Transformation Area 1: Integration of Care

Benchmark 1	**Hospital to Home (H2H) Care Transition Pilot:** Evaluate Member needs for mental health and chemical dependency services, with an emphasis on services for Members with serious and persistent mental illness, as well as physical health related needs upon discharge. Data reports support that H2H, mental health and alcohol and drug intervention as a package provide a more comprehensive intervention and reduce hospital readmission rates for the same diagnosis in a 30 day period.
How Benchmark will be measured (Baseline to July 1, 2015)	• Number of Members assessed. • Care coordination of additional services through Linn County. • Develop and report on readmission data.
Milestone(s) to be achieved as of July 1, 2014	• Contractor ensures that policy, procedure, data systems and coordination operational for all aspects of the H2H Care Transition Pilot. • Contractor ensures that 40% of eligible Members participate in H2H Care Transition Pilot; of those Members, 75% will not readmit to inpatient for the same diagnosis within 30 days.
Benchmark to be achieved as of July 1, 2015	• Contractor attains 8% increase over Baseline in Member participation in H2H Care Transition Pilot. Baseline and method of calculation to be determined and mutually agreed upon between Contractor and OHA. • Contractor attains 10% decrease from Baseline in H2H Care Transition Pilot Members' readmission rates to inpatient for same diagnosis within 30 days. Baseline and method of calculation to be determined and mutually agreed upon between Contractor and OHA.

1. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.

Activity *(Action taken or being taken to achieve milestones or benchmarks)*		Outcome to Date	Process Improvements
1.	Provide access to H2H program for Lincoln County residents	• Contracted with Adeo In-Home Care Services in Lincoln County to provide H2H to Lincoln County Residents • Sent two Adeo staff members to Coleman training in Colorado • Adeo staff started taking referrals September of 2014 • 14 consumers were referred to H2H in Lincoln County	• Continue to grow the program • Contract ends with Adeo in June – future funding and planning
2.	Expanded Referral criteria and marketed information for increased opportunity to refer	Changed program referral criteria: • No longer necessary for participant to discharge from hospital with one of 5 targeted diagnosis to be eligible • Now client just has to have one of targeted diagnosis to be eligible, not have it be the reason for the hospital admission	Assure all hospital personnel and Community partners know about broadened referral criteria

		• OR- be at risk in general or for frequent hospital readmissions	
3.	Dedicated staff "marketing" time to expand knowledge of H2H throughout the communities	• Visited all PCP, Primary Care Homes, skilled nursing facilities in Linn and Benton Counties • Expanded referral criteria to allow PCPs and clinic coordinators to make referrals directly to program	Develop a comprehensive list of community partners and an outreach plan for all three counties
4.	Increased coordination with hospital and community partners to capture all possible referrals	H2H have access to login to hospital EPIC system	Create MOUs between hospital and H2H program regarding access to patient information to streamline communications and the referral process
5.	Continued collaboration with partner agencies	Streamline information from hospitals to IHN-CCO who can coordinate with SDS staff	Have hospital provide better information to IHN-CCO about what consumers are utilizing services

1 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

The large number of discharge planning and case management staff and frequent staff turnover at Good Samaritan Regional Medical Center (GSRMC), our largest hospital, has made referrals from that hospital infrequent. We continue to try to build relationships with hospital staff hoping to increase the number of referrals from that hospital. We know that there are a large number of consumers who meet our referral criteria who are not being referred. Hospital statistics report that GSRMC admitted 99 patients with two of targeted H2H diagnoses (pneumonia and CHF) in the second quarter of 2014. If data was pulled regarding number of admissions for all of the 5 targeted diagnoses the number of consumers would have been higher. We received 10 total referrals from that hospital for the same time period.

1 c.)Describe any strategies you have developed to overcome these barriers and identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

We continue to work to develop relationships with hospital discharge planners and hospitalists. Care Transitions programs in other communities in Oregon have had increased numbers of consumers participate when the H2H staff have access to the EPIC system. In these areas the H2H staff identifies people in EPIC that have admitted to the hospital that meet the program criteria. The H2H coaches then go to the hospital and introduce themselves and the program to the consumers and pave the way for the home visit. All of this is done without any additional work from hospital staff. We are communicating with hospital management to try to gain access to the EPIC system, but gaining that access has been slow. Our Long Term Services and Support Innovator Agent has been a strong advocate for us and is helping to provide data that reflect the importance of H2H coaches gaining access to the EPIC system if we are going to make the program robust.

1 d.) How was the Community Advisory Council involved in the activities for this transformation area?

The Community Advisory Council has completed their Community Health Improvement Plan that highlights four Health Impact Areas. We continue to monitor the CHIP with a particular interest in Access to Care. In addition, the Chair of the Community Advisory Council receives updates on the H2H program through the Delivery System Transformation Steering Committee meeting.

1 e.) How was the CAC informed of the outcomes for activities in this transformation area?

Senior Services and Disability Services Advisory Council members, Oregon Cascades West Council of Governments OCWCOG's Senior and Disability Services Director, and our Long Term Services and Support Innovator Agent all regularly attend CAC meetings and report on H2H and its progress as requested.

Transformation Area 2: PCPCH

Benchmark 2.1	**Patient Assignment and Engagement Pilot – Phase 1** Use pilot sites panel of Members as a focus group to assess Emergency Department (ED) utilization and identify opportunities to enhance appropriateness of ED utilization.
How Benchmark will be measured (Baseline to July 1, 2015)	• Through analysis of claims data, demonstrated decrease in inappropriate utilization of ED.
Milestone to be achieved as of July 1, 2014	• Contractor develops data reports identifying Members who have utilized the ED more than six times in the prior year or for non-emergency purposes.
Benchmark to be achieved as of July 1, 2015	• Contractor ensures that Members will be redirected to the PCPCH; Contractor attains a reduction in ER usage by this group of Members by a measurement factor of 20%

1. a) Please describe the actions taken or being taken to achieve milestones in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Activity *(Action taken or being taken to achieve milestones)*	**Outcome to Date**	**Process Improvements**
1.	Map the desired process for patient assignment, identify key strategies for improvement, and identify desired outcome & metrics	Established baseline for matching PCP assignment between pilot sites & IHN-CCO. Baseline PCP discrepancy was 4%, 36%, & 24% for the 3 pilot sites	Established and implemented criteria for initial assignment when member does not select a PCP. Criteria include; 1) if a member was on OHP within the last 3 years, they will be reassigned to previous PCP. 2) match the member to the closest open PCP in their area of residence.
2.	Establish & test a web portal that allows pilot clinics to see current PCP assignments, identify newly assigned members to the pilot clinic, and support the	Web portal in place & tested	The portal is accessible and being used by clinic site staff. Overall the functionality is good. There needs to be improvement in consistency

	ability for members to change PCP at the pilot clinic		of having contact information (phone & address) available through the portal. There is improvement in matching the clinic's list of patients on their PCP panels with the IHN-CCO PCP assignment list. Discussion occurred regarding readiness to open the portal to other PCP sites. It was decided to open the portal to a limited number of additional sites. IHN-CCO is in process of identifying a long-term strategy for implementing the functionality currently available only through the portal. This process has been internalized operationally within IHN-CCO. The decision was made by the Delivery System Transformation Steering Committee to close this component of the pilot.
3.	Establish & test an engagement strategy for newly assigned IHN-CCO members	Limited resources impacted the ability to receive a report to benchmark the current length of time for new members from enrollment to first visit and where the first visit occurred (ED, Urgent Care, PCP	The engagement process was developed by a work group of RN Care Coordinators. The initial engagement visit is designed to include obtaining a health history, a brief risk assessment and screening, and an introduction to the medical home, including encouragement to call the PCP first for non-emergencies. An initial test of the strategy occurred over an 8 week period. Anecdotal results of one test week follows. • From a list of 142 names; 50% did not have a phone # available through the portal so unable to call the member and 10% were already enrolled and being seen by the pilot site.

			• Of the 35 patients called; over 50% were not interested or confused with the suggestion to schedule an engagement visit, 15% stated they had a different PCP, and 2 scheduled and completed a visit • Of the 2 patients receiving a visit that week, staff & patient felt it was helpful and 'patient-centered'. One of the pilot sites tested a group visit for new OHP members. Registration, a health history, and brief risk assessment were conducted. An Alternative Payment Methodology pilot is being launched in January 2015. It's anticipated those pilots will also be looking at new member engagement strategies. The Delivery System Committee is currently reaching out to see if there are any clinic sites interested in piloting engagement strategies.
4.	Initial data collection to identify members who have utilized the Emergency Department more than 6 times in the prior year for non-emergency issues.	Initial report received for each pilot site which needs refinement.	This information was difficult to retrieve from IHN-CCO system. Very preliminary review of data suggests that a high percentage of those individuals visiting the ED frequently had co-morbid, mental health, addiction, & chronic medical conditions.
5.	Meeting with Emergency Department staff and pilot steering committee to discuss potential strategies for minimizing ED use for non-emergent issues.	Meeting occurred	There are some challenges in implementing communication strategies to the PCP when an ED visit occurs. Some of the barriers include;

			until the assignment process completes its work on increasing accuracy there will be discrepancies in the information available; an automatic alert is when a patient uses the ED is available within the Samaritan Health Services system but not readily available to providers outside the system; challenges in implementing checking PCP assignment within the work flow of the ED if it requires additional steps. Samaritan Health System will be participating in the Emergency Department Information Exchange (EDIE) project which will partially assist in identification of frequent ED utilizers. Strategies will be discussed that are both proactive (i.e. member communication about when to use the ED) and reactive i.e. next day follow-up by the PCP when it is known a patient used the ED. An ED work group was formed outside of the Delivery System pilot and this focus will be included in their work. This focus area will be eliminated from this pilot project

1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.

There were no significant barriers; this work has now been operationalized within the CCO so the pilot will close.

1 c.)Describe any strategies you have developed to overcome these barriers and identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

There were no barriers identified to date that required intervention at the state level. All trouble-shooting to this point happened at the local level.

1 d.) How was the Community Advisory Council involved in the activities for this transformation area?

The Pilot Project Coordinator attended a Benton County Community Advisory Committee meeting to gain input regarding the assignment matching criteria and input regarding the initial engagement visit. Their suggestions were incorporated into the development of pilot strategies.

1 e.) How was the CAC informed of the outcomes for activities in this transformation area?

IHN-CCO Transformation Manager presented an information update to the CAC at the October Regional CAC meeting.

Transformation Area 2.2: PCPCH

Benchmark 2.2	**Integration of Mental Health, Addictions and Primary Care Pilot – Phase 1** Improve access to Behavioral/Mental Health Services
How Benchmark will be measured (Baseline to July 1, 2015)	• Contractor will measure the length of time from identification of Member need for behavioral or mental health services to the time when the Member is seen for an appointment.
Milestone to be achieved as of July 1, 2014	• Contractor establishes a Baseline from the time the Member with a need for behavioral or mental health services or with severe and persistent mental illness is identified to the time of actual implementation of services. • Contractor develops mechanism to record and report monthly on pilot progress.
Benchmark to be achieved as of July 1, 2015	• Contractor achieves improved timelines to access services over the course of the pilot for Members with severe and persistent mental illness.

1. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	This pilot was put on hold due to the pilot sponsor leaving the organization.		

1 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

The project sponsor is no longer with the organization.

1 c.)Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

We are regrouping internally to determine next steps.

1 d.) How was the Community Advisory Council involved in the activities for this transformation area?

1 e.) How was the CAC informed of the outcomes for activities in this transformation area?

The chair of the Community Advisory Council and the CAC Coordinator receives updates through the Delivery System Transformation Steering Committee meeting.

Transformation Area 3: Alternative Payment Methodologies

Benchmark 3	Develop a performance based reimbursement model which pays Samaritan Health Services (SHS) Participating Providers a quality bonus for achieving or exceeding identified Benchmarks, and a model that reimburses SHS specialist Participating Providers through bundled payments for specific types of services rendered.
How Benchmark will be measured (Baseline to July 1, 2015)	• Contractor will use known and measured Health Plan Employer Data and Information Set (HEDIS) Benchmarks to establish a Baseline. • Contractor will measure claims data before and after implementation of the

	bundled payments.
Milestone to be achieved as of July 1, 2014	• Contractor implements the bundled payment software and begins bundling payment to a small set of SHS specialist Participating Providers.
Benchmark to be achieved as of July 1, 2015	• Contractor compares utilization data on related services from Participating Providers who are not included in the model to those that are being bundled. • Contractor begins working on non-SHS Participating Provider contracts to implement performance based reimbursement.

1. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	The Alternative Payment Methodologies APM subcommittee received approval from the Delivery System Transformation Steering Committee, and has launched an alternative payment methodology in three Patient-Centered Primary Care Homes. The model replaces the fee-for-service model by reimbursing providers a Per Member Per Month (PMPM) capitation based on risks, identified by historical costs, for members assigned to them. The three clinics provide services to approximately 20% of the IHN-CCO population. The three clinics are working to build the tools and infrastructure necessary to share risk in the capitation payment beginning 01/01/2016. The model includes financial, utilization, access and clinic performance metrics that will be monitored to determine success.	The clinics signed their contract amendment, and therefore received their first capitation payment 01/01/2015. The meetings have been scheduled throughout the year, and the reports to use to effectively build upon the model are 60% complete. Communication is spreading throughout the community on the model, the future of the model, and the plans for inception by all PCPCH's.	Reporting. Both IHN-CCO and the provider clinics are working to change workflow, manage and engage patients, and monitor progress. All of these take a lot of time, system implementation, and committed resources. Many processes are being analyzed to ensure the improvements necessary for the model to successfully transition to a shared risk model.

1 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

Determining how to develop the PMPM payments took a lot of work and a lot of time due to not having a risk stratification workflow in place that is agreed upon by the entire IHN-CCO community. Therefore, the PMPM rates are based on historical costs.

Gaining buy-in from the provider clinics to accept the PMPM payment, and trust in the new methodology was a long process that required a lot of collaboration, transparency, and making data available.

1 c.)Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

The APM subcommittee has recommended that the Delivery System Transformation Steering Committee create a workgroup from key stakeholders in the community to work on a uniform risk stratification model. Once developed, the PMPM payment will be re-calculated against the agreed upon model.

IHN-CCO has set up ongoing meetings with each pilot site, and is developing the reports that both parties find important for sharing to monitor payments, and adjust if necessary. In addition to financial reports, the team will review access reports, utilization reports and clinic performance reports.

1 d.) How was the Community Advisory Council involved in the activities for this transformation area?

The Community Advisory Council receives reports on an ongoing basis on the payment methodology being implemented, and will continue to receive the outcomes of the performance being monitored.

1 e.) How was the CAC informed of the outcomes for activities in this transformation area?

The CAC receives information from IHN-CCO on all transformation projects, and goal achievements. The APM Subcommittee provides information for these reports on alternative payment outcomes for reporting to the CAC.

Transformation Area 4: Community Health Assessment and Community Health Improvement Plan

Benchmark 4	Collaboration with local public health and mental health authorities, professionally and culturally diverse community based organization, hospital systems(s), the Contractor Community Advisory Council (CAC) and Community partners and stakeholders to prepare strategies for development of a shared

	health assessment and improvement plan that serves as a strategic population health and health care system service plan for the Communities served by Contractor
How Benchmark will be measured (Baseline to July 1, 2015)	• Use the information gathered from Community participants to determine the strategic issues that must be addressed in order to reach Contractor vision. • Specify goals, objectives, strategies, budget and leadership for the strategic issues identified. • Describe the scope of the activities, services and responsibilities that Contractor considers upon implementation of the shared health assessment and improvement plan.
Milestone to be achieved as of July 1, 2014	• Contractor completes Community Health Assessment Plan (CHIP).
Benchmark to be achieved as of July 1, 2015	• Contractor measures health improvement against the Baseline and reports the results of its health improvement efforts to the Community.

1. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	The CAC and local committees participated in two half-day trainings on leadership and influence. The purpose of these trainings was to further assist the CAC and its local committees in understanding their role, how to collaborate successfully in groups with diverse perspectives and work styles, and how to effectively influence transformation of the health care system.	The trainings were well attended in June and Sept 2014. Evaluations were favorable and meetings have run more smoothly as a result. This allows the CAC to more effectively do their work.	The CAC and the local committees are better prepared to collaborate and understand their roles.
2.	The CAC formed a Communication Coordination Committee (CCC) consisting of CAC and local committee leadership, with technical assistance	The local committees have been able to share information, ideas, and to do CHIP related regional and local planning. A large	See previous column

	from the CCO CEO, a county Health Administrator, the CAC Coordinator, and the Innovator Agent. This group has met four times and will continue to meet at least bi-monthly.	part of their focus has been on planning how to do the first annual report due to OHA June 30.	
3.	In November 2014, the CAC accepted the CCC recommendation to ask the local committees to work on providing a list of outcomes they hope to see from their CHIP goals as well as a list of potential indicators.	The local committees accepted the tasks and have begun work. The CCO provided a report of their progress on all CHIP related activities.	Over time, more CCO specific data will be required for the CAC to do its work.
4.	The CAC and local committees are receiving training on "Moving from Goals to Outcomes" and they worked through an example.	The CAC and local committees have received the training and will begin work on identifying outcomes and potential indicators.	
5.	Through a collaborative effort, the CCO and the three counties established the Regional Health Assessment (RHA) Project to coordinate a wide variety of health assessments, including those of the counties, the hospitals, the Early Learning Hub (ELH), and various community organizations. As part of that project, the RHA team will identify available data and potential for new data becoming available and will create a repository of shared data for routine reporting and grant-related requirements.	An RHA Project Coordinator and a Public Health Planner were hired and have begun work on the project, including conducting the Goals to Outcomes trainings. The RHA Project Coordinator was appointed to the CAC. The CAC Coordinator met with ELH in fall 2014. It was agreed that once an ELH Coordinator was hired and the contracts were in place with the State, the CAC and ELH Coordinator would meet to look at the type of collaboration that will be useful. This meeting is planned for early April 2015.	This RHA project will streamline and improve processes and collaboration on many Community Health Assessments in the region and create a data repository.
6.	Fall 2014, the CAC Coordinator met with leadership of the still forming Early Learning Hub to discuss overlap of the two councils' work and collaboration opportunities.	A connection was made between the two councils, and there is a plan to meet early in 2015, once the ELH's contract informs them of their CHIP related requirements. The CAC anticipates that this collaboration will help them to include more early childhood related goals in their CHIP	
7.	Through a collaboration of community partners and the CCO, a Regional Healthy Communities	The Steering Committee meets quarterly. The CCO hired a Regional Project	This collaboration allows the community to be prepared

	Steering Committee was created to oversee and collaborate on the many grants they were awarded.	Coordinator to convene the Steering Committee and provide support to regional grant work. The focus of the Steering Committee is to build on strong, well-established partnerships to implement, evaluate and disseminate evidence based strategies shown to be effective in reducing tobacco use and related chronic diseases, preventing the development of secondary conditions, addressing mental health promotion and prevention, promoting healthier lifestyles, and ensuring health equity. This grants and the work of this committee has the potential to assist the CCO in reaching their CHIP goals.	when applying for future grants.
8.	Through a provider and CCO collaboration, the CCO has approved more than 20 transformational pilot/proof-of-concept projects. The pilot application required that all proposals fit within the scope of the CHIP.	Many pilots are in place; the remaining pilots will be in place in early 2015. These pilots have the potential to assist the CCO in reaching their goals.	
9.	The Coordinator and the IHN-CCO Regional Planning Council Management Group are working with the Innovator Agent to understand OHA's CHIP Guidelines and to determine how the CHIP meets those guidelines and where more work is needed.	CAC Coordinator and the Innovator Agent met with Office of Equity and Inclusion (OEI) to look at how OEI can collaborate with the CAC. See #10.	
10.	The CAC Coordinator and the Innovator Agent teleconferenced with a representative of OEI to discuss collaboration and to plan a potential training with the CAC. The Linn-Benton Health Equity Alliance Project Coordinator is scheduled	See previous column.	It would be helpful if OEI had a broader focus than just race & ethnicity.

	to meet regularly with the CAC Coordinator and CCO staff to assist them with identifying ways to create health equity and reduce health disparities.		

1 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

It took several months, perhaps six, to get a response from the Office of Equity and Inclusion to set up a meeting to discuss how the CAC and OEI may collaborate on the CHIP, as required in the contract. Also, it was learned that OEI has a very narrow focus on health disparities that doesn't address a great variety of disparities applicable to this region and which the CAC identified and targeted for improvement in the CHIP and which are also listed in the contract.

1 c.) Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

The CAC Coordinator and the Innovator Agent held a teleconference with a representative of OEI in January 2015. That was a productive meeting where OEI offered to provide CAC training on health disparities and health equity, as it relates to race and ethnicity. The CAC will be asked to make a decision about which trainings they want to prioritize for this year and the CAC Coordinator will offer this as one of the possibilities. Another potential way for the OEI and the CAC to collaborate is for the OEI to assist the CAC in obtaining data.

1 d.) How was the Community Advisory Council involved in the activities for this transformation area?

The CAC and its local committees are actively involved in shaping all aspects of the CHIP, as described above.

1 e.) How was the CAC informed of the outcomes for activities in this transformation area?

The CCO CEO provided a status update to the CAC and local committees in January 2015 and intends to provide another in March. The CAC Chair regularly attends the CCO's Regional Planning Council and Board of Directors meetings. He often attends the 2-3 per monthly Transformation Steering Committee meetings.

Transformation Area 5: EHR, HIE and meaningful use

Benchmark 5.1	Contractor agrees to participate in OHA's upcoming process to assess the next phase of statewide Health Information Exchange (HIE) development (including assessing the scope, financing, and governance of statewide HIE services). In particular, Contractor will make appropriate executive and staff resources available for an interview with an OHA consultant, and will participate in brief stakeholder workgroup meetings if requested by OHA. After the OHA process concludes and the next phase of statewide HIE services are defined, Contractor will update this HIE component of its transformation plan at the next update cycle.
How Benchmark will be measured (Baseline to July 1, 2015)	
Milestone to be achieved as of July 1, 2014	
Benchmark to be achieved as of July 1, 2015	
Benchmark 5.2	Development and implementation of Electronic Health Records structure, policy and workflows to support an electronically accessible Care Plan for all Participating Providers involved in a Members care.
How Benchmark will be measured (Baseline to July 1, 2015)	• Utilization of chosen Electronic Health Records structure by Participating Providers in the care of Members
Milestone to be achieved as of July 1, 2014	• Contractor develops roadmap for implementing Health Information Technology (HIT) in its Service Area. • Contractor gives access to case management staff to evaluate and educate Participating Providers. • Contractor pilots Epic Care Link usage between Contractor and a select Participating Provider panel.
Benchmark to be achieved as of July 1, 2015	• Contractor establishes a shared Electronic Health Record system for Participating Providers and partners to access in its Service Area, to enable a "community care plan".

1. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	IHN-CCO implemented a community wide Health Information Technology (HIT) Workgroup.	• Renamed the HIT Workgroup to Regional Health Information Collaborative (RHIC) Committee. We continue to meet every two weeks.	
2.	July 2014 – Contract Negotiations August 2014 – RHIC Project Work Shop with all data contributors September 2014 – Marketing Strategy and Adoption Strategy started. October 2014 – Contract Signed – Project Initiated November 2014 – Samaritan Clinical and Samaritan Health Plan Claims data extracts initiated. December 2014 – Systems and Environments configuration complete	• Contract signed on October 9th • Project Initiated • Data extracts initiated • Systems created and configured	

1 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.
None

1 c.)Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

IHN-CCO attended the CCO Summit held in Portland during December 2014. Several IHN-CCO employees attended the HIE breakout session.

In addition, IHN-CCO received assistance form HIXNY (Health exchange in New York) and RIQI (Health exchange in Rhode Island) in the form of documented best practices. We received user adoption guidelines from InterSystems and are currently incorporating them into our marketing plans.

1 d.) How was the Community Advisory Council involved in the activities for this transformation area?

CAC Chair has attended the RHIC Privacy Workgroup meetings held since September 2014.

1 e.) How was the CAC informed of the outcomes for activities in this transformation area?

Up to this time, there haven't been any formal communications to the CAC about the achieved milestones of this project.

Transformation Area 6: Communications, Outreach and Member Engagement

Benchmark 6	**Mental Wellness Literacy Campaign Pilot:** Increase awareness amongst Primary Care Providers (PCP), community and faith-based organizations, and local schools in Linn County, and the Contractor organization as a whole, of the ways all parties can take action to improve the wellness of people with mental health problems.
How Benchmark will be measured (Baseline to July 1, 2015)	• Focus groups comprised of community and faith-based organizations, educators, Contractor staff, and PCP's. • Member, stakeholder, and local resident surveys.
Milestone to be achieved as of July 1, 2014	• Contractor offers an online learning and resource center in multiple languages. • Contractor offers Community education campaign in culturally and linguistically appropriate ways. • Contractor targets an education campaign for community and faith-based organization, and local schools.
Benchmark to be achieved as of July 1, 2015	• Contractor ensures that 100% of Contractor staff and PCPs are aware of the online learning and resource center and have knowledge of its purpose. • Contractor ensures that participants in focus groups indicate awareness of

	the community education campaign and knowledge of its purpose through a measurement tool. • Contractor ensures that 35% of those surveyed indicate awareness of the community education campaign and knowledge of its purpose.

1. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements. (Actions since last report, 7/1/14-12/31/14)

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	Online Learning and Resource Center • Selection of platform for on-line training • Content development for professional training module, *Understanding Mental Illness* • Development of artwork, voice narration, background music, etc., for video training module	• Cornerstone platform selected • For training module: completed content development and final training video demo, incorporated focus group feedback	Successful use of vendor for translating content into training video will be model for future training modules.
2.	Education Campaign: Today I Am • English language Wellness Campaign, *Today I Am*, completed June 2014 in Linn County. • Marketing firm conducted post-survey of members, stakeholders, and local residents (307 Linn County residents) • Focus groups of Latino population conducted by marketing firm and completed November 2014 in Linn and Lincoln counties, to inform regional Spanish language Wellness Campaign	• *Today I Am* campaign post-survey completed Aug 2014 shows 51% familiarity with IHN-CCO, 65% familiarity with Wellness Campaign (exceeding target of 35%) • Latino Focus Groups completed November 2014	• Feedback from Latino focus groups will inform multiple CCO outreach efforts with Latino members. • Success of *Today I Am* campaign in Linn County has resulted in IHN-CCO plan to expand to rest of CCO region.
3.	Education Campaign: (STAND, Linn Together, CHANCE) Observance of Mental Health Awareness Month 2014 Utilization of local youth groups, prevention coalitions,	• Local prevention groups have been receptive to	• Linn Together middle school registration events (see below) Linn Together members completed 650

	and other community stakeholders in dissemination of Today I Am campaign material	incorporating Mental Health Promotion within their focus, and have been successfully mobilized to participate in education campaign. • Youth group developed and distributed youth-oriented campaign material consistent with 8 Dimensions of Wellness theme.	parent contacts providing the "Today I Am" campaign materials • STAND (Students Taking Action Not Drinking), school based mental health awareness campaign: Included nine Linn County high schools (Albany Options, Central Linn JR/SR High, Harrisburg High, Lebanon High, Santiam Canyon High, Scio High, South Albany High, Sweet Home High and West Albany High schools). Activities included dissemination of posters and other promotional incentives. • Collaborative planning with Linn County Mental Health Advisory Board to develop myth & fact table tents • CHANCE, Bridges to Recovery, provided "Today I AM" campaign materials and other resources to 400 community members
4.	Coalition of Local Health Educators • Convened coalition of prevention professionals and health educators to allocate funds for Mental Health Promotion and Prevention projects • Utilized this group as a model for partner groups in other counties in region to contribute local data and needs assessments to Regional Healthy Communities Steering Committee, under AMH Mental Health Promotion & Prevention (MHPP) Grant	Based on data and key informant interviews conducted as part of MHPP Grant, identified key needs for MH Literacy project funding, and awarded portion of current-year funds	• Key partners met to identify and prioritize target areas including (Girls Circle/Boys Council, LifeSkills Training, STAND and the Seven Project) • Partial funds distributed
5.	Grassroots Outreach In support of education campaigns noted above.	• Aug. 12, Calapooia Middle School	

		Registration, Albany • Aug. 12, Memorial Middle School Registration, Albany • Aug. 14-15, Seven Oak Middle School Registration, Lebanon • Aug. 18, Mill City Middle/High School Registration, Mill City • Aug. 19-20, Harrisburg Middle School Registration, Harrisburg • Aug. 19, North Albany Middle School Registration, Albany • Aug. 19-21, Scio Middle School Registration, Scio Aug. 20, Central Linn Middle/High School Registration, Halsey	

1 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

Continuing need for technical assistance in best strategies for culturally appropriate outreach and education strategies for Latino community.

1 c.)Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

Project Team has worked with local Health Equity Alliance and Oregon Office of Equity and Inclusion. Spanish-language focus groups have been very helpful.

1 d.) How was the Community Advisory Council involved in the activities for this transformation area?

CAC members participated in Focus Groups, helped form messages and strategies for education campaign, and members are involved with Coalition of Health Educators.

1 e.) How was the CAC informed of the outcomes for activities in this transformation area?

Drafts and updates of elements of education campaign and online learning resource were presented for review and comment during CAC public meetings.

Transformation Area 7: Meeting the culturally diverse needs of Members

Benchmark 7	Contractor staff and Participating Providers receive annual trainings that focus on but are not limited to health equity, health literacy, cultural competence, cross-cultural communication, working with non-traditional health care workers in clinical teams, diversity, and cultivating a diverse workforce.
How Benchmark will be measured (Baseline to July 1, 2015)	• Training process is developed. • New employees receiving trainings within 6 months of hire. • All employees receiving trainings on an annual basis.
Milestone to be achieved as of July 1, 2014	• Contractor develops a process for delivery and documentation of training. • Contractor ensures that identified staff and Participating Providers have received trainings focused on topics identified in this Benchmark.
Benchmark to be achieved as of July 1, 2015	• Contractor ensures that 100% of Contractor employees and Participating Providers have completed annual trainings that assist in assuring that the culturally diverse needs of Members are met.

1. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	All PCPs received the 2014 Annul Education. Within this	2014 – Completed	(1) Each year enhance the trainings and

	Annual Training were two modules titled: (1) The Journey to Cultural Competency and (2) Cultural Competency Tools.		introduce new topics. (2) Broaden the User population beyond PCPs – to include, but not limited to: Behavioral Health, DCOs, Specialist, Clinic Managers & Staff.
2.	The 2014 Annual Training used a new learning platform by Cornerstone. The platform is cloud-based allowing the Health Care Professionals to complete the training from any computer with an internet connection.	2014 – Learning Management System (LMS) implemented and distributed to all PCPs	(1) Work to add mobile devices as another avenue to receive trainings. (2) Work with Clinic Managers to increase their knowledge and understanding of the Cornerstone learning platform. This will allow them to assist the Health Care Professionals in completing the trainings and/or answer their questions.
3.	(1) The new learning platform will allow us to deliver trainings as new Health Care Professionals are uploaded into the LMS. Each learning object or curriculum can set parameters as determined. (2) Analytics are available to report on different areas of the LMS.	2014 – Completed and ongoing	(1) Increase the Administrators knowledge of the Cornerstone LMS to expand the use. (2) Increase time allotted to complete trainings – possibly rolling out learning objects quarterly instead of one curriculum. This may lessen the burden on the Health Care Professionals.

1 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area.

The working group was not completely formalized – therefore, meetings were not being held.

1 c.)Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

New chairperson has been established and meetings have been scheduled.

1 d.) How was the Community Advisory Council involved in the activities for this transformation area?

Informed of possible new team member.

1 e.) How was the CAC informed of the outcomes for activities in this transformation area?

To be developed.

Transformation Area 8: Eliminating racial, ethnic and linguistic disparities

Benchmark 8	Contractor will document the ethnicity data of its Members and will identify if there are any disparities in access based on ethnicity.
How Benchmark will be measured (Baseline to July 1, 2015)	• Baseline – No data to date. • Contractor researches and documents the ethnicity of its Members.
Milestone to be achieved as of July 1, 2014	• Contractor gathers Member ethnicity data either from state data or by contacting its Members.
Benchmark to be achieved as of July 1, 2015	• Contractor identifies any disparity in access based on ethnicity.

1. a) Please describe the actions taken or being taken to achieve milestones and/or benchmarks in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Action Taken or Being Taken to Achieve Milestones or Benchmarks	Outcome to Date	Process Improvements
1.	IHN-CCO identifies any disparity in access based on ethnicity.	Data still being analyzed	• Working with 1 pilot clinic to identify specific access issues and determine whether they are related to ethnicity • Focusing on pediatric Latino population first at the 1 pilot clinic

1 b.) Please describe any barriers to achieving your milestones and/or benchmarks in this Transformation Area. IHN-CCO hasn't had any specific "barriers" during this reporting period but did experience a delay due to scheduling conflicts with the pilot clinic and our committee members but this has been resolved and we are moving forward with the project.

1 c.)Describe any strategies you have developed to overcome these barriers. Identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

N/A

1 d.) How was the Community Advisory Council involved in the activities for this transformation area?

The CAC Coordinator is a member of the Race and Ethnicity sub-committee. This individual reports to the CAC and brings their recommendations to the Race and Ethnicity sub-committee. An update is also provided to the Transformation Manager every two weeks for report to the Delivery System Transformation Steering Committee which is attended by the CAC Coordinator.

1 e.) How was the CAC informed of the outcomes for activities in this transformation area?

The CAC coordinator is a member of the Race and Ethnicity sub-committee. This individual reports to the CAC. An update is also provided to the Transformation Manager every two weeks for report to the Delivery System Transformation Steering Committee which is attended by the CAC Coordinator.