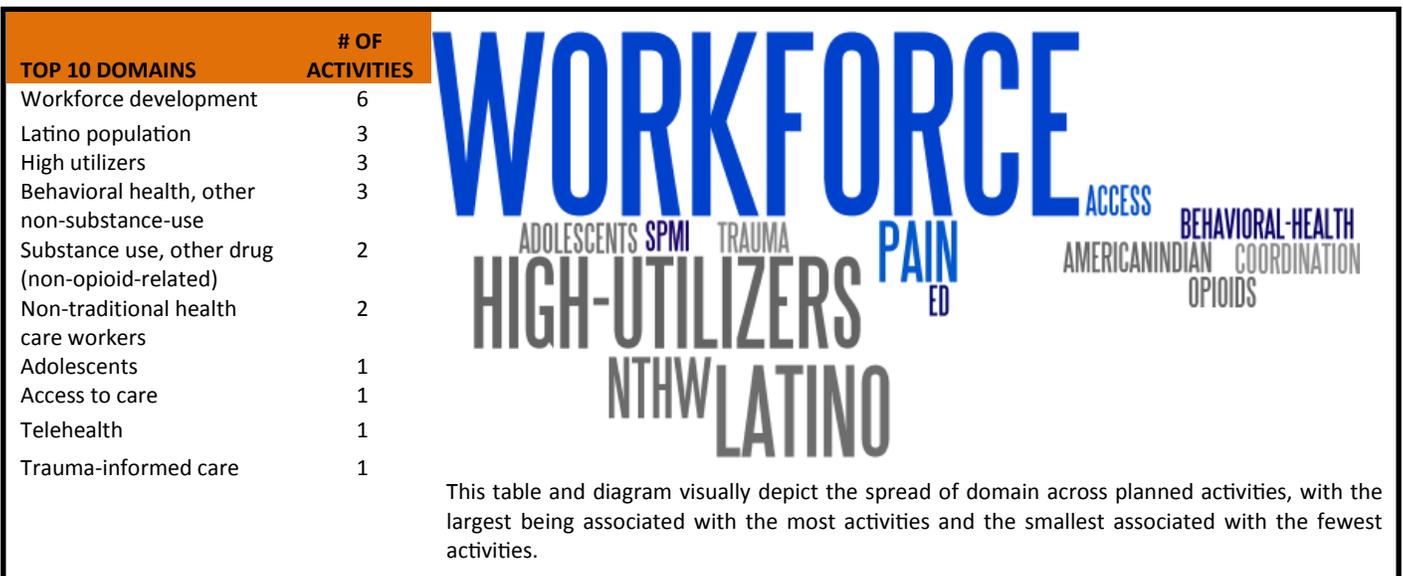
TRANSFORMATION AREAS: COMMUNICATIONS & TECHNOLOGY FOCUS

Columbia Pacific’s planned activities across each transformation area were aggregated using summative content analysis to determine where efforts and resources were focused. The table to the left displays the spread of planned activities across transformation areas.

- Columbia Pacific had 20 planned activities (either milestones or benchmarks).
- Although a fifth of their efforts were focused on PCPCH, over half were related to communication/technology improvements: Communications, Outreach, and Member Engagement (15%), Integration (15%), Meeting Members Culturally Diverse Needs (15%), and HIT (15%).
- They focused less on Eliminating Health Disparities (5%) and CHA and CHIP (5%) activities.

DOMAIN AREAS: EMPHASIZING DEVELOPMENT & SPECIFIC POPULATIONS

Summative analysis was utilized to ascertain the various domains associated with each activity. There was a clear pattern of focus on certain areas, depicted in the figure below. Columbia Pacific made significant investment in workforce development, Hispanic or Latino populations, high-utilizers, and behavioral health (non-substance-use). Access to care, telehealth, and trauma-informed care were of lesser focus. Columbia Pacific had seven activities without an associated domain.



GOAL ACHIEVEMENT & BARRIERS TO SUCCESS

Transformation Plan Reports

Columbia Pacific CCO succeeded at implementing various projects to meet many of their contracted milestones and benchmarks. Particularly successful areas and activities include:

- **Integration:** co-location of behaviorists within all CCO primary care clinics.
- **APM:** alternative payment methodologies implemented among primary care providers, and capitation payments among behavioral health providers.
- **PCPCH:** increased the percentage of members assigned to Tier 3 PCPCH clinics to 73.6% by providing intensive technical assistance for key clinics.
- In addition, CPC developed an alternative pain management model for patients with complex co-morbid conditions thereby reducing the number of opioids prescribed. and implemented the use of peer navigators, care coordinators and non-traditional health workers (NTHW) to assist high-risk, high-utilizing members.

Milestones Met

90%

17 of 19

Benchmarks Met

71%

10 of 14

Other Reports

There were three health priorities included in the CHIP report - obesity, mental health, and substance abuse. Within the obesity priority there were 15 activities. A few examples of these are as follows: an Rx for Play pilot project that prescribed physical activity and provided members with an annual parks pass and a punch card for activities, a 2-day clinic for children ages 0-3 providing developmental screenings, medical, hearing and vision exams, and nutritional counseling, and partnership with Food Roots to engage low-income community members in Seed to Supper garden training series. Mental health had seven projects and substance abuse had five activities. These projects focused mainly on birth outcomes, substance abuse and addiction, outreach initiatives, mental health awareness, and adverse childhood events.

Transformation fund grant (TFG) activities were numerous (10). Some of the more significant projects completed were:

- a prescribing initiative including hiring of new pharmacy staff.
- SBIRT screening training for providers.
- developing a crisis respite.
- increasing detox capacity.
- implementing tele-medicine.
- community-wide Resilience Trumps ACEs training.
- staffing NTHW to address excessive and inappropriate ED use.

Barriers Across All Reports

General barriers cited among the various reports were lack of clinic leadership, competing priorities within clinics, lack of dedicated staffing, inability to gain necessary race/ethnicity data from OHA/state entities, and building trusting relationships within relatively small communities. Lack of staffing and leadership within clinics was cited multiple times throughout reports, in various transformation areas, and was by far the most common barrier.

OTHER OBSERVATIONS & CONCLUSIONS

Columbia Pacific's reports did not always follow the format of previous reports, and at times, appeared to have been written by multiple individuals. It wasn't always clear in the progress reports whether or not progress was made on a particular activity, and because of this, completion of particular benchmarks may be understated in this summary.

Based on analysis, Columbia Pacific developed and completed activities primarily within the coordination and workforce domains. Columbia Pacific had diversity among activities throughout reports, opting for many small pilot projects as opposed to only a few large projects. It was also observed that some activities were dovetailed with other reported activities, the opioid prescribing projects are a primary example. Overall, Columbia Pacific set clear, identifiable goals and succeeded in accomplishing many of their milestones and benchmarks.

EASTERN OREGON TRANSFORMATION PROFILE

SUMMARY

Eastern Oregon Community Care Organization (EOCCO) serves members of the Oregon Health Plan in 12 Oregon counties. EOCCO is administered by Greater Oregon Behavioral Health, Inc. (GOBHI) and Moda Health. The CCO had high aspirations and attempted to complete a sizable number of activities—37 planned milestone activities and 28 benchmark activities.

TRANSFORMATION AREAS & DOMAINS

Eastern Oregon Transformation Areas

Transformation Area	# of Planned Activities
APM	10
Integration	6
Eliminating Health Disparities	6
Communications, Outreach, and Member Engagement	4
HIT	4
PCPCH	4
CHA and CHIP	4
Meeting Members Culturally Diverse Needs	2

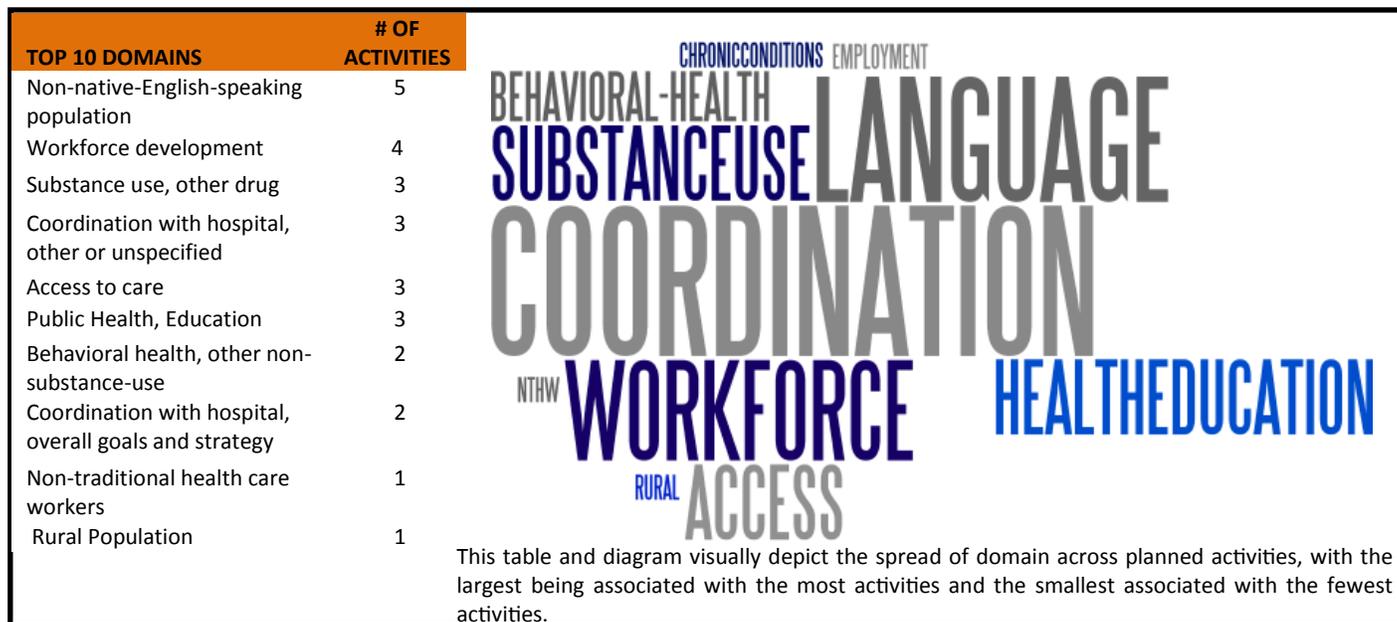
TRANSFORMATION AREAS: DRIVEN BY APM, DISPARITIES, & INTEGRATION

EOCCO’s planned activities across each transformation area were aggregated using summative content analysis to determine where efforts and resources were focused. The table to the left displays the spread of planned activities across transformation areas.

- EOCCO had 40 planned activities (either milestones or benchmarks).
- Over quarter of their efforts were focused around APMs (28%). Nearly a third of their activities were related to Eliminating Health Disparities (15%) and Integration (15%).
- Meeting Members Culturally Diverse Needs was focused on less (5%).

DOMAIN AREAS: EMPHASIZING COORDINATION, LANGUAGE, & WORKFORCE DEVELOPMENT

Summative analysis was also used to determine the types of domains associated with each activity. There was a pattern of focus on certain areas, depicted in the figure below. EOCCO’s transformation efforts were targeted to non-native-English-speaking populations and workforce development. Coordination-related domains also accounted for high number of CCO activities. There was less focus on non-traditional health care workers and rural population. EOCCO had 22 activities without an associated domain.



GOAL ACHIEVEMENT & BARRIERS TO SUCCESS

Transformation Plan Reports

Eastern Oregon CCO was initially very ambitious with the goals and activities in the Transformation Plan narrative, but did not report progress on many of those activities. One of the activities they did not meet was to contract with medical clinics in at least three additional counties. They made progress, but their reports were not specific enough to consider this benchmark as met. For CHA and CHIP, the CCO wanted 100% of the CCO area counties represented in the CAC and CHIPS.

EOCCO successful activities included:

- Established an HIT steering committee.
- Developed and implemented an HIE strategy plan.
- Measured the number of members that access the online portal.
- Revised 75-85% of EOCCO member materials to meet the cultural sensitivity and health literacy standards.
- Provided 100% of members with materials translated in their primary language.

Unsuccessful activities and/or transformation areas (TA) were:

- Calculate a rate of the number of staff who has received training due to no standardized reporting database to track activities among varying entities and ownership.
- All activities related to Meeting Members Culturally Diverse Needs. These activities were often missing from progress reports altogether.
- All activities within the TA of Eliminating Health Disparities.

Barriers Across All Reports

EOCCO often neglected to report barriers to activities, even if they did not meet a milestone and a benchmark. Some reported barriers were related to a lack of resources, staffing, and funds, and a large increase in members due to the Affordable Care Act. Since EOCCO covers a large geographic area, it was often difficult to coordinate and communicate with partners and providers throughout the CCO. To overcome this, they established collaboration teams to begin to develop a more formal and consistent process for documentation of collaboration meeting content, results, and/or required follow up including, but not limited to, structured minutes. They have also used other methods of communication such a Go to Meeting and Turning Point software to communicate with partners and providers. Finally, many providers resisted moving away from the FFS payment model and toward APM risk contracts.

OTHER OBSERVATIONS & CONCLUSIONS

EOCCO covers 12 counties in Oregon, which makes it the CCO with the largest geographic area. This made communication, coordination, and scheduling a challenge. Considering this and the fact that this was new territory for the CCOs, they were successful overall and accomplished many of their benchmarks and milestones proposed in the 2013-2015 Transformation Plan. They could have benefited from a template and guidelines on how to write the reports as well as how to identify barriers to achieving their goals. EOCCO has some confusion about their PIP topics and their TFG proposal was vague and broad, so they could benefit from more guidance from OHA in this area as well.

Milestones Met

76%

28 of 37

Benchmarks Met

57%

16 of 28

FAMILYCARE TRANSFORMATION PROFILE

SUMMARY

FamilyCare, Inc (FCI) serves more than 115,000 members in Oregon, including Multnomah, Clackamas, Washington, and Marion counties. In general, the contracted activities this CCO chose were focused on integrating medical, dental, and mental health services, through the use of alternative payment methodologies (APMs), health information technology (HIT), and provider surveys. FCI also progressed toward many activities in their community health improvement plan (CHIP) pertaining to the needs of members age 18-25 (transition aged youth or TAY) within their service area. They succeeded in achieving a large majority of their contracted milestones and benchmarks.

TRANSFORMATION AREAS & DOMAINS

FamilyCare Transformation Areas

Transformation Area	# of Planned Activities
CHA and CHIP	7
Meeting Members Culturally Diverse Needs	4
HIT	3
Integration	3
APM	3
Eliminating Health Disparities	2
Communications, Outreach, and Member Engagement	2
PCPCH	2

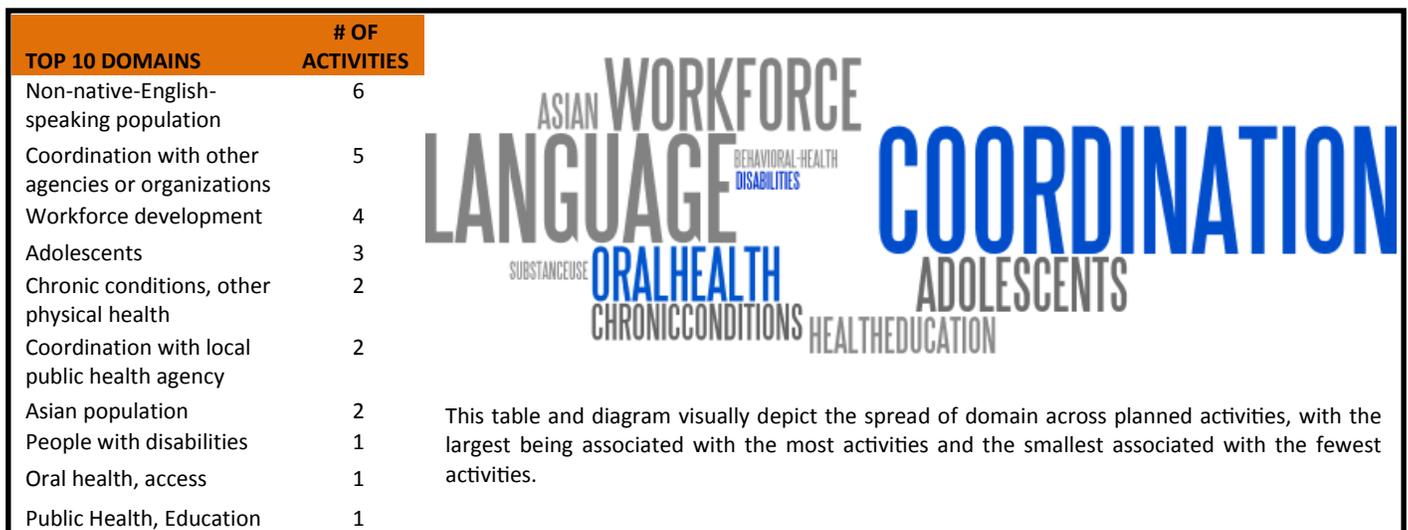
TRANSFORMATION AREAS: HEAVY CHA & CHIP FOCUS

FamilyCare’s planned activities across each transformation area were aggregated using summative content analysis to determine where efforts and resources were focused. The table to the left displays the spread of planned activities across transformation areas.

- FamilyCare had 26 planned activities (either milestones or benchmarks).
- A quarter of their efforts were focused around CHA and CHIP (27%) activities.
- They focused less on Eliminating Health Disparities (8%) and Communications, Outreach, and Member Engagement (8%) activities.

DOMAIN AREAS: EMPHASIZING LANGUAGE, COORDINATION, & WORKFORCE DEVELOPMENT

There was a clear pattern of focus on certain domain areas, depicted in the figure below. FamilyCare’s transformation efforts were targeted toward non-native-English-speaking population and coordination with other agencies or organizations (non-hospital). They also made significant investment in workforce development and adolescents. Public health education, oral health, and people with disabilities were of lesser focus. FamilyCare had eleven activities without an associated domain.



GOAL ACHIEVEMENT & BARRIERS TO SUCCESS

Transformation Plan Reports

FCI met many of their milestones and benchmarks prior to the benchmark report.

- **PCPCH:** Surpassed their milestone and benchmark prior to the first progress report, having 77.5% of their members enrolled in a Tier 2 or 3 PCPCH. They surpassed their original goal by 22.5%.
- **HIT:** Met all milestones and benchmarks by the milestone report. In fact, the Health Information Exchange (HIE) adoption rate of FCI providers was 80%, the highest within the state.
- **APM:** Successfully developed and implemented four varying APMs for non-primary care providers.
- Matched members with a known language preference other than English to a provider who fluently speaks the same language. Language agreements with over 50 providers have already been established.

Other Reports

The CHIP report has three priority areas focused on transition age youth (TAY): Community Assessment of Engagement of Transition Age Youth in Their Health and Healthcare, Increased Care Coordination and Engagement, and Improved Cultural Competency of TAY members. The specific activities outlined in the CHIP report were vague and only three of 13 were completed. The three completed activities were related to hiring and planning.

FCI indicated progress on Transformation Fund Grant projects:

- Re-engineering of integrated care, implementing a team of care management professionals to help manage groups of providers based on region, specialty, or patient populations.
- Increased technical assistance to clinics seeking certification, or tier upgrades, as an Oregon PCPCH. During the reporting period they provided practice coaching to 12 PCP groups.
- Improved HIT infrastructure by developing an ED information exchange in collaboration with OCHIN and OHA. The exchange provided automated alerts to care management staff, providers, and community health resources in response to specific emergency visits or hospital admissions meeting defined criteria.
- Placed OSU dietetic interns in clinics to promote enhanced health and wellness among members, and share best practices for nutrition with providers. The final project was a partnership with Outside-In to provide community health education programs and family resources.

Barriers Across All Reports

FCI struggled to meet milestones and benchmarks for eliminating health disparities, citing inadequate information provided in the 834 eligibility fund as a major barrier. The shortage of staffing, time, and resources were mentioned as major barriers for smaller practices. There were no other significant barriers revealed.

Milestones Met

87%

20 of 23

Benchmarks Met

82%

9 of 11

OTHER OBSERVATIONS & CONCLUSIONS

FCI achieved a majority of their contracted transformation plan activities. Many of the CCO's milestones and benchmarks were met prior to the milestone report, indicating that their goals were conservative and feasible. Within the areas of Integration and PCPCH, FCI also achieved many non-contracted activities. Their reports clearly outlined what they intended to achieve within each transformation area and they typically followed the plan as written. The reports were written concisely and had a consistent structure, making it easier to follow progress throughout the reports. Overall, FCI set attainable goals and achieved them through the completion of clearly articulated activities.

HEALTH SHARE OF OREGON TRANSFORMATION PROFILE

SUMMARY

Health Share of Oregon (HSO) services Medicaid members in the Portland-Metro area. Their 2013-2015 Transformation Plan narrative opens with a description of four main focus areas: community health integration, delivery system transformation, regional health information technology, and accountability, which have shaped and guided their chosen activities.

TRANSFORMATION AREAS & DOMAINS

Health Share Transformation

Transformation Area	# of Planned Activities
APM	5
HIT	5
Communications, Outreach, and Member Engagement	3
Eliminating Health Disparities	2
Integration	1
PCPCH	1
CHA and CHIP	1
Meeting Members Culturally Diverse Needs	1

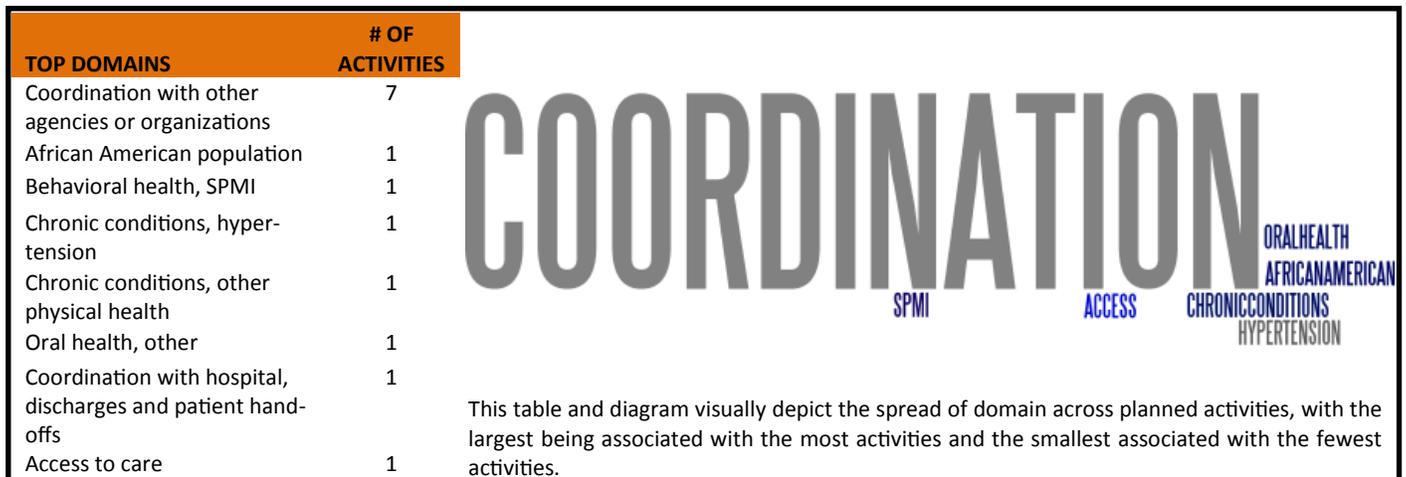
TRANSFORMATION AREAS: HEAVY TECHNICALLY

HSO's planned activities across each transformation area were aggregated using summative content analysis to determine where efforts and resources were focused. The table to the left displays the spread of planned activities across transformation areas.

- HSO had 19 planned activities (either milestones or benchmarks).
- Over half of their efforts were focused on technology advancements: APMs (27%) and HIT (26%).
- Of lesser focus were CHA and CHPI, Integration, Meeting Members Culturally Diverse Needs, and PCPCH (all at 5%).

DOMAIN AREAS: EMPHASIZING THE IMPORTANCE OF COORDINATION

Summative analysis was also used to determine the types of domains associated with each activity. There was a pattern of focus on certain areas, depicted in the figure below. HSO's transformation efforts were heavily targeted to coordination. All other activities had one activity each. HSO had 8 activities without an associated domain.



GOAL ACHIEVEMENT & BARRIERS TO SUCCESS

Transformation Plan Reports

HSO was successful, at least partially, in meeting many of the milestones and benchmarks they originally set in the 2013-2015 Transformation Plan reports. Overall, HSO was most successful at meeting goals that were not data or measurement driven.

In fact, the milestones and benchmarks that went unmet were all data driven:

- Measure hospitalization rate for those with SPMI.
- Measure percent of providers participating in APMs.
- Report baseline utilization and prevalence of disparity conditions to OHA and attain 10% improvement over baseline.
- Improve CAHPS cultural competence set scores.

APMs & HITs Successes: HSO was successful in achieving most APM goals that revolved around developing policies and establishing medical loss ratios. They also achieved all HIT goals, which included measuring communication across care settings and use of secure messaging as well as collaboration with O-HITEC, OCHIN, and other delivery systems.

Community-Centered Success: HSO was also successful in activities that were more community-centered including completion and distribution of the CHIP, assessment of cultural competence practices, and implementation of a QI plan that addresses top three race, ethnicity, and language category conditions.

Barriers Across All Reports

HSO acknowledged multiple barriers that interfered with the success of activity completion:

- Infrastructure for development of data support and programming: They struggled with obtaining data and tracking members, so it was difficult to identify the most needed health issues. This also made it difficult to achieve benchmarks that had been set with no pre-existing data or baselines.
- Lack of funding, especially for PCPCH achievement and CHIP activities.
- Large influx of new members due to Medicaid expansion, as providers reported being overwhelmed and needing more support/technical assistance.
- Lack of engagement of both members (especially those that have been historically disengaged) and stakeholders.

To overcome these barriers, HSO used a few different strategies:

- Shift activities from “all CCO-based” to a pilot project or by narrowing components of an activity such as “develop strategies to address gaps in current cultural competence activities” to “focus on three specific activities.”
- Adjustments based on target audience to improvement engagement. For stakeholders, HSO held less frequent meetings so partners could fully participate and also clarified roles and responsibilities for partners based on meetings or workgroups. For providers, HSO invested in testing new models of onboarding, training, and engagement. Finally, for members, HSO outlined a more in-depth process for member outreach, and invested in incorporating better the community voice by interviewing more members for CHA/CHIP.

Milestones Met

82%

14 of 17

Benchmarks Met

71%

10 of 14

OTHER OBSERVATIONS & CONCLUSIONS

HSO could have benefited from having a template for many of these reports. Their 2013-2015 Transformation Plan narrative was quite long and included many activities that were never discussed in subsequent reports, and progress reports had many sections that were copy and pasted from one report to the next report. Many of the activities for the 2015-2017 Transformation Plan were new, meaning that they were not continuations of previous activities. This could possibly point to the struggles they had with quantifying milestones and benchmarks. One unique activity identified in a CHIP report was developing APMs specifically for school-based health centers.

INTERCOMMUNITY HEALTH NETWORK TRANSFORMATION PROFILE

SUMMARY

InterCommunity Health Network (IHN) serves more than 60,000 Oregon Health Plan members in Benton, Lincoln, and Linn Counties. IHN completed work in each transformation area through individual pilot projects that comprise numerous activities. Through these pilot projects they were able to implement a performance based payment plan for providers, create an online learning and resource center for provider and staff training, launch a community education campaign, lower hospital readmission rates care transition coaching, and develop a website indicating provider spoken language or members.

TRANSFORMATION AREAS & DOMAINS

Intercommunity Health Network Transformation Areas

Transformation Area	# of Planned Activities
HIT	4
Communications, Outreach, and Member Engagement	3
Integration	3
PCPCH	3
APM	2
Meeting Members Culturally Diverse Needs	2
Eliminating Health Disparities	1
CHA and CHIP	1

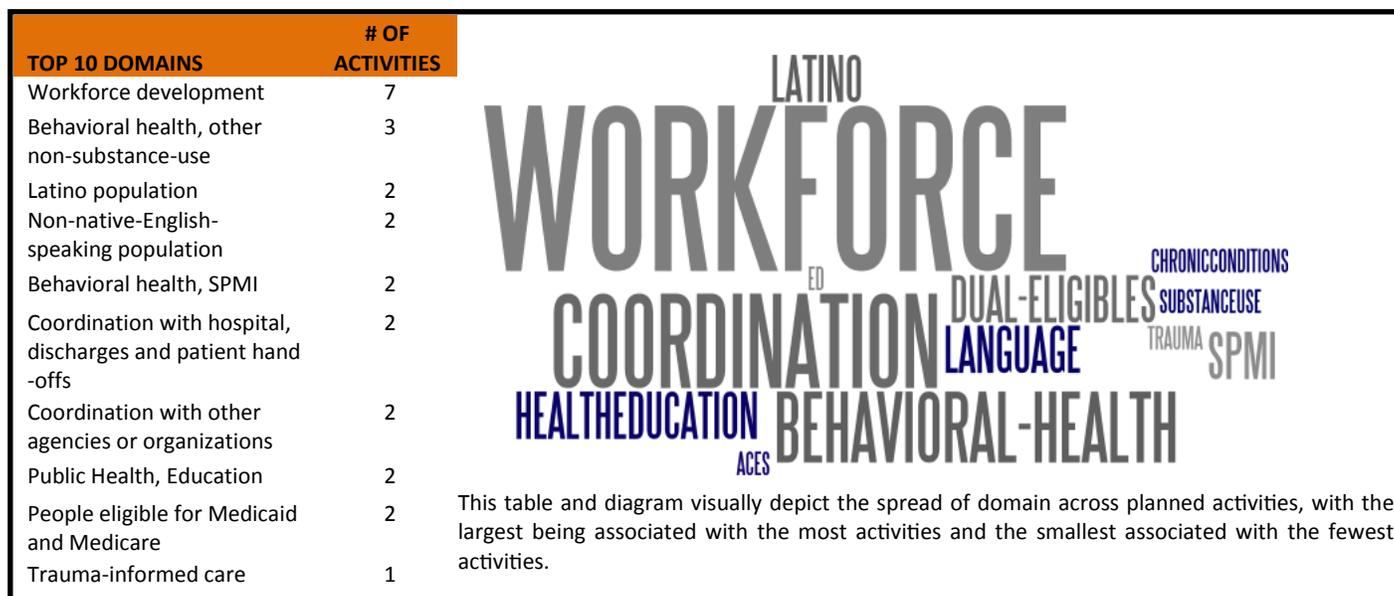
TRANSFORMATION AREAS: INTEGRATING TECHNOLOGY

IHN's planned activities across each transformation area were aggregated using summative content analysis to determine where efforts and resources were focused. The table to the left displays the spread of planned activities across transformation areas.

- IHN had 19 planned activities (either milestones or benchmarks).
- Over half of their efforts were focused around new innovations: HIT (21%), Integration (16%), and PCPCH (16%).
- They focused less on CHA and CHIP (5%), and Eliminating Health Disparities (5%) activities.

DOMAIN AREAS: EMPHASIZING WORKFORCE DEVELOPMENT & BEHAVIORAL HEALTH

Summative analysis was also used to determine the types of domains associated with each activity. There was a pattern of focus on certain areas, depicted in the figure below. IHN's transformation efforts were targeted to workforce development and behavioral health. IHN focused the least on trauma-informed care activities. IHN had five activities without an associated domain.



GOAL ACHIEVEMENT & BARRIERS TO SUCCESS

Transformation Plan Reports

IHN was able to achieve a majority of its contracted goals through various pilot projects. The CCO's documents were lengthy, highly granular, and often difficult to follow across consecutive reports. Often, a pilot project would apply to several transformation areas and domains. The amendment documents were more useful to decipher activities than the narrative, which was far too delineated.

There were four pilot projects that encompassed activities within all eight transformation areas:

- Mental Wellness Literacy Campaign.
- Patient Assignment & Engagement.
- Integration of Mental Health, Addictions, and Primary Care.
- Hospital To Home Care Coordination.

Specific achievements found in the transformation plan include:

- Develop and implement a performance-based reimbursement model.
- Complete a community health improvement plan (CHIP).
- Create an online resource center available in multiple languages.
- Initiate an education campaign to bring awareness to mental health issues.
- Enroll members to participate in Hospital to Home (H2H) pilot.
- Ensure that 100% of staff have completed annual cultural competency training.

Milestones Met

88%

14 of 16

Benchmarks Met

85%

11 of 13

Other Reports

IHN's CHIP contained 44 distinct activities, each related to one of the four pilot projects described above. In addition, activities were related to four major areas: access to healthcare; behavioral health; chronic disease management and prevention; and maternal and child health.

Of the 44 activities in the CHIP report, 37 were documented as completed. The completed activities fell within measurement, training, documenting, and planning the various pilot projects. Specific progress toward each project was detailed and abundant, so much that it was challenging to document it all within the coding spreadsheet.

Barriers Across All Reports

The major barrier preventing the attainment of all transformation area milestones and benchmarks was attributed to the loss of the pilot sponsor. A new pilot sponsor had been identified by the benchmark report. Other barriers revealed in the reports were specifically related to each activity, and a general barrier was not evident.

OTHER OBSERVATIONS & CONCLUSIONS

The reporting format of four pilot projects made it challenging to attribute specific activities to eight specific transformation areas. However, the process of implementing many small pilot projects made their goals and activities more pragmatic and attainable. They accomplished many of their milestones and benchmarks through the use of these pilot projects. Only two of the ten contracted benchmarks and one of the sixteen milestones were left unmet. Overall, IHN had realistic activities relating to detailed pilot projects (often too detailed making it difficult for coding), but allowing them to achieve nearly all of their contracted goals.

JACKSON CARE CONNECT TRANSFORMATION PROFILE

SUMMARY

Jackson Care Connect (JCC) services roughly two-third of the Medicaid population in Jackson County. Compared to the other CCO operating in Jackson County, JCC acknowledges that, as an organization, they are still in their infancy and, therefore, are focusing a lot of their efforts on developing new relationships, crafting policies and charters, and initiating planning efforts.

TRANSFORMATION AREAS & DOMAINS

Jackson Care Connect Transformation Areas

Transformation Area	# of Planned Activities
Integration	17
Communications, Outreach, and Member Engagement	11
HIT	7
Meeting Members Culturally Diverse Needs	7
PCPCH	6
APM	5
CHA and CHIP	5
Eliminating Health Disparities	4

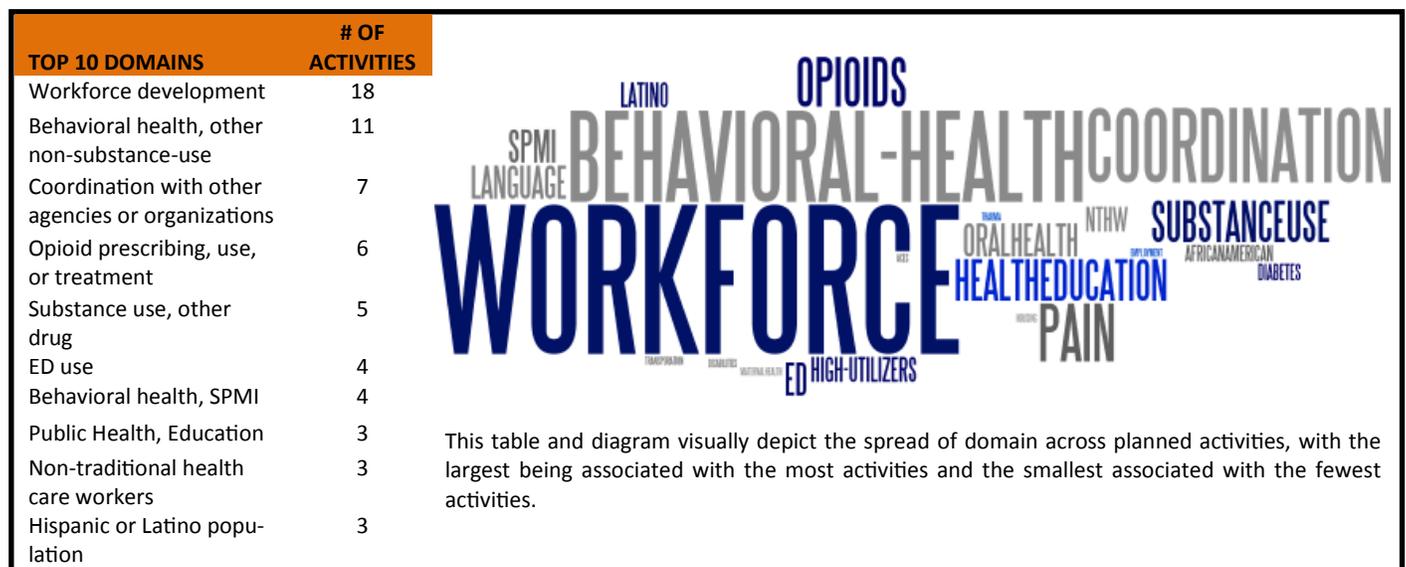
TRANSFORMATION AREAS: INTEGRATION AND MEMBER ENGAGEMENT EFFORT

JCC's planned activities across each transformation area were aggregated using summative content analysis to determine where efforts and resources were focused. The table to the left displays the spread of planned activities across transformation areas.

- JCC had 62 planned activities (either milestones or benchmarks).
- A quarter of their efforts were focused on Integration (27%). And nearly a fifth were centered around Communications, Outreach, and Member Engagement (18%).
- Of lesser focus were APM (8%), CHA and CHIP (8%), and Eliminating Health Disparities (7%).

DOMAIN AREAS: EMPHASIZING DEVELOPMENT, COORDINATION, & BEHAVIORAL HEALTH

Summative analysis was also used to determine the types of domains associated with each activity. There was a pattern of focus on certain areas, depicted in the figure below. JCC's transformation efforts were targeted to workforce development. Additionally, they made significant investment in behavioral health (other non-substance-use). Public health education, non-traditional health care workers, and Hispanic/Latino population were of lesser focus. JCC had 11 activities without an associated domain.



GOAL ACHIEVEMENT & BARRIERS TO SUCCESS

Transformation Plan Reports

JCC contracted many goals with OHA, and they were very successful in meeting almost all of them:

- Met all member-centered activities for **Communications, Outreach, and Member Engagement, Meeting Members Culturally Diverse Needs, and Eliminating Health Disparities**: Developed quality improvement plans and providing education to providers around stigma and health disparities to collect community level data; performed an environmental scan of the community; and identified standards and set metrics that address health outcomes, quality of care, workforce and language.
- Met **CHA and CHIP**: Completion of a CHA and distribution of the CHIP.
- Met **APMs and HIT**: Created an infrastructure for APMs and HIT planning. Many of these activities included coordination and engagement across the CCO network with diverse providers and community-based organizations.
- **PCPCH**: Sustained and increased the number of clinics qualifying as a PCPCH, and developed strategies and incentives for smaller clinics that may struggle with the PCPCH certification process.

The one area where this CCO struggled was Integration. JCC completed a majority of these activities that included integrating CHWs to work with high utilizers, co-locating behaviorists and addictions providers in primary care clinics, and collecting data and developing a plan to change local opioid prescribing patterns. JCC was not able to develop MOUs across entities to ensure timely transitions of care between primary care and behavioral health clinics, implement sustainable funding mechanisms for interdisciplinary care teams, or initiate partnerships with social services and school-based providers to provide addictions screening and interventions for adolescents.

Barriers Across All Reports

Regardless of the JCC's success, they did encounter multiple barriers along the way:

- Difficulties designing and implementing effective APM across the CCO, especially because APMs require new workflows, forms, and processes for providers and staff.
- Providers often lack the infrastructure (including funding and staffing) needed to manage and report for outcomes-based payments, and providers are slow to change.
- Struggled to decide on a tool to measure partner organizations' cultural competency levels.
- Barriers regarding communication and expectations set by OHA, especially in regards to CHIP and billing configurations. OHA was also looked at as a gatekeeper for community health disparities information, which delayed reporting in these areas.
- Hurdles due to laws that prohibit data sharing across entities and policies that were ambiguous about data sharing regulations that slowed and hindered these efforts.
- Challenges with creating a CAC that was representative of the community.
- Coordination was challenging, particularly when working with three other CCOs in the region and when working across multiple organizations.

To address these barriers, JCC built many strong partnerships, including with CAP, Board Finance Committee, OHSU, Regional Health Equity Coalition, and other community partners. They also participated in many national and state level committees and workgroups. To build the capacity of the CAC, JCC requested that current members conduct outreach to CCO members to encourage their participation. They also hired a consultant and added new positions to help with some the issues related to technical and reporting efforts, capacity, and coordination. The Innovator Agent was utilized to communicate and coordinate with OHA.

Milestones Met

98%

55 of 56

Benchmarks Met

88%

15 of 17

OTHER OBSERVATIONS & CONCLUSIONS

Many of JCC's activities and goals were concentrated on transformation areas that required complex integration and that were member-facing. They also seem focused on the long-term benefit of building strong partnerships with diverse organizations and committees.

PACIFICSOURCE: CENTRAL OREGON TRANSFORMATION PROFILE

SUMMARY

PacificSource Community Solutions is a subsidiary of PacificSource Health Plans that is divided into two CCO's — PacificSource Columbia Gorge and PacificSource Central Oregon (PSCO). PSCO serves the Medicaid population in Central Oregon (Deschutes, Jefferson, and Crook Counties).

TRANSFORMATION AREAS & DOMAINS

PacificSource: Central Oregon Transformation Areas

Transformation Area	# of Planned Activities
HIT	3
Integration	3
Eliminating Health Disparities	3
Communications, Outreach, and Member Engagement	2
PCPCH	2
APM	2
CHA and CHIP	1
Meeting Members Culturally Diverse Needs	0

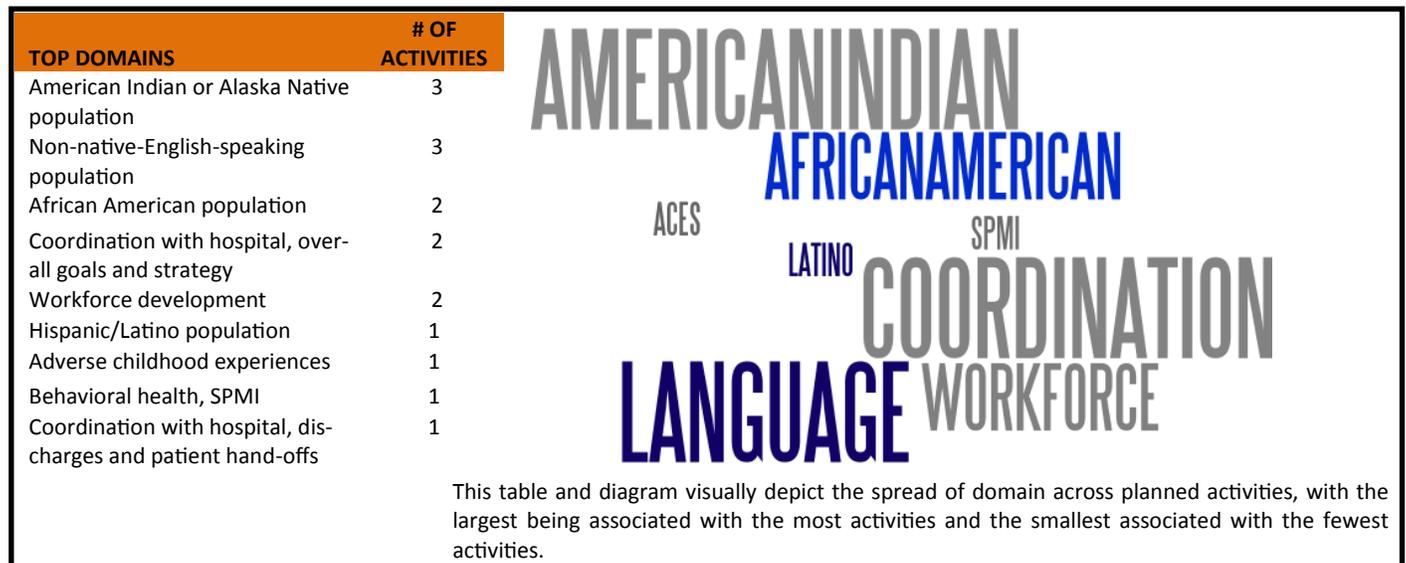
TRANSFORMATION AREAS: FOCUS ON DISPARITIES AND TECHNOLOGY

PSCO's planned activities across each transformation area were aggregated using summative content analysis to determine where efforts and resources were focused. The table to the left displays the spread of planned activities across transformation areas.

- PSCO had 17 planned activities (either milestones or benchmarks).
- About a fifth of their efforts were focused around disparities (17%) and HIT (17%).
- They focused less on CHA and CHIP (6%), and Meeting Members Culturally Diverse Needs (6%) activities.

DOMAIN AREAS: EMPHASIZING LANGUAGE & AMERICAN INDIAN/ALASKA NATIVE POPULATIONS

Summative analysis was also used to determine the types of domains associated with each activity. There was a pattern of focus on certain areas, depicted in the figure below. PSCO's transformation efforts were targeted to populations that are non-native-English-speaking and American Indians or Alaska Natives. Activities associated with Hispanic/Latino population, ACE, SPMI, and coordination with hospital discharges were of lesser focus. PSCO had nine activities without an associated domain.



GOAL ACHIEVEMENT & BARRIERS TO SUCCESS

Transformation Plan Reports

PSCO was successful in the majority of milestones and benchmarks set in the original 2013-2015 Transformation Plan amendment. They were initially very ambitious with the goals set in their narratives, but they did not report any progress on these activities in subsequent reports.

There were two themes in the types of activities listed:

- 1) establish standards or a baseline of measurement.
- 2) increase member or provider engagement.

The 2015-2017 Transformation Plan changed focus and established completely new activities, milestones, and benchmarks. These new plans were more defined and narrow in scope than those in the previous report. The activities for the more community centered transformation areas (elements 6-9) were more focused on assessment of cultural competence and trainings, populations facing disparities, and developing high priority quality improvement strategies.

PSCO initially included a ninth element to their transformation plan and titled it “Primary Care and Public Health Partnership to Improve Population Health.” The activities were somewhat similar to activities in other transformation plan areas as well as the CHIP. The focuses of these activities were women, children, and families. They appear to have abandoned this transformation area as it was not included in any progress reports.

Other Reports

The CHIP proposal had 320 activities listed; however, the progress report did not address any of the activities listed in the original CHIP report. Additionally, PSCO did not complete the Transformation Fund Grant proposal, so it was not clear what activities were originally planned. However, the TFG progress reports were very detailed and organized.

Barriers Across All Reports

PSCO acknowledged many barriers to completing their activities. Limited funding was a barrier reported in nearly every transformation area as well as strain on facilities and staff. Providers were often unable or unwilling to make the changes needed to make progress on the proposed activities. Smaller practices faced significant economic and resource hurdles to becoming PCP-CHs or adopting APMs. Inability to effectively collect data proved challenging for many of the activities. Personal discomfort and communication difficulties were barriers for a few of the community based transformation areas. To overcome these barriers, PSCO used a few different strategies, including working more closely with OHA, increased communication and negotiations, analyzing member experiences through Health Equity Task Force findings, and forming work groups.

Milestones Met

94%

15 of 16

Benchmarks Met

100%

9 of 9

OTHER OBSERVATIONS & CONCLUSIONS

PSCO was very ambitious early on and could have benefited from having a clearer direction in their goals and activities. They could have also benefited from a template and guidelines on how to write the reports. Their CHIP was extremely long and without a clear direction. Their 2013-2015 Transformation Plan narrative was quite long and the majority of the activities were never discussed in subsequent reports. The CCO’s TFG proposal was vague without any specific plans, but the progress reports were more detailed and organized. The activities listed in the TFG progress reports did not match up with any of the transformation plan activities.

PACIFICSOURCE: COLUMBIA GORGE TRANSFORMATION PROFILE

SUMMARY

Together, PacificSource and Columbia Gorge Health Council lead the PacificSource Columbia Gorge Coordinated Care Organization (PSCG), which includes nearly every healthcare provider in the region and currently serves members of the Oregon Health Plan (OHP).

TRANSFORMATION AREAS & DOMAINS

PacificSource: Columbia Gorge Transformation Areas

Transformation Area	# of Planned Activities
Integration	3
Eliminating Health Disparities	3
Communications, Outreach, and Member Engagement	2
HIT	2
PCPCH	2
CHA and CHIP	1
Meeting Members Culturally Diverse Needs	1
APM	1

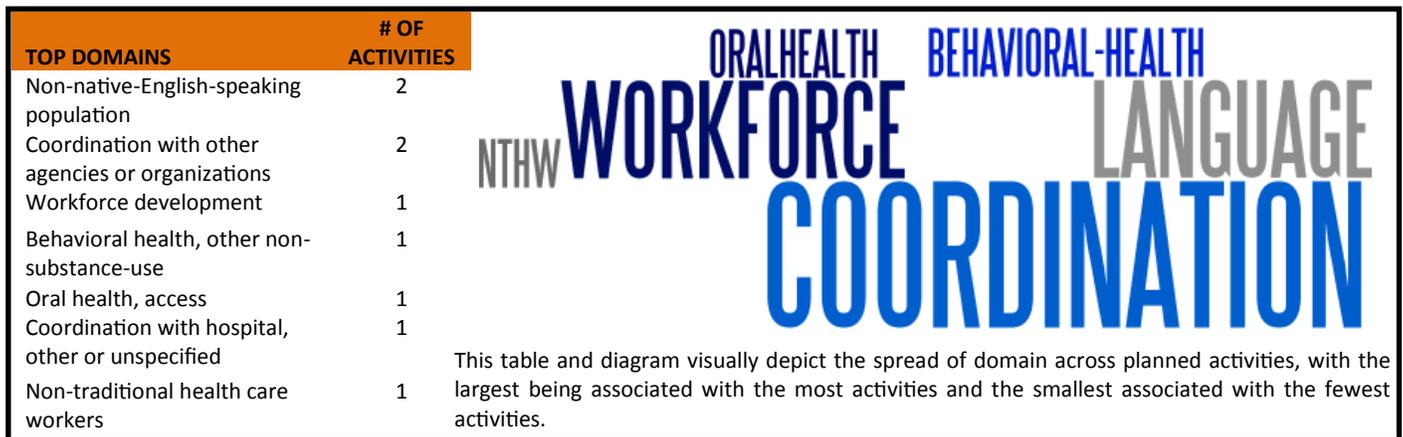
TRANSFORMATION AREAS: PSCG DRIVEN TOWARD DISPARITY ELIMINATION & INTEGRATION

PSCG’s planned activities across each transformation area were aggregated using summative content analysis to determine where efforts and resources were focused. The table to the left displays the spread of planned activities across transformation areas.

- PSCG had 15 planned activities (either milestones or benchmarks).
- About a fifth of their efforts were focused around disparities (20%) and Integration (20%).
- They focused less on CHA and CHIP (7%), and Meeting Members Culturally Diverse Needs (7%) activities.

DOMAIN AREAS: EMPHASIZING COORDINATION & LANGUAGE

Summative analysis was also used to determine the types of domains associated with each activity. There was a pattern of focus on certain areas, depicted in the figure below. PSCG’s transformation efforts were targeted to non-native-English-speaking populations and coordination efforts with other agencies or organizations (non-hospital). Activities associated with access to oral health, coordination with hospitals, and non-traditional health care workers were of lesser focus. PSCG had ten activities without an associated domain.



GOAL ACHIEVEMENT & BARRIERS TO SUCCESS

Transformation Plan Reports

PSCG was successful in meeting the majority of, and in some cases surpassing, its milestones and benchmarks proposed in the 2013-2015 Transformation Plan. Many of these milestones and benchmarks were met by the first progress report.

Integration Activities:

- Created work teams.
- Trained providers on SBIRT screening.
- Currently have seven PCPCHs providing some degree of physical and behavioral health.
- Establish a set of performance standards for integrated care with specific benchmarks for the SPMI population—did not report any progress or barriers for this activity.

PCPCH Activities:

- Worked with the Columbia Gorge Health Council and other groups to achieve a high PCPCH adoption rate.
- At least 94.53% of PSCG members are currently assigned to a Tier 3 PCPCH.
- Work groups were established to develop recommendations on alternative payment methodologies and embed them in provider contracts

Goals for the community focused transformation areas were highly data driven. Assessments were conducted to identify population disparities, increase member engagement, and evaluate the CCO's capabilities to report, track and develop a QI plan to eliminate disparities in population health by race, ethnicity, and language.

Other Reports

Though PSCG did not submit a CHIP proposal, they did submit a progress report providing updates of CAC and CAP activities.

Barriers Across All Reports

PSCG noted that sanctioned rural health reform initiative (RHRI) made promoting APMs in hospital contracts challenging. A large primary care group ceded from the IPA creating a bifurcated care base, and Dental Care organizations lobbied in state legislature to ensure dental services remained consistent. In other transformation areas they were challenged to move more clinics into PCPCH status, but it was difficult for smaller clinics who did not have the resources to do so. The chosen areas for their CHA and CHIP transformation areas were broad and topics were complex and time consuming.

To overcome some of these barriers, PSCG relied on workgroups, and modified their timelines. They also worked with the Columbia Gorge Health Council and finance committee to better inform all parties. In response to the wide-ranging topics and areas, they created prioritizes, used the Collective Impact Model, formed workgroups, and consulted with their innovator agent.

OTHER OBSERVATIONS & CONCLUSIONS

PSCG met all but two contracted transformation areas milestones and benchmarks. They could have benefited from guidance and a report template to assist them in their reports. They often copied and pasted information from one report to the next. The Transformation Plan narrative included many activities that were never reported on in subsequent reports. They did not include a CHIP proposal, but did include 10 vague updates in their CHIP progress report. Despite a few challenges with the reports and having barriers to overcome, PSCG succeeded in meeting the vast majority of its contracted goals.

Milestones Met

93%

14 of 15

Benchmarks Met

88%

7 of 8

PRIMARY HEALTH OF JOSEPHINE COUNTY TRANSFORMATION PROFILE

SUMMARY

PrimaryHealth of Josephine County (PHJC) is a Coordinated Care Organization (CCO) is a network of health care providers who have agreed to work together in their community and was established in 2012 to serve residents of Josephine County who receive their health benefits from the Oregon Health Plan.

TRANSFORMATION AREAS & DOMAINS

PrimaryHealth of Josephine County Transformation Areas

Transformation Area	# of Planned Activities
Integration	7
Meeting Members Culturally Diverse Needs	6
Communications, Outreach, and Member Engagement	5
PCPCH	4
HIT	3
APM	1
Eliminating Health Disparities	1
CHA and CHIP	1

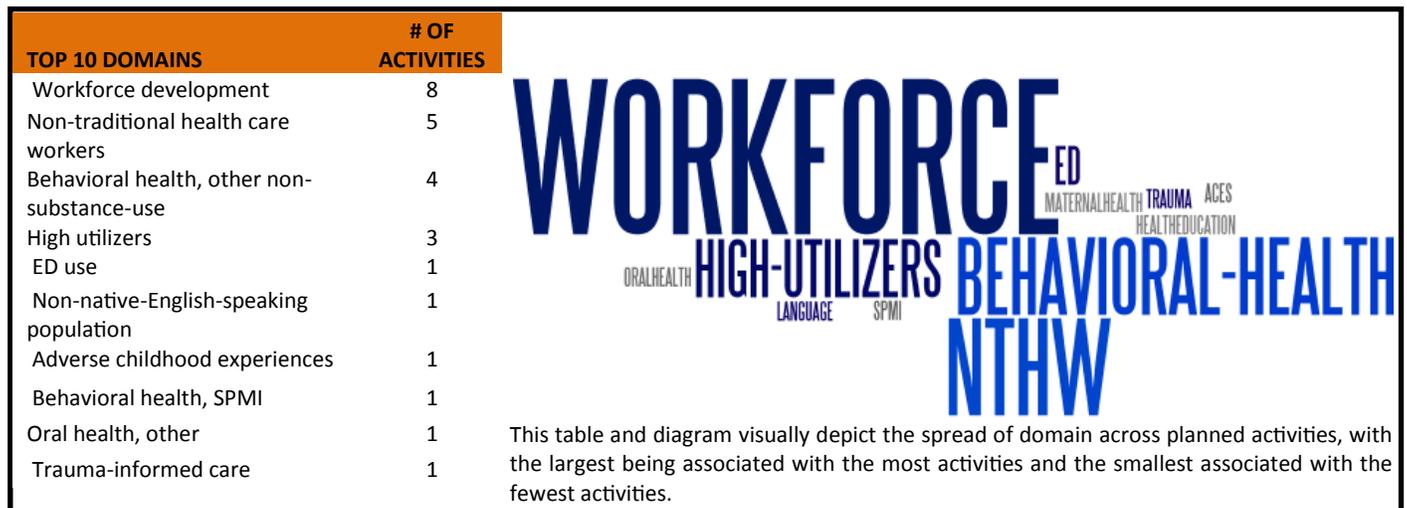
TRANSFORMATION AREAS: DRIVEN TOWARD INTEGRATION & MEMBER NEEDS & ENGAGEMENT

PHJC's planned activities across each transformation area were aggregated using summative content analysis to determine where efforts and resources were focused. The table to the left displays the spread of planned activities across transformation areas.

- PHJC had 28 planned activities (either milestones or benchmarks).
- Over half of their efforts were either focused around Integration (25%), or member-needs such as Meeting Members Culturally Diverse Needs (21%) and Communications, Outreach, and Member Engagement (18%).
- CHA and CHIP was the least focused on transformation area (3%).

DOMAIN AREAS: EMPHASIZING WORKFORCE DEVELOPMENT, NTHWs, & BEHAVIORAL HEALTH

Summative analysis was also used to determine the types of domains associated with each activity. There was a pattern of focus on certain areas, depicted in the figure below. PHJC's transformation efforts were targeted to workforce development. Additionally, they made investment in non-traditional health care workers and behavioral health (other non-substance-use). ACEs, SPMI, and trauma-informed care were of lesser focus. PHJC had 13 activities without an associated domain.



GOAL ACHIEVEMENT & BARRIERS TO SUCCESS

Transformation Plan Reports

PHJC struggled to meet many of their contracted milestones and benchmarks. Activities discussed in their Transformation Plan reports include:

- **Overall:** Identifying high utilizers through data analysis in an effort to reduce inappropriate and unnecessary use of resources, and improving health outcomes for utilizers; hiring and training Community Outreach Workers to assist in this area.
- **PCPCH:** Building infrastructure, support, and education to support PCPCH model; attending PCPCH learning collaboratives, and developing a dashboard.
- **APM:** Expanding incentives for PCPCH clinics.

Communications, Outreach, and Member Engagement is an example of PHJC's struggles in accomplishing goals. PHJC sought to create a vital document registry and a Cultural Competency Action plan. They did not fully accomplish either goal. They had initially planned to develop a cross training program for providers on behavioral health issues with a special focus on communications, Member engagement, and culturally competent care for Members with mental health and/or addictions disorders. Although they began work on this, they chose to move forward with a different program— an evidence-based program called Mental Health First Aid. However, no providers participated because the training took too much time. PHJC is attempting to adapt the training and make it shorter.

Despite some struggles, the CCO had many accomplishments:

- Distributed over 1000 books to kids at events, and put books in their largest pediatric office.
- Attended learning hubs and collaboratives to learn about Kindergarten readiness and education reform, as well as ACES, trauma, and family dynamics.
- Offered alcohol and drug prevention programs to high schools as well as screening for youth at risk of developing chemical dependency.
- Launched a new chronic pain program, but they found that it was difficult for members to attend due to transportation and childcare needs.
- Provided free gym memberships to their members as long as they go at least 10 times a month.

Barriers Across All Reports

PHJC tended to report there were no barriers to achieving their goals, even if they did not make progress on them. Some of the barriers they reported were technically not barriers at all. For instance, the activities listed for the Eliminating Health Disparities transformation area were mostly about creating the CHA and CHIP. While they did not report a barrier, they were unable to create data points to identify racial, cultural, or disease specific disparities for their member population because the software they use cannot identify data by race or ethnicity in order to accomplish their goals.

OTHER OBSERVATIONS & CONCLUSIONS

Similar to other CCOs, PHJC was very ambitious in the goals they set in their 2013 Transformation Plan narrative reports, but did not report on all activities in subsequent progress reports. PHJC could have benefited from having some a template and guidance on how to write all the reports and proposals. The CCO was very successful in meeting most benchmarks set in their transformation plan reports as well as their TFG report, but often neglected to report barriers, even if they were not successful with a milestone or benchmark.

Milestones Met

73%

19 of 26

Benchmarks Met

56%

5 of 9

TRILLIUM COMMUNITY HEALTH TRANSFORMATION PROFILE

SUMMARY

Trillium Community Health CCO is a community focused organization and health plan committed to transforming healthcare for Lane County Members into a system that makes dramatic and sustainable progress toward achievement of the triple aim. Trillium successfully met a majority of contracted milestones, but only achieved 30% of their benchmarks.

TRANSFORMATION AREAS & DOMAINS

Trillium Transformation Areas

Transformation Area	# of Planned Activities
APM	3
Meeting Members Culturally Diverse Needs	2
Communications, Outreach, and Member Engagement	1
HIT	1
Integration	1
PCPCH	1
Eliminating Health Disparities	1
CHA and CHIP	1

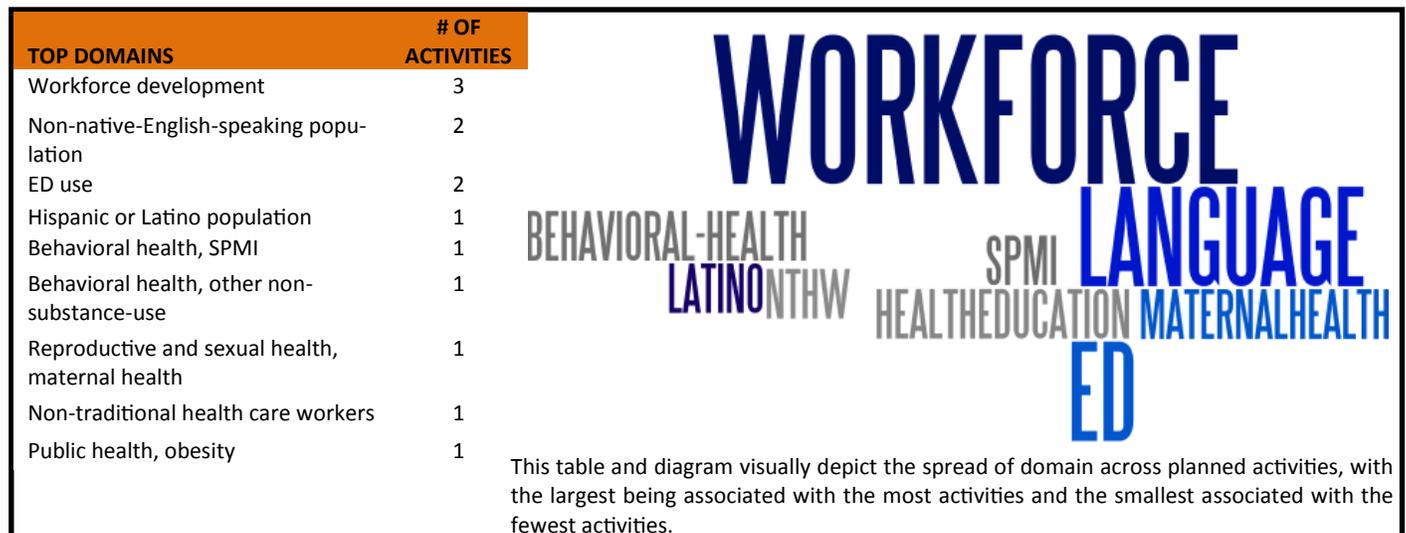
TRANSFORMATION AREAS: TRILLIUM'S DUAL FOCUS

Trillium's planned activities across each transformation area were aggregated using summative content analysis to determine where efforts and resources were focused. The table to the left displays the spread of planned activities across transformation areas.

- Trillium had 11 planned activities (either milestones or benchmarks).
- Over quarter of their efforts were focused around APMs (28%). Meeting Members Culturally Diverse Needs was the second most focused on area (18%).
- All other transformation areas were evenly focused on (9% for each area).

DOMAIN AREAS: EMPHASIZING WORKFORCE DEVELOPMENT, LANGUAGE, & ED USE

Summative analysis was also used to determine the types of domains associated with each activity. There was a pattern of focus on certain areas, depicted in the figure below. Trillium's transformation efforts were targeted to workforce development. Additionally, they made investment in non-native-English-speaking populations and emergency department use. Hispanic/Latino population, behavioral and maternal health, non-traditional health care workers and obesity activities was of lesser focus. Trillium had three activities without an associated domain.



GOAL ACHIEVEMENT & BARRIERS TO SUCCESS

Transformation Plan Reports

Trillium was successful in meeting milestones and benchmarks in some of the activities proposed in the Transformation Plan, but struggled in others. Activities included:

- Developed and promoted system-wide screening for depression and other mental health conditions in PCP clinics.
- Staff members were trained in SBIRT screenings and a Quality of Life measure was introduced.
- Increased the percentage of PCPs practicing in a recognized PCPH.
- Reduced the PMPM amount paid to ER physicians by 2%.
- ER physicians and nine behavioral health providers paid using care rate payments.

Despite the success with the reduction in payment to providers, they were unable to reduce the number of ER visits by members. Additionally, they were unable to meet the benchmark they set for HIT, and lost their contracted software vendor required for integration activities. Trillium successfully adopted and distributed both their CHIP and CHA; however, the proposed activities in their CHIP proposal did not match any of the activities in their CHIP progress report.

Other Reports

Their TFG report was confusing and difficult to record. They reported significant progress in every activity, but did not successfully complete any of them. There were four categories of activities:

- Care Coordination Quality.
- Patient Activation.
- Health Information Exchange.
- Engage Members in Their Care and Well Being.

Barriers Across All Reports

Trillium experienced a number of barriers to accomplishing their Transformation goals. The large increase in membership due to the Affordable Care Act (ACA) made meeting milestones and benchmarks difficult, especially for changes in EHR and capitation contracts. Smaller practices found that meeting the requirements to become a PCPCH was beyond their abilities. Smaller practices also struggled to make referrals for depression screenings. Developing and monitoring for transformation projects was intensive. Trillium developed a Model of Care with a much broader focus than depression screening. Another company purchased the Shared Care Plan vendor for HIT and the CCO was forced to scramble to find a new vendor. Providers were reluctant to address health disparities and it was difficult to assess cultural appropriateness of member materials.

Milestones Met

80%

8 of 10

Benchmarks Met

30%

3 of 10

OTHER OBSERVATIONS & CONCLUSIONS

Trillium made a great deal of progress on some of its milestones and benchmarks listed in the 2013-2015 Transformation plan, but might have suffered from some over-ambition: they did not successfully meet their goals for most activities. Many activities were either abandoned or not reported on beyond the initial Transformation Plan narrative report. They would benefit from guidance and a template for writing the reports and documenting their results. Most of the activities in the 2015-2017 Transformation Plan were exact copies of those from the 2013-2015 report.

UMPQUA HEALTH ALLIANCE TRANSFORMATION PROFILE

SUMMARY

The Umpqua Health Alliance is Douglas County’s Coordinated Care Organization (CCO). It is one of several CCOs in Oregon approved by the Oregon Health Authority to improve health care and make it more affordable for the population being served through the Oregon Health Plan. In Douglas County, collaborators of the CCO include Adapt (alcohol and drug abuse prevention and treatment), Advantage Dental, ATRIO Health Plans, DCIPA, LLC, Douglas County Mental Health, Douglas County Health & Social Services, Greater Oregon Behavioral Health, Inc. (GOBHI), Mercy Medical Center, SouthRiver Community Health Center, and Umpqua Community Health Center.

TRANSFORMATION AREAS & DOMAINS

Umpqua Transformation Areas

Transformation Area	# of Planned Activities
Integration	5
CHA and CHIP	4
Meeting Members Culturally Diverse Needs	4
Communications, Outreach, and Member Engagement	3
Eliminating Health Disparities	3
HIT	2
PCPCH	1
APM	1

TRANSFORMATION AREAS: FOCUS ON INTEGRATION & COMMUNITY/MEMBER NEEDS

Umpqua’s planned activities across each transformation area were aggregated using summative content analysis to determine where efforts and resources were focused. The table to the left displays the spread of planned activities across transformation areas.

- Umpqua had 24 planned activities (either milestones or benchmarks).
- Over half of their efforts were either focused around Integration (21%), or member-needs such as CHA & CHIP (17%) and Meeting Members Culturally Diverse Needs (17%).
- APMs was the least focused on transformation area (8%).

DOMAIN AREAS: EMPHASIZING SPMI, DEVELOPMENT, & EMPLOYMENT

Summative analysis was also used to determine the types of domains associated with each activity. There was a pattern of focus on certain areas, depicted in the figure below. Umpqua’s transformation efforts were targeted to SPMI and workforce development. Additionally, they made significant investment in employment activities. ED use and public health education were of lesser focus. Umpqua had 11 activities without an associated domain.



GOAL ACHIEVEMENT & BARRIERS TO SUCCESS

Transformation Plan Reports

Umpqua was successful in all of their contracted benchmarks set in the original 2013-2015 Transformation plan amendment. The major focus of the integration element of the transformation plan was on improving access and care coordination for the SPMI population. They created an expanded care clinic in an effort to decrease ED visits and increase PCP visits and medication compliance. The stated goals for this area in the 2013-2015 report are:

- Decrease Emergency room Utilization by 20%.
- Increase PCP utilization by 30%.
- Ensure a Tier 2 or 3 PCPCH served at least 30% of members.
- Updated benchmark for the 2015-2017 Transformation plan: Ensure that 90% of members are served by a Tier 2 or 3 PCPCH.

Umpqua developed their CHA and CHIP early, with no barriers listed and the next steps, as reported in the Transformation Plan for 2015-2017, are to evaluate the results from the initial CHIP, create action plans to support the prioritized areas, and publish the results. A total of 97% of their members have been assigned to PCP's using electronic health records.

Umpqua was successful in their community-focused activities in the later transformation areas. They identified a curriculum for Culture of Poverty training and held several sessions by the first progress report. They developed a QI plan to address disparities for its specific population, which was a challenge due to the relatively small ethnic and racial diversity in their membership (the 2013 census determined that 93.2% of members were Caucasian). Umpqua determined that poverty was the most common theme of diversity. They developed a QI plan by the Benchmark Report, which included mailing out colorectal cancer screening kits to members in identified High Poverty Hotspots and providing SBIRT educational materials to the two largest clinics in the area. To increase health literacy the CCO collaborated with the community to create a weekly health-related article in the local newspaper with opportunities to submit health questions to providers and read their responses. They also created a local radio program to interview health leaders. Though they made progress on each activity, they were not successful in meeting any of their goals identified in the TFG report.

Barriers Across All Reports

Umpqua encountered a few barriers in meeting their milestones and benchmarks. A common theme observed in the barriers listed was provider unwillingness or inability to participate in the transformation activities. Members were also sometimes unwilling to participate, specifically when it came to joining the Expanded Care clinic. This prompted them to develop a scoring system to better identify patient inclusion. Staff turnover and limited resources was another barrier. They have addressed this by working more closely with their innovator agent. Some smaller providers were reluctant to participate in the PCPCH process so Umpqua developed an outreach program that simplified the participation requirements and offered support to clinics. They reported that it was difficult to narrow the focus areas for the CHIP and that the many focus areas identified in the CHA generated a compulsion to create a plan to address every issue. They further engaged with community members in an effort to help narrow the focus on the CHIP.

Milestones Met

95%

18 of 19

Benchmarks Met

100%

11 of 11

OTHER OBSERVATIONS & CONCLUSIONS

UHA had many accomplishments. They could have benefited from a template and guidelines on how to write the reports as well as how to identify barriers to achieving their goals. While the majority of the activities listed in the transformation plan were easier to accomplish, the activities listed in the TFG proposal were too ambitious and not attainable. Broad goals, communication issues, and lack of consensus among partners and staff were common barriers listed to achieving these proposed activities. Better communication strategies and narrowing their focus to more specific, achievable goals might benefit this CCO.

WESTERN OREGON ADVANCED HEALTH TRANSFORMATION PROFILE

SUMMARY

Western Oregon Advanced Health (WOAH) CCO is an association of local physicians, dentists, mental health professionals, hospitals, and allied health workers who have long been providing quality health care services to individuals and families on the Oregon Health Plan who live in the CCO that now serves Coos, Curry, and Western Douglas Counties.

TRANSFORMATION AREAS & DOMAINS

Western Oregon Transformation Areas

Transformation Area	# of Planned Activities
APM	2
Eliminating Health Disparities	2
Communications, Outreach, and Member Engagement	1
HIT	1
Integration	1
PCPCH	1
CHA and CHIP	1
Meeting Members Culturally Diverse Needs	1

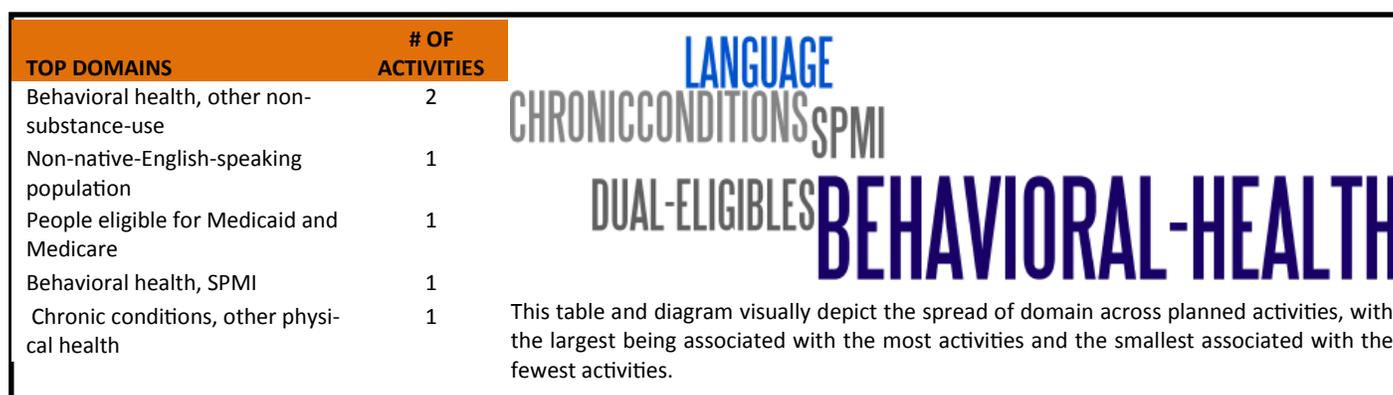
TRANSFORMATION AREAS: DUAL FOCUS ON APM & DISPARITY ELIMINATION

WOAH's planned activities across each transformation area were aggregated using summative content analysis to determine where efforts and resources were focused. The table to the left displays the spread of planned activities across transformation areas.

- WOA had 10 planned activities (either milestones or benchmarks).
- A fifth of their efforts were either focused around APMs (20%) and another fifth around Eliminating Health Disparities (20%).
- All other activities were spread evenly across the remaining transformation areas (10% per area).

DOMAIN AREAS: EMPHASIZING BEHAVIORAL HEALTH

Summative analysis was also used to determine the types of domains associated with each activity. There was a pattern of focus on certain areas, depicted in the figure below. WOA's transformation efforts were targeted to behavioral health. Other domains had one associated activity each. WOA had 4 activities without an associated domain.



GOAL ACHIEVEMENT & BARRIERS TO SUCCESS

Transformation Plan Reports

While WOH was unsuccessful in meeting many of the milestones and benchmarks proposed in their 2013-2015 Transformation Plan, they were successful at:

- Creating an afterhours clinic.
- Implementing and training staff and providers on SBIRT screenings.
- Increasing the number of providers using an EHR.

Integration: An example of how WOH struggled to achieve goals is seen in the Integration. WOH was extremely ambitious in the 2013 Transformation Plan narrative and listed 75 activities for Integration, but only one activity was contracted (measure the A1C for members with both SPMI and diabetes). They were unable to work on this goal until the second progress report due to a lack of inclusive data from OHA and they have not reported meeting the benchmark. Another challenge they faced was an inability to integrate bilaterally between mental health and primary health care. They discovered that while mental health is fully integrated with primary health care, the inverse is not true.

Other Reports

WOH made some progress on activities in the TFG and CHIP reports:

- Decreasing food insecurity.
- Integrating treatment for children.
- Increasing the number of people who have health insurance.
- Hiring community health workers.

Barriers Across All Reports

WOH often cited OHA as the barrier to meeting their milestones and benchmarks. They stated that OHA was slow to provide data essential to completing goals and, furthermore, OHA prevented them from meeting their PCPCH benchmark. WOH stated that “OHA’s decision to sunset incentive payments for PCPCHs is a disincentive and complicates WOH’s advocacy work.” To overcome this barrier, they used APMs to redistribute cost savings to offset PCPCH costs to providers. The large influx of members due to the Affordable Care Act overwhelmed WOH and was another barrier to accomplishing some goals.

OTHER OBSERVATIONS & CONCLUSIONS

WOH was the most frustrated of all the CCOs. They expressed that OHA is appearing to be “just another level of bureaucracy, rather than an agent of change.” WOH was very ambitious in the 2013-2015 Transformation Plan narrative and could have benefited from having some guidance and support with writing the reports. WOH was not successful with many of the milestones and benchmarks and many of their goals were written in statistical formulas rather than plan language so interpretation was often difficult.

Milestones Met

67%

6 of 9

Benchmarks Met

44%

4 of 9

WILLAMETTE VALLEY TRANSFORMATION PROFILE

SUMMARY

Willamette Valley Community Health (WVCH) serves members in Marion and Polk counties. Of their roughly 100,000 members, 39% identify as Hispanic and over 20% are Spanish-speaking, though little of their transformation effort was geared toward meeting culturally diverse needs. Instead, WVCH focused on activities designed to engage their network of providers.

TRANSFORMATION AREAS & DOMAINS

Willamette Valley Transformation Areas

Transformation Area	# of Planned Activities
Integration	3
Communications, Outreach, and Member Engagement	1
HIT	1
PCPCH	1
APM	1
Eliminating Health Disparities	1
CHA and CHIP	1
Meeting Members Culturally Diverse Needs	1

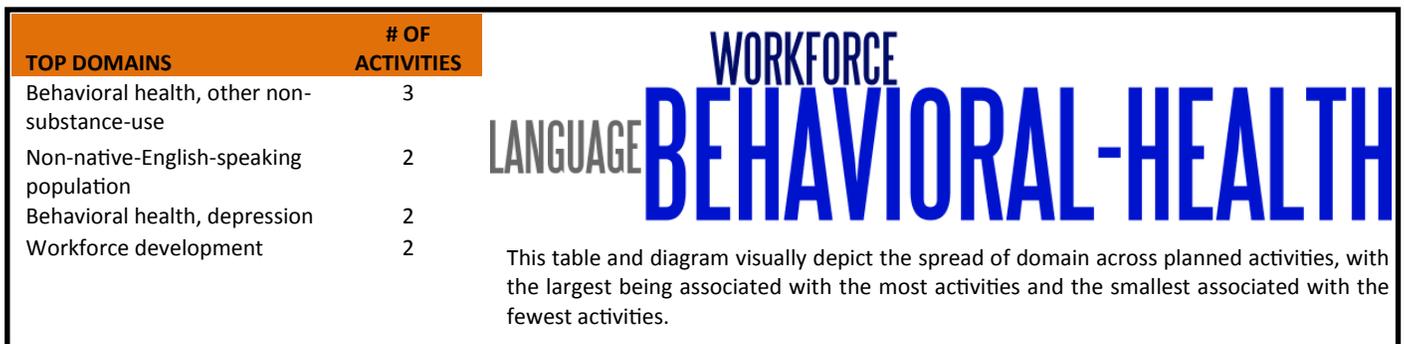
TRANSFORMATION AREAS: INTEGRATION CENTERED

WVCH's planned activities across each transformation area were aggregated using summative content analysis to determine where efforts and resources were focused. The table to the left displays the spread of planned activities across transformation areas.

- WVCH had 10 planned activities (either milestones or benchmarks).
- Nearly a third of their efforts were focused on Integration (30%) activities.
- All other activities were evenly distributed across the remaining transformation areas (all at 10%).

DOMAIN AREAS: EMPHASIZING WORKFORCE DEVELOPMENT

Summative analysis was also used to determine the types of domains associated with each activity. There was a pattern of focus on certain areas, depicted in the figure below. WVCH's transformation efforts were targeted to behavioral health. The other three domains had two activities associated with each. WVCH had 3 activities without an associated domain.



GOAL ACHIEVEMENT & BARRIERS TO SUCCESS

Transformation Plan Reports

Overall, WVCH was fairly successful in working on contracted activities. This CCO was able to meet nearly all of the contracted milestones and benchmarks they laid out in the original 2013-2015 Transformation Plan. WVCH was very discrete when laying out their contracted activities. Activities were deliberate and very straight-forward, possibly making them easier to achieve. These activities included the following:

- Measured the number of providers that participate in the Program Oriented Payment program.
- Measured the number of providers that demonstrate compliance with Meaningful Use Standards for EHR adoption.
- Measured the total number of members enrolled in either a Tier 2 or Tier 3 PCPCH.
- Offered cultural competence training for providers and staff.
- Produce a completed CHIP.

Many of these activities are provider-facing, and even the activities that should be more member-centered are focused on inclusion of providers. WVCH did not complete the contracted activity for assisting PCPCHs to incorporate depression screenings, which had challenges with the collection of depression screening data.

Barriers Across All Reports

As with many of activities, most of the barriers discussed by WVCH were focused around the providers:

- Providers (and clinics) lack of knowledge and resources to fully take advantage of available data.
- Providers struggled to understand APMs.
- Disconnect between the CCO and those drafting the CHA/CHIP (community members).
- Difficulty in engaging providers to attend diversity and cultural competency trainings.
- Issues with OHA both in communication and data sharing around race, ethnicity, and language.
- Funding constraints made it difficult to roll out a network-wide plan for EHR.

WVCH has taken steps to overcome these barriers including increasing engagement activities for providers. WVCH has made an effort to have consistent dialogue with providers and offer more CME opportunities, especially for diversity and cultural competency trainings. The CCO has also participated in state-wide workgroups and learning collaboratives, as well as initiated partnerships with diverse organizations such as George Fox University. WVCH has also invested in training and retention of CAC members.

OTHER OBSERVATIONS & CONCLUSIONS

WVCH is unique because their documents reflect a more provider-focused orientation and strategy than other CCOs that are more concerned with members. Given that much of the discourse around the success of Accountable Care acknowledges that provider behavior change is key, WVCH offers an example in which transformation energy was devoted to the care-deliverers with the clear intention that change would trickle down to the care recipient. Thus WVCH emerges as a CCO to pay close attention to as time goes on.

Milestones Met

90%

9 of 10

Benchmarks Met

90%

9 of 10

YAMHILL TRANSFORMATION PROFILE

SUMMARY

Yamhill Coordinated Care Organization (YCCO) services Medicaid members primarily in Yamhill County, and parts of Clackamas, Washington, Polk, Marion, and Tillamook counties. Historically, this community has had the largest percentage of non-managed, open-card OHP members and many new members, and health care entities, have not been engaged in previous OHP systems; making most of these transformation efforts entirely new for this community and health care system.

TRANSFORMATION AREAS & DOMAINS

Yamhill Transformation Areas

Transformation Area	# of Planned Activities
Integration	21
APM	5
Eliminating Health Disparities	5
Communications, Outreach, and Member Engagement	5
Meeting Members Culturally Diverse Needs	5
CHA and CHIP	2
PCPCH	2
HIT	1

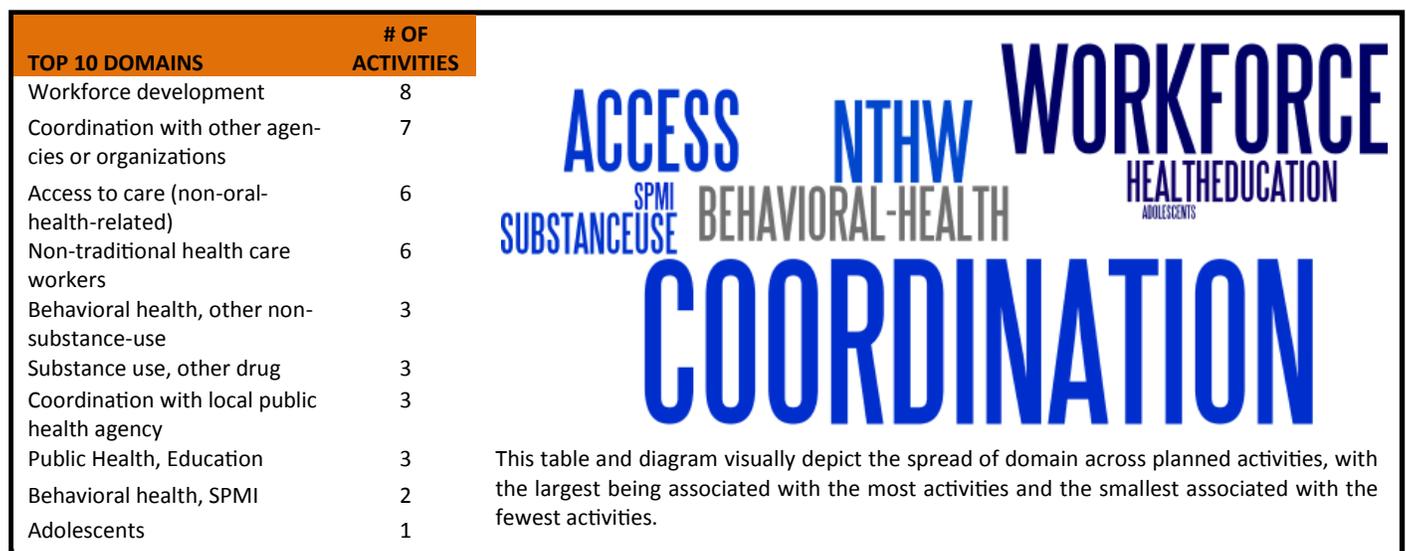
TRANSFORMATION AREAS: INTEGRATION FOCUS

YCCO's planned activities across each transformation area were aggregated using summative content analysis to determine where efforts and resources were focused. The table to the left displays the spread of planned activities across transformation areas.

- YCCO had 46 planned activities (either milestones or benchmarks).
- Nearly half of their efforts were focused solely on Integration (46%).
- Of lesser focus were PCPCH (4%) , CHA and CHIP (4%) , and HIT (2%).

DOMAIN AREAS: EMPHASIZING COORDINATION, WORKFORCE DEVELOPMENT, & ACCESS

Summative analysis was also used to determine the types of domains associated with each activity. There was a pattern of focus on certain areas, depicted in the figure below. YCCO's transformation efforts were targeted to workforce development and coordination. Additionally, they made significant investment in access to care and non-traditional health care workers. Domains related to adolescents was of lesser focus. YCCO had 15 activities without an associated domain.



GOAL ACHIEVEMENT & BARRIERS TO SUCCESS

Transformation Plan Reports

YCCO focused a lot of effort on Integration and was successful in accomplishing many goals in this area, including the following:

- Hiring Peer Wellness Specialists for individuals with mental health and addiction challenges, as well as linking individuals to treatment through non-traditional health workers.
- Meeting all activities related to implementing SBIRT screenings in multiple care settings.
- Measured the number of behaviorists hired and trained and the number of members enrolled with a behaviorist, as well as the number of PCPCHs qualifying at a Tier 3 and the number of members assigned to an on-site PCP.
- Ensured scheduling and billing practices were in place.
- Offered a continuum of preventive and health promotion services.
- Provided coordinated care teams for all members with serious mental illness.

However, YCCO struggled to achieve goals in other transformation areas including APMs, HIT, Communications & Member Outreach, Meeting Members Diverse Needs, and Eliminating Health Disparities. Many HIT activities were unachievable due to failure of the Crimson population health information system to provide YCCO with usable data. Subsequently, YCCO was unable to achieve many activities that required Crimson and data tracking.

Barriers Across All Reports

YCCO encountered a few barriers to accomplishing their milestones and benchmarks including the following:

- Issues around data: lack of data, problems with obtaining data, and using data to report on clinical and operational measures.
- Problems regarding integration of physical health and mental health services.
- Struggles with coordination of services, developing a shared vision and mission, and overall lack of collaboration between both physical and mental health.
- Rural location of the CCO made it difficult to recruit behaviorists and other providers who meet the cultural and language goals of the community.
- Already employed providers reported lack of time and capacity, and many did not have training or experience in technical areas including value-based payments.
- Clinics generally found it difficult to balance the priorities of the clinic and implementing transformation goals.
- Difficult to recruit new members into the CAC.

To overcome these barriers, YCCO provided staff training on new screenings and technology, cultural competency and health literacy, and developed subcommittees and workgroups to discuss new models and workflows. YCCO also worked to develop new pathways for communication, especially in regards to APMs and HIT changes. To address the issue with recruiting new providers, YCCO used Transformation Funds to add more behaviorists and provided new incentives to local providers. As there were a few barriers to integration, a director of operations was hired to oversee integration of physical health and mental health services. An external consultant was also brought in to work with providers and staff around issues with APMs, and the CAC held public forums to gather more community input.

OTHER OBSERVATIONS & CONCLUSIONS

YCCO struggled to complete many activities across multiple transformation areas, which is understandable considering that they acknowledge most of the transformation territory is new to many partners. However, YCCO was very mindful in their reporting style. Many activities could be followed across various reports, and most reports were organized and easy-to-follow. It is clear that their focus should be on small activities that gradually builds to bigger action, and this is shown in the 2015-2017 Transformation Plan planned activities.

Milestones Met

60%

24 of 40

Benchmarks Met

18%

4 of 22

PROFILE HIGHLIGHTS & CONCLUSIONS

CCOs were a big idea, and they have triggered big changes. CCOs set big, broad goals and launched a significant amount of transformational activity around the state. They have had significant success in achieving some of these goals, especially around care integration, but there is also room to continue progressing down a transformative path, especially around issues of diversity and addressing disparities. Much of the early work cut across transformation domains and may prove foundational to additional efforts down the road. As the transformation landscape evolves, so too will the focus of transformation efforts specific to each CCO.

PATTERNS OF EFFORTS

Lesser efforts toward HIT and APM may be explained by the fact that 1) they are interrelated and 2) improvement in HIT requires a significant financial investment, which CCOs might have been hesitant to make early on. This, in turn, may have precluded a focus on APM, because models like paying for performance require outcomes data. This reasoning also sheds light on the lack of focus around health disparities and culturally appropriate services: both of these types of efforts require de-aggregated population data. Most CCOs chose to focus their activities on Integration and CHA/CHIP transformation areas. As we speculated earlier, the overwhelming drive toward integration might have been a relic of the fact that many CCOs appeared to choose to tackle integration first, and the chronology of choice continued to define their transformation strategy over time. There are likely good reasons CCOs picked integration as an initial area to strive toward. First, most CCOs are operated by health systems that have the infrastructure in to align with providers and other partners. Second, integration and better coordinated care have clear cost benefits, which may have made more appealing.

The successful completion of CHA/CHIP activities was likely due to the fact that these documents are required annually by ORS 414.627. The typical CCO activity documented within the CHA/CHIP transformation area is “complete a community health improvement plan,” which in itself is not a specific strategy, but rather an overarching goal. Oregon statute provides precise guidelines and rules for developing the CHIP, creating a tangible outline from which to work. Additionally, the CHIP is completed by the community advisory council, rather than CCO staff, alleviating possible staffing barriers from the equation.

SUCCESS STORIES

Umpqua Health Alliance and PacificSource: Central Oregon were the most successful CCOs when it came to meeting milestones and benchmarks. While many CCOs struggled with staffing and workforce issues, Umpqua focused many of their efforts on developing their workforce and hiring more staff. These activities appear to have had a substantial influence on their overall success. PacificSource: Central Oregon led in terms of overall activities but contracted for very few. This targeted approach likely contributed to their success.

CHALLENGED ORGANIZATIONS

Cascade, Yamhill, and Western Oregon Advanced Health (WOAH) were the least successful CCOs at meeting contracted milestones and benchmarks. Cascade Health Alliance became a CCO late in the development process and many of their reports were late or missing. Their late start, deficient reporting, and large geographic area posed many challenges for the CCO. Yamhill CCO struggled to obtain the data they needed to meet milestones and benchmarks. Though they may have made meaningful progress toward their activities, they were unable provide data to quantify it. WOAH in particular used their documents as an outlet to vent frustration about working with state stakeholders and the burden of the documentation process. Their activities and goals were often presented as equations.

A DIFFERENT APPROACH

The two CCOs who appeared to have the most radical approaches to their transformation efforts, when compared with other CCOs, were Health Share and Willamette Valley

HSO: HSO had a unique approach and focused heavily on reducing Health Disparities. This is probably due to additional funding that was secured (CMMI Transformation Grant), but regardless of financing their push in this direction makes them the most experienced in this regard and therefore could be used as a resource for other organizations who want to do the same down the line.

WVCH: WCVH focused less on members and more on providers than other organizations. They can perhaps now serve as a case study in “trickle down change,” because providers are the true middle-men between patients and administration and this strategy could prove highly effective over the longer run, especially if it can prevent burnout and turnover.

APPENDIX A

KEY

(1) TRANSFORMATION AREAS

TRANSFORMATION AREAS	DEFINITIONS
Integration	Developing and implementing a health care delivery model that integrates mental health and physical health care and addictions and dental health, when dental services are included. This area of transformation must specifically address the needs of individuals with severe and persistent mental illness.
Patient-Centered Primary Care Homes (PCPCH)	Continuing implementation and development of Patient-Centered Primary Care Home (PCPCH).
Alternative Payment Methodologies	Implementing consistent Alternative Payment Methodologies that align payment with health outcomes.
Community Health Assessment & Community Health Improvement Plan	Preparing a strategy for developing Contractor’s Community Health Assessment and adopting an annual Community Health Improvement Plan consistent with SB 1580 (2012), Section 13.
Health Information Exchange	Developing a plan for encouraging Electronic Health Records, health information exchange, and meaningful use.
Communications, Outreach, Member Engagement	Assuring Communications, Outreach, Member engagement, and Services are tailored to cultural, health literacy, and linguistic needs.
Meeting Members Culturally Diverse Needs	Assuring that the culturally diverse needs of Members are met (Cultural Competence training, provider composition reflects Member diversity, non-traditional health care workers composition reflects Member diversity).
Eliminating Health Disparities	Developing a Quality Improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes.

(2) ACTIVITY TYPES

ACTIVITY TYPES	DEFINITIONS
Research	Any activity that involves data collection, measurement, and analysis.
Planning	Any activity that references an idea to take action, but does not necessarily indicate action.
Hiring	Any activity that speaks to increasing staffing and/or the creation of new staff positions.
Contracting	Any activity where the CCO references hiring an external or third party to do work.
Implementing	Any activity where the CCO has taken a clear action on a new activity.
Training	Any activity that references staff and provider training and/or education.
Outreach	Any activity that references communication and/or interaction with the community.
Other	All other activities that do not fall into the above activity types.

KEY CONTINUED

(3) DOMAINS

POPULATIONS

- Asian Populations
- Black or African American population
- American Indian or Alaska Native population
- Native Hawaiian or Pacific Islander population
- Hispanic or Latino population
- Non-Native-English-Speaking population
- LGBTQ population
- Children in foster care
- Adolescents
- Seniors
- People with disabilities
- High utilizers, including expanded care/"hot-spotter" clinics
- Rural
- Urban

SOCIAL

- Social determinants of health — housing or built environment
- Social determinants of health — Food
- Social determinants of health — Education
- Social determinants of health — Transportation
- Social determinants of health — Crime or public safety
- Social determinants of health — employment or income

DELIVERY SYSTEM

- Access to care (non-oral health)
- Early learning or school readiness
- Emergency room use
- End of life care
- Flexible services
- Health care acquired infections
- Immunizations
- Injury prevention
- Long term service & supports
- Non-traditional health care workers
- Opioid prescribing, use or treatment
- Pain management, not explicitly related to opioids
- Pharmacy, including medication therapy
- Telehealth
- Workforce development, including staff training
- Trauma-informed care or trauma-informed services

PUBLIC HEALTH

- Public health — chronic disease
- Public health — nutrition
- Public health — obesity
- Public health — physical activity
- Public health — tobacco
- Public health — education

HEALTH CARE AREAS AND HEALTH CONDITIONS

- Adverse childhood events
- Behavioral health—depression
- Behavioral health—severe and persistent mental illness (SPMI)
- Behavioral health—other on-substance use
- Substance use—alcohol
- Substance use —tobacco
- Substance use—other drug (non-opioid related)
- Chronic conditions—asthma
- Chronic conditions—pain (non-opioid related)
- Chronic conditions—diabetes
- Chronic conditions—hypertension
- Chronic conditions—other physical health
- Oral health—access
- Oral health—prevention
- Oral health—other
- Reproductive and sexual health—Maternal health
- Reproductive and sexual health—Preconception health
- Reproductive and sexual health—Contraception
- Reproductive and sexual health—Other

APPENDIX B

SOURCE DOCUMENT APPENDIX

The chart below shows each document type used for this study and how many of those documents we received for this study. One of the strengths of this study was the completeness of the data set. For the few reports that we did not receive, the reasons for not acquiring them for this study are detailed below.

REPORT TYPE	# RECEIVED	REPORT DESCRIPTIONS
Transformation Plan for 2013—2015	16 of 16	Required plan for how the CCO will improve health outcomes, increase member satisfaction, and reduce overall costs that includes strategies in eight transformation areas. CCOS must report progress carrying out transformation plans in January and July of each year. Transformation plans for 2013 – 2015 and 2015 – 2017 were used for this study.
Transformation Plan for 2015—2017	16 of 16	
Transformation Plan Progress Report due January 2014 ¹	15 of 16	
Transformation Plan Milestone Report due July 2014	16 of 16	
Transformation Plan Progress Report due January 2015	16 of 16	
Transformation Plan Benchmark Report due July 2015 ¹	15 of 16	
Community Health Improvement Plan (CHIP) 2014 ²	15 of 16	Required strategic plan for how the CCO will address health disparities and meet health needs in the community. CHIPs are informed by a community health assessment, and by work of CCOs' community advisory councils. Each CCO must complete a new CHIP every 5 years and report progress annually.
Community Health Improvement Plan (CHIP) Progress Report due June 2015 ³	15 of 16	
Community Health Improvement Plan (CHIP) Checklist	7	
Performance Improvement Project Notification Form (PIPNF) - 2 Project	16 of 16	Document describing a CCO's performance improvement projects (PIPs). PIPs are topical projects designed to achieve significant and sustained improvement in specific areas that are relevant to the CCO's enrollees. Each CCO was required to conduct one statewide PIP on diabetes and severe and persistent mental illness; three PIPs on topics they choose; and a focus study.
Performance Improvement Project Notification Form (PIPNF) - Focus Study ⁴	6 of 16	
Transformation Fund Grant Proposal Report 2013	16 of 16	CCOs' plan for using grants from the Health System Transformation Fund. Each CCO received Transformation Fund grants to make strategic investments and support innovative projects aimed at better health, better care, and lower costs.
Transformation Fund Grant Progress Report due July 2014 ⁵	15 of 16	
Transformation Fund Grant Progress Report due January 2015	16 of 16	

- 1) 1 CCO was on a different reporting plan which fell out of the timeline of this project.
- 2) 1 CCO received approval to submit a different type of community improvement document and that document was omitted.
- 3) 1 CCO progress report was omitted because there was no updates in the report.
- 4) Focus studies were documented differently than the other 2 PIPs, which did not make all reports available for this project.
- 5) 1 CCO did not have an executed grant agreement at the time of this progress report.

APPENDIX C

CODING METHODS

TRAINING

Before our team began the coding process, we had two days of training held by the Oregon Health Authority (OHA). The first day of training consisted of background education around CCOs and health care transformation efforts in Oregon. The second day of training focused on the coding process and included a training from an OHA staff member on how to read, analyze and code the various types of documents for the project. After the two trainings, CORE staff analyzed and coded documents as a group in order to practice the coding process without OHA staff. Once the CORE team held multiple internal group work sessions and the team was comfortable with the coding process, CORE staff started coding independently. Once the CORE staff began coding independently, weekly meetings were scheduled and initially attended by an OHA staff member who answered various coding questions that emerged during the week.

HOW DID WE CODE THE DOCUMENTS?

OHA designed a coding framework to capture and categorize discrete CCO activities. Text-based CCO documents were synthesized into a single spreadsheet that includes numeric flags for sorting and querying, and descriptions of activities and their associated efforts.

2013-2015 Transformation Plan (TP) documents: We read through these documents and identified discrete activities that CCOs indicated they would carry out around a particular transformation area. Activities were summarized and entered into the spreadsheet. If the activity included a milestone or a benchmark we would flag in the appropriate columns to differentiate between the two. If the activity did not describe how they were going to do something, rather just an outcome and was stated as a benchmark, we would enter that text into the benchmark column (not the activity column) for that report and flag to indicate.

TP Reports: If the same activity, milestone or benchmark from a previous report was described we would record the update in the same row under the progress report column and flag to indicate if progress was made or not. When an activity, milestone or benchmark was found that was not in a previous report, we would put that activity, milestone or benchmark in a new row. We repeated this process with the milestone report, second TP progress report and benchmark report. In those reports, CCOs also reported barriers they faced to achieving progress on an activity, milestone or benchmark. These barriers were recorded in the barriers column of the associated report. The same coding process was applied to the 2015-2017 TP plan documents.

Community Health Improvement Plans (CHIPs) reports, Transformation Fund Grant Progress Reports (TFGs) & Performance Improvement Plans (PIPs): same process as described above.

Final step: After all the CCO documents were coded, we read through each row in the spreadsheet and flagged for each activity, milestone or benchmark for all the transformational areas that were described, which PIP topics they aligned with, if the focus was a *regional* – general geographic area of the CCO, *targeted* – specific locale (or unknown if not clearly stated), if the focus was on the *broad* CCO population or a *defined* subpopulation (or unknown if not clearly stated), what general type of activity it was, and up to five domains for the activity, milestone or benchmark covered. We would only flag something if it was clearly stated in the activity, milestone or benchmark.

AUDIT PROCESS

We systematically audited a random sample of coded data in each group to ensure validity. Approximately 5% of pages were double coded and then compared with the original to assess inter-rater reliability.

The auditor looked for four specific criteria:

1. Was the activity, milestone, or benchmark identified and entered into the spreadsheet?
2. Was the activity, milestone or benchmark recorded in the correct spot in the spreadsheet (i.e. column, row)?
3. Was the activity, milestone, or benchmark correctly summarized?
4. Were the correct flags applied?

Each category was worth one point. Points were added up for each activity and then added to an overall score to calculate an overall percentage. If the total was not at least 80%, then the documents would need to be recoded and additional teaching would be applied. The reports were reviewed with the original coder to discuss and correct discrepancies and ensure a shared agreement before moving forward to the next set of documents. The reports were shared with OHA for review and sign off at each stage.