

>> Opportunities for Oregon's Coordinated Care Organizations to advance health equity



**Opportunities for Oregon's
Coordinated Care Organizations
to Advance Health Equity**

June 2017

**Oregon Health Authority
Transformation Center**

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Author: Ignatius Bau, Technical Assistance Bank Consultant

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For more information, contact:
 Ignatius Bau
 564 Market Street Suite 305
 San Francisco, CA 94104
<http://ignatiusbau.com>

Executive summary

Since 2012, Oregon's 16 coordinated care organizations (CCOs) have been implementing an innovative model of health system transformation. The CCOs have been leveraging federal funding from Medicaid and from the Centers for Medicare & Medicaid Services (CMS) Innovation Center to work toward better care, healthier people and smarter spending.¹ One of the goals integrated throughout the CCO model is advancing health equity; the Institute for Healthcare Improvement has called health equity the forgotten aim of health care quality improvement.²

CCOs are obligated to identify and pursue opportunities to advance health equity in several ways. Three of the eight transformation plan areas in their Oregon Health Authority (OHA) contracts require CCOs to meet their diverse members' cultural and linguistic needs and to reduce racial and ethnic disparities. These obligations include:

- Assuring that communications, outreach and member engagement are tailored to cultural, health literacy and linguistic needs
- Assuring that the culturally diverse needs of members are met including:
 - Cultural competence training
 - Provider composition that reflects member diversity
 - Certified traditional health workers and traditional health workers composition reflecting member diversity and
- Developing a quality improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, care experience and outcomes.

Other contractual requirements also support health equity by ensuring access to and continuity and coordination of health care for CCO members. An example is assigning CCO members to patient-centered primary care homes (PCPCHs). The requirements for implementing electronic health records and participating in electronic health information exchange primarily support improved care coordination and transitions of care. However, they can also identify disparities using CCO member demographic information.

In addition, CCOs have been measuring and reporting their performance on more than 30 health care quality measures. OHA has reported statewide CCO performance on those quality measures, stratified by race and ethnicity (and, more recently, by disability and mental health diagnosis), as part of its accountability to CMS and to the public.³ These stratified data highlighted the continuing racial and ethnic disparities in health care access and outcomes among Oregon's diverse CCO members:

- Hispanic/Latina women are less likely to have timely prenatal care.

¹ Conway P. Transforming health care delivery through the CMS Innovation Center: better care, healthier people, and smarter spending. The CMS Blog, January 5, 2017, at:

<https://blog.cms.gov/2017/01/05/transforming-health-care-delivery-through-the-cms-innovation-center/>

² Institute for Healthcare Improvement, Achieving Health Equity: A Guide for Health Care Organizations (2016), at: <http://www.ihl.org/resources/Pages/IHlWhitePapers/Achieving-Health-Equity.aspx>

³ Oregon's Health System Transformation CCO Metrics 2015 Mid-Year Update (January 2016), at: <http://www.oregon.gov/oha/Metrics/Documents/2015%20Mid-Year%20Report%20-%20Jan%202016.pdf>;

Oregon's Health System Transformation: CCO Metrics 2015 Final Report (June 2016), at: http://www.oregon.gov/oha/Metrics/Documents/2015_performance_report.pdf; and Oregon's Health System

Transformation: CCO Metrics 2016 Mid-Year Report (January 2017), at: http://www.oregon.gov/oha/Metrics/Documents/2016_Mid-Year_Report.pdf

- American Indian children are less likely to receive developmental screening.
- Hawaiian/Pacific Islander children are less likely to receive immunizations.
- Children with disabilities and American Indian and Hawaiian/Pacific Islander children are less likely to receive dental sealants.
- Adolescents of color and from households speaking languages other than English are less likely to receive adolescent well care.
- Latinos/Hispanics are less likely to receive colorectal cancer screening
- American Indians have the highest rates of smoking.
- Asian Americans are less likely to receive screening for alcohol and substance misuse.
- Asian American women at risk for unintended pregnancy are less likely to have effective contraception use.
- American Indians, African Americans/Blacks and individuals with disabilities have higher rates of emergency department use.

CCOs have had access to their own CCO-level quality measure data, stratified by their own members' race, ethnicity, household language and disability.⁴ CCOs can use these data to identify specific ways to reduce disparities and advance health equity among their members.

Finally, there are robust requirements for CCOs to engage the diverse communities that they serve by conducting community needs assessments and by developing and implementing community health improvement plans (CHPs) responsive to the identified community needs. Many of these community needs go beyond health care and highlight the social determinants of health fundamental to advancing health equity. CCOs have invested significant efforts and financial resources in the communities they serve through these CHPs, including addressing social determinants of health that support health equity. CCOs also hold themselves accountable through community advisory councils (CACs), which include CCO members, and other formal and informal structures for continuous community engagement and partnership.

While each of the CCOs has developed and implemented multiple activities to meet these responsibilities to advance health equity, no systematic effort has documented, analyzed or supported these activities. Beginning in March 2016, the OHA Transformation Center developed and offered voluntary, tailored technical assistance to the CCOs to support their health equity activities. This report describes how the Transformation Center delivered that tailored technical assistance to all 16 CCOs. The report also summarizes the rich discussions with the CCOs about their opportunities to advance health equity for their diverse members and communities.

⁴ These data were first publicly reported by the OHA Office of Health Analytics at a Metrics and Scoring Committee meeting in June 2016:

<http://www.oregon.gov/oha/analytics/MetricsDocs/Measures%20by%20Race.%20Ethnicity.%20CCO.pdf>

Introduction

This report is organized as follows:

Section 1 provides an overview of the CCOs and their members, and provides an overview of the obligations of the CCOs to advance health equity. **Section 2** describes how the tailored technical assistance provided to the CCOs on health equity was developed, refined, and delivered, from March through November 2016.

Section 3 provides detailed data about the diverse demographic characteristics of CCO members throughout Oregon. **Section 4** presents detailed data about CCO performance statewide and at the individual CCO level on a set of 18 health care quality measures (CCO incentive measures for 2016) and identifies opportunities to advance health equity through improvements on those measures. This section includes the highlights of the discussions and follow-up ideas about these incentive measures at the health equity consultations with the 16 CCOs.

Section 5 reviews the benchmarks and milestones in CCO transformation plans and highlights how improvements in the transformation areas can advance health equity. This section also includes the discussions and follow-up ideas about the transformation areas at the health equity consultations with the CCOs. **Section 6** is an overview of the previously developed CHPs and those that the CCOs are implementing, with examples of how they are advancing health equity.

Section 7 summarizes the follow-up technical assistance to support health equity made available and provided to nine of the CCOs after the health equity consultations. Finally, **Section 8** compiles the key recommendations that emerged from the consultations, discussions and follow-up technical assistance. An **appendix** summarizes the evaluations and written feedback from the over 140 CCO staff and community stakeholders who participated in the health equity consultations.

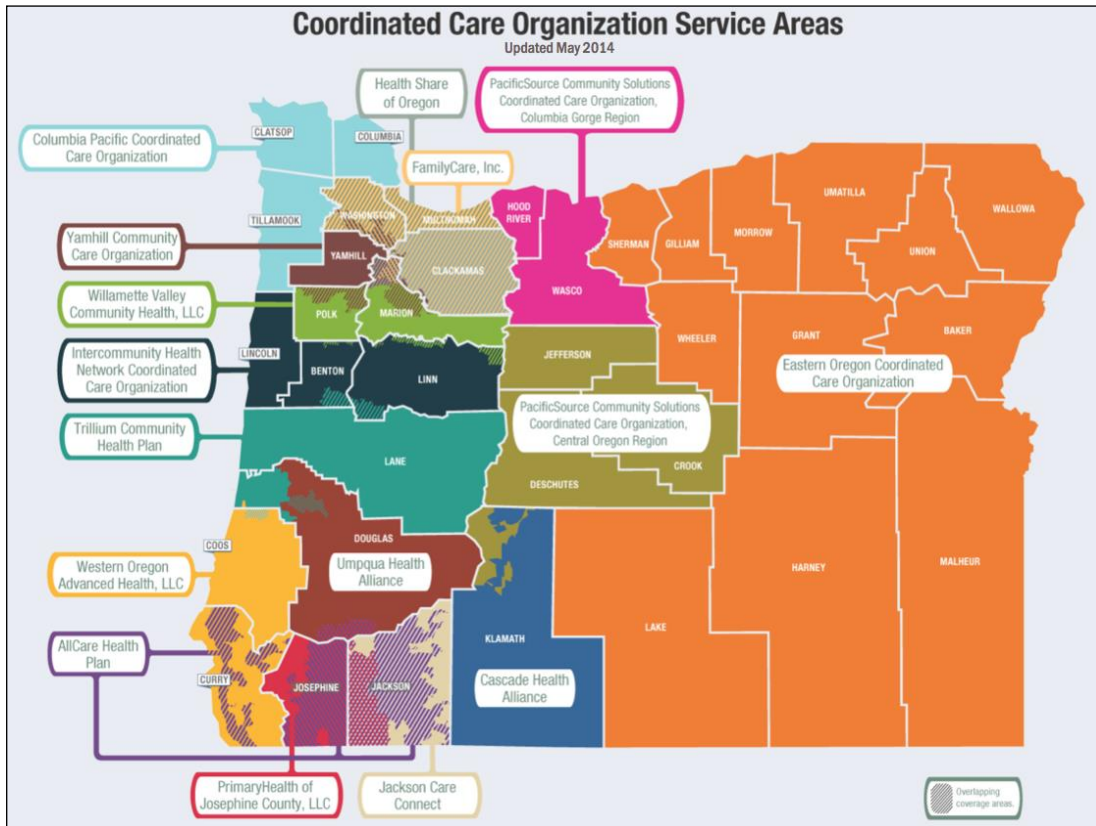
These health equity consultations identified and documented many activities and innovative ideas to advance health equity that Oregon's 16 CCOs are implementing. Among the lessons learned from the CCOs about how to advance health equity are the following:

- Create a CCO-wide plan to advance health equity
- Use each CCO's own data to identify and prioritize disparities
- Partner with diverse members and communities served
- Engage clinics and providers
- Build and sustain a diverse workforce
- Integrate equity into health system transformation
- Be accountable for advancing health equity.

As Oregon's CCOs continue their work toward their goals of health system transformation that will result in better care, healthier people and smarter spending, they also have opportunities to make progress toward reducing disparities and achieving health equity for the diverse Oregon community members they serve.

Section 1: Background on Oregon’s coordinated care organizations (CCOs) and members

In 2012, the Oregon Health Authority (OHA) obtained a five-year Medicaid section 1115 waiver⁵ from the Centers for Medicare & Medicaid Services (CMS) to implement a health system transformation program through Oregon’s Medicaid program (Oregon Health Plan), integrating physical, behavioral, and oral health care services through a new model of coordinated care called coordinated care organizations (CCOs).⁶ To implement the program, OHA contracted with 16 CCOs throughout Oregon, entering into initial three-year contracts through 2015.



Later in 2012, OHA also obtained a State Innovation Model grant from CMS to support additional health system transformation activities by the CCOs.⁷ As a result of Medicaid expansion through the Affordable Care Act, tens of thousands of Oregon residents became eligible for Medicaid beginning in 2014, and most were enrolled in the CCOs. In 2015, OHA renewed its contracts with the 16 CCOs for another three years, through 2017. Earlier this year, CMS approved another five-year section 1115 waiver to continue support for the CCOs.⁸

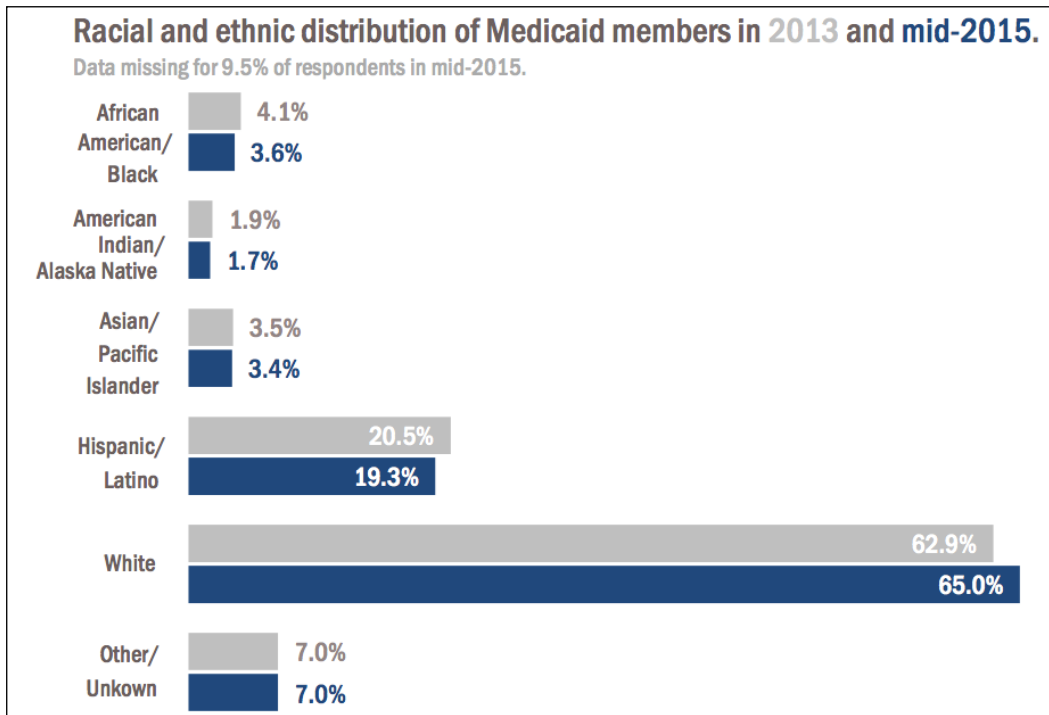
⁵ <https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html>

⁶ <http://www.oregon.gov/oha/hpa/Medicaid-1115-Waiver/Pages/2012-2017-Demonstration-Overview.aspx>

⁷ <https://www.oregon.gov/oha/OHPR/Pages/sim/index.aspx>

⁸ <http://www.oregon.gov/oha/hpa/Medicaid-1115-Waiver/Pages/Waiver-Renewal.aspx>

Between July 2014 and June 2015⁹, there were more than 1 million Oregon residents enrolled in Medicaid, with almost all enrolled as members of the 16 CCOs. Statewide, more than one in four Oregonians used Medicaid for their health insurance coverage. There was demographic diversity among these Medicaid members. At least 28% were communities of color including: 19.3% Hispanic/Latino, 3.6% African American/Black, 3.4% Asian and Pacific Islander, and 1.7% American Indian/Alaska Native.¹⁰



According to 2015 data from the U.S. Census Bureau, 25% of Oregon’s population is from communities of color:

⁹ Oregon’s Health System Transformation CCO Metrics 2015 Mid-Year Update (January 2016), at: <http://www.oregon.gov/oha/Metrics/Documents/2015%20Mid-Year%20Report%20-%20Jan%202016.pdf>
 As explained in Section 4, the health equity consultations primarily used CCO member and quality measures data for the 12-month rolling period of July 2014–June 2015, which were the latest available data at the time the consultations began. For comparison, as of March 2017, there were more than 978,000 Oregon residents enrolled in Medicaid.
<http://www.oregon.gov/oha/healthplan/DataReportsDocs/March%202017%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf>

¹⁰ Oregon’s Health System Transformation CCO Metrics 2015 Mid-Year Update (January 2016), at: <http://www.oregon.gov/oha/Metrics/Documents/2015%20Mid-Year%20Report%20-%20Jan%202016.pdf>
 Statewide, the race and ethnicity of 7% of CCO members was not known so it is likely that the percentage from communities of color is higher than 28%.

HISPANIC OR LATINO AND RACE			
Total population	4,028,977	****	4,028,977
Hispanic or Latino (of any race)	511,898	****	12.7%
Mexican	419,208	+/-8,812	10.4%
Puerto Rican	12,734	+/-2,342	0.3%
Cuban	8,582	+/-2,356	0.2%
Other Hispanic or Latino	71,374	+/-7,990	1.8%
Race alone or in combination with one or more other races			
Total population	4,028,977	****	4,028,977
White	3,606,157	+/-11,976	89.5%
Black or African American	109,403	+/-2,892	2.7%
American Indian and Alaska Native	129,579	+/-5,524	3.2%
Asian	227,243	+/-1,966	5.6%
Native Hawaiian and Other Pacific Islander	29,529	+/-2,657	0.7%
Some other race	124,070	+/-9,291	3.1%

Source: American Community Survey, 2015 One-year Estimate (Table DP05)

In terms of languages spoken, English was reported as the household language for 57.3% of CCO members; 6.3% reported Spanish as the household language, with thousands of CCO members from households where the language spoken was Russian, Vietnamese, Cantonese, Somali, Arabic and other languages. In total, more than 8% of CCO members were from households where the primary language spoken was not English. However, the household language of a significant number of CCO members was other/undetermined or missing (see discussion in Section 3).

Household language July 2014-June 2015	English	Spanish	Russian	Vietnamese	Cantonese	Somali	Arabic	Burmese	Nepali	Karen
CCO members	649,178	71,282	6,751	3,990	2,044	1,789	1,215	510	441	403
1,132,846	57.3%	6.3%	0.6%	0.4%	0.2%	0.2%	0.1%	<0.0%	<0.0%	<0.0%

Household language July 2014-June 2015	Korean	Farsi	Romanian	Hmong	Cambodian	Bosnian	Laotian	Swahili	Amharic	Oromo
CCO members	354	350	333	240	221	146	136	133	123	110
1,132,846	<0.0%	<0.0%	<0.0%	<0.0%	<0.0%	<0.0%	<0.0%	<0.0%	<0.0%	<0.0%

Household language July 2014-June 2015	Afrikaans	Other languages (<100 for any language)	Other/undetermined	Missing
CCO members	107	1,048	324,133	67,809
1,132,846	<0.0%	0.1%	28.6%	6.0%

Source: OHA Office of Health Analytics

2015 Census data indicates that the 15% of Oregon residents lived in households where the primary language spoken was not English. This indicates the data for CCO members living in households where the primary language spoken is not English is probably under-reported:

Subject	Total		Percent	
	Estimate	Margin of Error	Estimate	Margin of Error
Speak only English	3,226,975	+/-13,520	84.9%	+/-0.4
Speak a language other than English	572,863	+/-13,512	15.1%	+/-0.4
SPEAK A LANGUAGE OTHER THAN ENGLISH				
Spanish	348,284	+/-11,175	9.2%	+/-0.3
5 to 17 years old	95,183	+/-5,246	2.5%	+/-0.1
18 to 64 years old	237,294	+/-7,505	6.2%	+/-0.2
65 years old and over	15,807	+/-1,586	0.4%	+/-0.1
Other Indo-European languages	91,218	+/-6,616	2.4%	+/-0.2
5 to 17 years old	13,480	+/-2,314	0.4%	+/-0.1
18 to 64 years old	60,192	+/-4,665	1.6%	+/-0.1
65 years old and over	17,546	+/-2,062	0.5%	+/-0.1
Asian and Pacific Island languages	111,500	+/-5,587	2.9%	+/-0.1
5 to 17 years old	16,426	+/-2,058	0.4%	+/-0.1
18 to 64 years old	83,333	+/-4,166	2.2%	+/-0.1
65 years old and over	11,741	+/-1,385	0.3%	+/-0.1
Other languages	21,861	+/-4,661	0.6%	+/-0.1
5 to 17 years old	4,304	+/-1,858	0.1%	+/-0.1
18 to 64 years old	16,150	+/-3,455	0.4%	+/-0.1
65 years old and over	1,407	+/-634	0.0%	+/-0.1

Source: American Community Survey, 2015 One-year estimate (Table S1601)

6.3% of CCO members were identified with a disability. For these data, disability is defined as “people who qualify for Medicaid based on an impairment that has prevented them from performing substantial gainful activity for at least one year, or is expected to prevent them from performing substantial gainful activity for at least one year; this may include physical, mental, emotional, learning, developmental or other disabilities; these individuals may or may not also be qualified for Medicare” (see discussion in Section 3).

July 2014– June 2015	Members without disability	Members with disability
CCO members	1,061,759	71,087
1,132,846	93.7%	6.3%

Source: OHA Office of Health Analytics

Census data from 2015 report a higher percentage of Oregonians with a disability, using a broader definition of disability¹¹:

DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION			
Total Civilian Noninstitutionalized Population	316,450,569	+/-15,477	316,450,569
With a disability	39,906,328	+/-98,669	12.6%

Source: American Community Survey, 2015 One-Year Estimate (Table DP02)

¹¹ The Census defines disability using six questions: 1) Is this person deaf or does he/she have serious difficulty hearing? 2) Is this person blind or does he/she have serious difficulty seeing even when wearing glasses? 3) Because of a physical, mental or emotional condition, does this person have serious difficulty concentrating, remembering or making decisions? 4) Does this person have serious difficulty waking or climbing stairs? 5) Does this person have difficulty dressing or bathing? 6) Because of a physical, mental or emotional condition, does this person have difficulty doing errands such as visiting a doctor’s office or shopping? <https://www.census.gov/people/disability/methodology/acs.html>

These statewide data demonstrate there is racial, ethnic, linguistic and other diversity among the members served by the CCOs.

Health equity is the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.¹²

Oregon's CCOs seek to transform health systems as they improve health care and health outcomes for Oregon's Medicaid members. Since CCOs are engaged in the work of health system transformation (changing organizational relationships and structures), they have a unique opportunity to address the historical and contemporary inequalities a resulting from societal and structural factors that have created barriers to access and opportunity. As part of their 2015–2017 contracts with the OHA, CCOs are responsible for eight transformation areas:

- 1 — Integrate physical, mental health and addiction, and oral health services
- 2 — Develop patient centered primary care homes
- 3 — Use alternative payment methodologies that align payment with health outcomes
- 4 — Implement community health assessments and improvement plans
- 5 — Employ electronic health records and health information technology
- 6 — Develop initiatives that address members' cultural, health literacy, and linguistic needs
- 7 — Enhance provider networks and administrative staff to meet culturally diverse community needs
- 8 — Establish quality improvement plans to eliminate racial, ethnic, and language disparities

Source: Mathematica Policy Research

Three of the transformation areas directly relate to health equity:

Transformation area 6: Assuring communications, outreach, member engagement and services are tailored to cultural, health literacy and linguistic needs

Transformation area 7: Assuring that the culturally diverse needs of members are met (cultural competence training, provider composition reflects member diversity, certified traditional health workers' and traditional health workers' composition reflect member diversity)

¹² U.S. Department of Health and Human Services, *National Stakeholder Strategy for Achieving Health Equity* (2011), at: <http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286>

Transformation area 8: Developing a quality improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care and outcomes

CCOs establish their own benchmarks and milestones for improvement for each of these transformation areas.¹³ In its midpoint evaluation of Oregon's section 1115 waiver, Mathematica Policy Research reported:

Relative to the other elements of transformation, most CCOs have placed less emphasis on their development of initiatives to address members' cultural needs and disparities. While the transformation elements related to addressing members' unique cultural needs, increasing the diversity of staff and providers and their cultural competence, and eliminating health disparities are distinct objectives the barriers to addressing them overlap. In particular the definition of vulnerable or at-risk populations, access to data, and lack of resources and expertise were commonly cited barriers.¹⁴

In its September 2016 First Quarterly Report to the Oregon Legislature, OHA referred to CCO activities in these transformation areas, noting their work on member engagement, cultural competency and health disparities.¹⁵ According to that report, 14 of 15 CCOs met their benchmarks for member engagement, nine of 15 CCOs met their benchmarks for cultural competency, and nine of 15 CCOs met their benchmarks for health disparities.¹⁶ According to that OHA report, only five of 15 CCOs (PacificSource Central Oregon, PacificSource Columbia Gorge, PrimaryHealth, Umpqua Health Alliance, and Willamette Valley Community Health) met their benchmarks for all three of these transformation areas.

Three other transformation areas indirectly relate to health equity:

Transformation area 2: Continuing implementation and development of patient-centered primary care homes

Transformation area 5: Developing a plan for encouraging electronic health records, health information exchange and meaningful use

Transformation area 4: Preparing a strategy for developing a community health assessment and adopting an annual community health improvement plan

The standards for patient-centered primary care homes (PCPCHs) require the collection and documentation of CCO member demographic data (standard 4C) and the provision

¹³ <http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/Oregon-CCO-Transformation-Plans.aspx>

¹⁴ Mathematica Policy Research, Midpoint Evaluation of Oregon's Medicaid Section 1115 Demonstration: Mid-2012 Through Mid-2014 (2015), page 26, at: <https://www.oregon.gov/oha/OHPB/Documents/Final%20Report%20for%20the%20Midpoint%20Evaluation%20%204-30-2015.pdf>

¹⁵ Oregon's Health System Transformation Quarterly Legislative Report, Q1 2016 (September 2016), at: http://www.oregon.gov/oha/analytics/Documents/LegislativeReport_Q1_2016.pdf

¹⁶ The last CCO to contract with OHA, Cascade Health Alliance, was exempted from reporting for this period.

of culturally and linguistically appropriate services to CCO members (standard 6A).¹⁷ Both are “must-pass” standards. Being assigned to a PCPCH means that a CCO member has a regular source of care and is more likely to receive preventive screenings and achieve effective clinical management of chronic conditions.

In addition, the CCOs are supporting electronic health record implementation by their providers and use of electronic health information exchange to improve their access to real-time quality measure data about their patients. There is an opportunity to include member demographic data as part of that electronic documentation and information exchange to provide additional data about apparent disparities and opportunities to advance health equity.

Finally, the community health assessments (CHAs) and community health improvement plans (CHPs) engage local community stakeholders and establish priorities and support for interventions to improve health at the community or population health level.¹⁸ Many of the CHAs and CHPs identify and address the social determinants of health essential to achieving health equity but that may not be adequately addressed by health care providers and systems.¹⁹

These contractual requirements in the CCO transformation plans provide a strong framework for the CCOs to advance health equity. Since the CCOs regularly report their activities and progress on achieving their benchmarks and milestones for each of these transformation areas, there are readily available indicators from all the CCOs for systematic review and analysis to support their work on health equity.

In addition, CCOs have been measuring and reporting their performance on more than 30 health care quality measures. As part of its accountability to CMS and to the public, OHA has reported statewide CCO performance on those quality measures stratified by race and ethnicity (and more recently, by disability and mental health diagnosis).²⁰ CCOs have had access to their own CCO-level quality measure data, stratified by their own members’ race, ethnicity, household language and disability.²¹ These data can be used by CCOs to identify specific opportunities to reduce disparities and advance health equity among their members.

¹⁷ <http://www.oregon.gov/oha/pcpch/Documents/TA-Guide.pdf>

¹⁸ <https://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/cco-chip.aspx>

¹⁹ Oregon Health Authority Office of Equity & Inclusion, Engaging Oregonians in Identifying Health Equity Policy Priorities (2014), at:

<http://www.oregon.gov/oha/oei/reports/Engaging%20Oregonians%20in%20Identifying%20Health%20Equity%20Policy%20Priorities%20-%20a%20Modified%20Policy%20Delphi%20Approach.pdf>

²⁰ Oregon’s Health System Transformation CCO Metrics 2015 Mid-Year Update (January 2016), at:

<http://www.oregon.gov/oha/Metrics/Documents/2015%20Mid-Year%20Report%20-%20Jan%202016.pdf>;

Oregon’s Health System Transformation: CCO Metrics 2015 Final Report (June 2016), at:

http://www.oregon.gov/oha/Metrics/Documents/2015_performance_report.pdf; and Oregon’s Health System

Transformation: CCO Metrics 2016 Mid-Year Report (January 2017), at:

http://www.oregon.gov/oha/Metrics/Documents/2016_Mid-Year_Report.pdf

²¹ These data were first publicly reported by the OHA Office of Health Analytics at a Metrics and Scoring Committee meeting in June 2016:

<http://www.oregon.gov/oha/analytics/MetricsDocs/Measures%20by%20Race.%20Ethnicity.%20CCO.pdf>

This overview highlights that there are many data sources available and many activities being conducted by each CCO to advance health equity. While the CCOs have been implementing these activities since the CCOs were established in 2012, the preparation for the technical assistance described in this report was the first systematic effort to document and review all that data and all those activities across all the CCOs.

Section 2: Technical assistance approach to support health equity

While each of the CCOs have developed and implemented multiple activities to meet their responsibilities to advance health equity, there has not been a systematic effort to document, analyze or support these activities. In March 2016, the OHA Transformation Center contracted with one of its Technical Assistance Bank consultants,²² Ignatius Bau, to develop a technical assistance approach to support CCOs in their work on health equity.

Mr. Bau worked with OHA Transformation Center staff and OHA Office of Health Analytics staff²³ to identify both statewide and CCO-specific data to inform health equity technical assistance.²⁴ CCO-specific incentive quality measure data stratified by member race, ethnicity and household language were compiled and analyzed. He also reviewed all the CCO transformation plans, the Community Health Improvement Plan and CCO progress reports to obtain additional information that could be useful in supporting health equity.

Mr. Bau developed a template for sharing and discussing this data and information with each of the CCOs during an on-site, two-hour consultation. OHA Office of Equity & Inclusion staff also joined in planning and implementing the consultations. OHA Office of Health Analytics staff reviewed and provided feedback on how the incentive quality measure data would be presented and shared.

OHA Transformation Center staff then reached out to the CCOs and their respective innovator agents²⁵ and asked if any CCOs were interested in piloting these voluntary health equity consultations. It was emphasized that OHA was not requiring these consultations and that these were not compliance reviews or audits about CCO performance on their contractual obligations. The consultation was offered as an opportunity to receive technical assistance from the OHA Transformation Center, similar to other technical assistance opportunities.

Both Willamette Valley Community Health and Yamhill Community Care Organization immediately volunteered to be pilot CCOs, and pilot consultations were scheduled on May 5, 2016. The CCOs were encouraged to invite their staff leadership, board members, medical and clinical staff leadership, quality staff, community engagement staff, community advisory committee members, clinical advisory panel members, and any other community stakeholders they wished to participate in the consultation. The CCOs and innovator agents worked together to identify the participants for the consultation.

Prior to each consultation, a preparation call was held with Mr. Bau, OHA Transformation Center staff, OHA Office of Equity & Inclusion staff and each CCO's

²² <https://www.oregon.gov/oha/Transformation-Center/Pages/Technical-Assistance-Bank.aspx>

²³ <http://www.oregon.gov/oha/analytics/Pages/About-Us.aspx>

²⁴ Oregon's Health System Transformation CCO Metrics 2015 Mid-Year Update (January 2016), at: <http://www.oregon.gov/oha/Metrics/Documents/2015%20Mid-Year%20Report%20-%20Jan%202016.pdf>

²⁵ <https://www.oregon.gov/oha/healthplan/Pages/Innovator-Agents.aspx>

innovator agent. Draft materials for the consultation, including the CCO-specific incentive quality measure data stratified by race, ethnicity and household language, and health equity opportunities in the CCO's transformation plan and community health improvement plan, were reviewed and discussed during the preparation call. The innovator agents were very useful in providing background about each CCO and the expected participants in the consultation and in updating information for the draft materials. Mr. Bau made edits and updates to the draft materials and then the materials were shared with all the CCO participants several days before the consultation.

Mr. Bau attended and facilitated each two-hour consultation. OHA Transformation Center staff, OHA Office of Equity & Inclusion staff and the CCO's innovator agent also attended in person. After introductions by the participants, each consultation began with a review and discussion of the race, ethnicity and household language data about that CCO's members. (See Section 3 for discussion of CCO member demographic data.) The participants then reviewed statewide and CCO-specific data about performance on the 18 incentive quality measures, stratified by race, ethnicity and household language. (See Section 4 for discussion of incentive quality measures.) As apparent disparities were identified, there was a facilitated discussion about potential interventions and best practices and resources to address such apparent disparities.

The participants then reviewed the CCO's transformation plan and the CCO's latest progress reports for opportunities to advance health equity, focusing on transformation areas 2, 4, 5, 6, 7 and 8. (See Section 5 for discussion of transformation plans.) The participants also reviewed the CCO's community health improvement plan and the CCO's latest progress report. (See Section 6 for discussion of community health improvement plans.) Community health needs related to health equity and opportunities to advance health equity through community health improvement activities were discussed. CCO staff and community partners and stakeholders often provided updated information about transformation plan and community health improvement plan implementation activities that contributed to the discussion at the consultations.

The final part of the two-hour consultation was a discussion about what technical assistance, resources or other support could be useful in following up on some of the health equity opportunities identified and discussed during the consultation. OHA Transformation Center and OHA Office of Equity & Inclusion staff provided information about the technical assistance available and the processes for requesting such technical assistance. The consultation concluded with an opportunity for the participants to provide any immediate verbal feedback. Participants also completed written evaluation forms.

Mr. Bau then prepared a draft summary report of the consultation, including documentation of the discussions during the consultation about the CCO-specific data, transformation plan, community health improvement plan and any potential follow-up actions. He compiled the results and feedback from the verbal and written evaluations. The draft summary report provided citations and references to all the resources, best practices and technical assistance discussed during the consultation.

The draft summary report was then shared and discussed in a debriefing call with Mr. Bau, OHA Transformation Center staff, OHA Office of Equity & Inclusion staff and the CCO's innovator agent. Based on that discussion, Mr. Bau made edits to the draft summary report and shared it with all the participants in the consultation, with a request

for any corrections or suggested edits. After incorporating any corrections and suggested edits received, the summary report was finalized and shared with all the participants who attended each health equity consultation.

Based on the feedback and evaluations from the two pilot consultations, it was determined that the format and length of the two-hour consultations was appropriate. However, as part of a process of continuous quality improvement, several refinements were made for subsequent consultations. After the two pilot consultations, OHA Office of Health Analytics staff and additional OHA Transformation Center and OHA Office of Health Equity & Inclusion staff began participating in subsequent consultations, both in person and by phone. The Transformation Center staff developed, updated and shared a one-page description of all the technical assistance available to the CCOs relevant to the incentive measures and to health equity. There often were opportunities to clarify the status of pending requests for technical assistance from the CCO, with follow-up from the Transformation Center staff and the CCO's innovator agent.

The Office of Health Equity & Inclusion also began sharing materials with the CCOs about the Developing Equity Leadership through Training and Action (DELTA) Program²⁶, as well as multilingual information for CCO members on language assistance services. It was useful to have many graduates of the DELTA Program among the participants at the health equity consultations. Three individuals in the most recent cohort for the DELTA Program participated in the health equity consultations.

At the suggestion of a staff member in the Office of Equity & Inclusion, statewide and CCO-specific disability data were obtained and added to the data shared with the CCOs. With the publication or availability of updated incentive measure data (end of 2015 data were published in July 2016) and progress reports (Community Health Improvement Plan progress reports were submitted in June 2016 and CCO Transformation Plan milestone reports were submitted in August 2016),²⁷ data and information in the consultation materials were updated. Eventually, a summary table of follow-up actions discussed at each consultation was added to the summary reports.

OHA Transformation Center staff continued to work with the other CCOs and their Innovator Agents to offer and schedule these health equity consultations. It continued to be emphasized that these were voluntary opportunities to receive technical assistance, and were not being required by OHA.

All 16 CCOs participated in a health equity consultation between May and November 2016, with a total of 144 participants. A table with the dates and the number of participants for all the health equity consultations follows:

²⁶ <http://www.oregon.gov/oha/oei/Pages/DELTA.aspx> Eleven of the sixteen CCOs have had staff members participate in the DELTA Program.

²⁷ <http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/Oregon-CCO-Transformation-Plans.aspx>

Date	CCO	Location	Participants
5/5/16	Willamette Valley Community Health	Salem	N=7 (CEO, COO, CMO, quality staff, provider)
5/5/16	Yamhill Community Care Organization	McMinnville	N=9 (CEO, director of operations, quality staff, community engagement staff, provider and board member)
7/12/16	Columbia Pacific CCO	Portland	N=4 (CEO, CMO, clinical integration manager, community partnership manager)
7/13/16	FamilyCare	Portland	N= 8 (VP of IT, quality staff, director of health care analytics, population health staff, grants administrator, health equity staff)
7/13/16	Health Share of Oregon	Portland	N=5 (quality staff, health systems manager, community engagement staff, health equity staff)
9/6/16	AllCare CCO	Grants Pass	N=22 (CEO, CMO, VP of government relations, Chief Quality Officer, quality staff, clinical services staff, provider services staff, member services staff, human resources staff, early education integration coordinator, health equity staff, former board member)
9/6/16	PrimaryHealth	Grants Pass	N=5 (COO, director of health strategy, CCO coordinator, CAC member)
9/7/16	Jackson Care Connect	Medford	N=7 (CEO, clinical operations, quality staff, community engagement staff, member outreach staff)
9/7/16	Cascade Health Alliance	Klamath Falls	N=3 (quality staff, medical informatics staff)
9/20/16	Trillium Community Health Plan	Eugene	N=13 (manager of governmental relations, quality staff, metrics and data staff, provider relations staff, behavioral health staff, community health worker, health equity staff)
9/21/16	Western Oregon Advanced Health	Coos Bay	N=8 (COO, CMO, manager of medical services, quality staff, data analytics staff, provider services staff, communications staff, human resources staff)
9/22/16	Umpqua Health Alliance	Roseburg	N=7 (CEO, CMO, pharmacy director, clinical management director, population health manager, CAC coordinator, CAC chair)
11/2/16	PacificSource Columbia Gorge	Hood River	N=16 (CCO director, operations consultant, data analyst, hospital chaplain, local health departments, community health worker, CAC members, regional health equity coalition)
11/3/16	Eastern Oregon CCO	Hermiston	N=6 (director of community health development, community health improvement coordinator, member and diversity coordinator, local health department, CAC member)

Date	CCO	Location	Participants
11/4/16	PacificSource Central Oregon	Bend	N=9 (CCO director, CCO project coordinator, quality staff, health equity staff)
11/17/16	InterCommunity Health Network CCO	Corvallis	N=15 (CCO transformation manager, quality staff, CAC coordinator, CAC members, health disparities workgroup members, regional health equity coalition)

There was a high degree of CCO leadership participation in the consultations: six chief executive officers (CEOs) and the staff leaders for three other CCOs (that are part of larger organizations and do not have a CEO specifically for the CCO) participated in the consultations. Five chief medical officers (CMOs) and five chief operating officers (COOs) or their equivalents also participated in the consultations. One CCO board member and one former board member participated. Besides the chief medical officers, there was less participation from CCO clinical staff and providers, and only one participant was a member of a clinical advisory panel (CAP).

As expected, there was significant participation by CCO staff responsible for quality, data and provider relationships. There also was strong participation from community advisory council (CAC) coordinators or their equivalents (N=7), as well as CAC members and other community stakeholders. Five CCOs had staff members with full- or part-time responsibilities explicitly focused on health equity participation in the consultations. Representatives from several regional health equity coalitions²⁸ also participated in the consultations.

A compilation of the evaluations, feedback and comments from the participants at the health equity consultations is reported in an appendix to this report.

²⁸ <https://www.oregon.gov/oha/oei/Pages/rhec.aspx>

Section 3: Demographic data about CCO members

One of the foundations for identifying opportunities to advance health equity is the collection of demographic data about CCO members. OHA has required and supported the collection and use of member demographic data by the CCOs. However, in its 2015 mid-point evaluation, Mathematica Policy Research reported:

CCOs universally cited the lack of data as a barrier to addressing these transformation elements during their interviews in April and May 2014. CCOs desire more reliable individual level data on members' race, ethnicity, and language preference. The information is not consistently transferred to CCOs from the application process. CCOs also noted the lack of data on the quality metrics stratified by race, ethnicity and language as delaying their ability to identify disparities and to know what populations are most at risk. Finally, consistent with their focus on community, several CCOs noted the lack of population level data (in contrast to CCO member data) as a barrier to understanding the context of their member data and where to focus their efforts to improve population health.²⁹

Each health equity consultation began with a review of the demographic data about that specific CCO's members. Below are tables with the number and percentage of members by race, ethnicity, household language, and disability for each CCO for the 12-month rolling period of July 2014–June 2015:

CCO number of members July 2014–June 2015	White	African American/ Black	Hispanic/ Latino	American Indian/ Alaska Native	Asian American	Hawaiian/ Pacific Islander	Other race	Unknown
AllCare CCO	43,266	508	6,376	673	380	185	1,678	7,600
60,666	71.3%	0.8%	10.5%	1.1%	0.6%	0.3%	2.8%	12.5%
Cascade Health Alliance	13,417	302	3,046	453	115	32	568	2,458
20,391	65.8%	1.5%	14.9%	2.2%	0.6%	0.2%	2.8%	12.1%
Columbia Pacific CCO	24,804	242	3,258	293	224	121	1,102	4,020
34,064	72.8%	0.7%	9.6%	0.9%	0.7%	0.4%	3.2%	11.8%
Eastern Oregon CCO	34,713	467	14,432	761	286	179	1,713	6,410
58,961	58.9%	0.8%	24.5%	1.3%	0.5%	0.3%	2.9%	10.9%
FamilyCare	79,748	9,086	25,613	1,107	6,919	1,041	7,580	25,905
156,999	50.8%	5.8%	16.3%	0.7%	4.4%	0.7%	4.8%	16.5%
Health Share of Oregon	141,354	22,032	52,681	2,196	16,862	1,601	9,212	37,778
283,721	49.8%	7.8%	18.6%	0.8%	5.9%	0.6%	3.2%	13.3%
InterCommunity Health Network CCO	18,154	271	6,069	244	182	44	924	3,454
29,342	61.9%	0.9%	20.7%	0.8%	0.6%	0.1%	3.1%	11.8%
Jackson Care Connect	23,116	343	5,558	364	241	122	1,000	4,976

²⁹ Mathematica Policy Research, Midpoint Evaluation of Oregon's Medicaid Section 1115 Demonstration: Mid-2012 Through Mid-2014 (2015), page 26, at: <https://www.oregon.gov/oha/OHPB/Documents/Final%20Report%20for%20the%20Midpoint%20Evaluation%20%204-30-2015.pdf>

35,720	64.7%	1.0%	15.6%	1.0%	0.6%	0.3%	2.8%	13.9%
CCO number of members July 2014– June 2015	White	African American/ Black	Hispanic/ Latino	American Indian/ Alaska Native	Asian American	Hawaiian/ Pacific Islander	Other race	Unknown
PacificSource Central Oregon 66,232	46,331 70.0%	380 0.6%	8,239 12.4%	1,072 1.6%	379 0.6%	81 0.1%	2,509 3.8%	7,241 10.9%
PacificSource Columbia Gorge 15,762	8,311 52.7%	107 0.7%	5,039 32.0%	229 1.5%	83 0.5%	104 0.7%	462 2.9%	1,427 9.1%
PrimaryHealth 14,818	10,823 73.0%	76 0.5%	1,174 7.9%	129 0.9%	100 0.7%	48 0.3%	558 3.8%	1,910 12.9%
Trillium Community Health Plan 108,682	75,522 69.5%	1,937 1.8%	10,986 10.1%	1,226 1.1%	1,316 1.2%	229 0.2%	3,056 2.8%	14,410 13.3%
Umpqua Health Alliance 32,897	26,008 79.1%	152 0.5%	2,080 6.3%	434 1.3%	190 0.6%	48 0.2%	852 2.6%	3,133 9.5%
Western Oregon Advanced Health 25,203	19,376 76.9%	166 0.7%	1,834 7.3%	410 1.6%	147 0.6%	53 0.2%	610 2.4%	2,607 10.3%
Willamette Valley Community Health 120,617	62,386 51.7%	1,773 1.5%	33,662 27.9%	1,156 1.0%	1,571 1.3%	973 0.8%	3,401 2.8%	15,695 13.0%
Yamhill Community Care Organization 29,342	18,154 61.9%	271 0.9%	6,069 20.7%	244 0.8%	182 0.6%	44 0.1%	924 3.1%	3,454 11.8%

Source: OHA Office of Health Analytics

Note: Hispanic/Latino ethnicity is coded as primary, so there may be an undercount of racial groups when members identified both as Hispanic/Latino and a member of a racial group

CCO number of members July 2014– June 2015	English	Spanish	Other languages (<30 for any language)	Other/ undetermined	Missing	Members without disability	Members with disability
AllCare CCO 60,666	38,873 64.1%	1,453 2.4%	45 0.1%	16,829 27.7%	3,466 5.7%	56,926 93.8%	3,740 9.2%
Cascade Health Alliance 20,391	13,007 63.8%	715 3.5%	18 0.1%	5,325 26.1%	1,326 6.5%	18,886 92.6%	1,505 7.4%
Columbia Pacific CCO 34,064	21,112 62.0%	945 2.8%	23 0.0%	9,943 29.1%	2,031 6.0%	31,948 93.8%	2,116 6.2%
Eastern Oregon CCO 58,961	34,816 59.1%	5,090 8.6%	50 0.0%	15,784 26.8%	3,222 5.5%	55,464 94.1%	3,497 5.9%
FamilyCare 156,999	77,514 49.4%	8,824 5.6%	See details below	52,865 33.7%	13,901 8.9%	152,648 97.2%	4,351 2.8%
Health Share of Oregon 283,721	150,790 53.2%	24,227 8.5%	See details below	78,324 27.6%	15,579 5.5%	152,648 97.2%	22,071 7.8%
InterCommunity Health Network CCO 29,342	16,379 55.8%	2,413 8.2%	43 0.1%	8,917 30.4%	1,590 5.4%	28,234 96.2%	1,108 3.8%
Jackson Care Connect 35,720	21,642 60.6%	1,895 5.3%	33 0.1%	10,206 28.6%	1,944 5.4%	33,570 94.0%	2,150 6.0%
PacificSource Central Oregon 66,232	40,365 60.9%	2,470 3.7%	19 0.1%	19,662 29.7%	3,675 5.6%	62,819 94.8%	3,413 5.2%

PacificSource Columbia Gorge 15,762	7,671 48.7%	2,413 15.3%	19 0.1%	4,759 30.2%	900 5.7%	15,045 95.5%	717 4.5%
CCO number of members July 2014– June 2015	English	Spanish	Other languages (<30 for any language)	Other/ undeter- mined	Missing	Members without disability	Members with disability
PrimaryHealth 14,818	9,128 61.6%	168 1.1%	9 0.1%	4,372 29.5%	1,141 7.7%	13,863 93.6%	955 6.4%
Trillium Community Health Plan 108,682	68,710 63.2%	2,772 2.6%	See details below	30,741 28.3%	6,262 5.8%	100,422 92.4%	8,260 7.6%
Umpqua Health Alliance 32,897	22,484 68.4%	178 0.5%	16 0.0%	8,513 25.9%	1,703 5.2%	30,280 92.0%	2,617 8.0%
Western Oregon Advanced Health 25,203	17,016 67.5%	261 1.0%	10 0.0%	6,538 25.9%	1,378 5.4%	22,934 91.0%	2,269 9.0%
Willamette Valley Community Health 120,617	66,446 55.1%	15,110 12.5%	See details below	32,160 26.7%	5,837 4.8%	113,199 93.8%	7,418 6.2%
Yamhill Community Care Organization 29,342	16,379 55.8%	2,413 8.2%	43 0.1%	8,917 30.4%	1,590 5.4%	28,234 96.2%	1,108 3.8%

Source: OHA Office of Health Analytics

Note: Household language data should be interpreted with caution because of the large percentage of CCO members with undetermined and missing data, and household language may not = need for language access services.

Note: Disability is defined as “people who qualify for Medicaid based on an impairment that has prevented them from performing substantial gainful activity for at least one year, or is expected to prevent them from performing substantial gainful activity for at least one year; this may include physical, mental, emotional, learning, developmental or other disabilities; these individuals may or may not also be qualified for Medicare.”

While such rolling 12-month data have been regularly reported in mid-year and end-of-year metrics reports, many participants at the health equity consultations noted that these member numbers are often significantly higher than any point-in-time or monthly enrollment. This underscores one of the challenges of any quality improvement activities by the CCOs with diverse membership that is constantly churning, enrolling and disenrolling, and may not have consistent access to or use of health care services. However, most CCO participants who were familiar with their current enrollment and member demographic data indicated that, while the 12-month figures were higher than what they were used to seeing on a monthly basis, the percentages of members by race, ethnicity, household language and disability did seem to remain relatively consistent over time.

For every CCO, the largest racial or ethnic group was Whites, and the second largest was Hispanics/Latinos. The percentage of Hispanic/Latino members ranged from 32.0% for PacificSource Columbia Gorge to 6.3% for Umpqua Health Alliance. Health Share of Oregon had the highest number of Hispanic/Latino members (52,681), followed by Willamette Valley Community Health (33,662) and FamilyCare (25,613).

While many participants at the health equity consultations interpreted the demographic data as affirming their understanding that their counties and members were predominantly White and “not very diverse,” it was important to note the actual numbers of members from the racial and ethnic groups, rather than just the percentages. For example, while less than 1% of AllCare CCO’s members were African American/Black,

that meant the CCO had 508 African American/Black members; similarly, while the percentage of African American/Black members for Trillium Community Health Plan was less than 2%, that meant that there were nearly 1,937 African American/Black members served by the CCO.

During several of the health equity consultations, there were questions and discussion about the source of these racial and ethnic categories, including how they have changed over time. At least one consultation included a discussion about the increasing number of individuals who identified with more than one race and how such multiple race individuals were assigned a primary race category in these data.

At some consultations, there also was acknowledgement and discussion about the need for more granular, disaggregated categories for certain racial groups, e.g., for Chinese and Vietnamese rather than the aggregated category of Asian American. The racial and ethnic categories OHA currently uses follow current federal Office of Management and Budget guidelines.³⁰

At each consultation, the OHA Office of Health Equity and Inclusion shared information and updates about the more disaggregated race, ethnicity, language and disability data categories it has developed³¹ and are implementing throughout OHA operations, including the demographic data collected in the Oregon Health Plan application. It was noted that there have been additional challenges in collecting these data through the ONE online application for the Oregon Health Plan, which began implementation at the beginning of 2016.³²

There also was discussion about the meaning of the “other/undetermined” and “missing” categories: members coded as “other/undetermined” are likely members who are long-time Medicaid beneficiaries with race and ethnicity data collected and recorded in legacy systems that are not transferrable to the current categories. The “missing” category is the number of members where the optional race and ethnicity data have not been completed by the Oregon Health Plan applicant. The number of these members should decrease over time as their demographic and other data are updated. Unfortunately, the percentage of Oregon Health Plan members with “other/undetermined” and “missing”

³⁰ U.S. Office of Management and Budget, *Revisions to the Standards for Classification of Federal Data on Race and Ethnicity*, 62 Fed. Reg. 58782-58790 (October 30, 1997), at:

<https://www.gpo.gov/fdsys/pkg/FR-1997-10-30/pdf/97-28653.pdf> It was noted during the later consultations that the OMB requested comments in September 2016 about potential changes to these 1997 guidelines, including whether there should be additional disaggregation of the categories, and the use of a Middle Eastern and Northern African classification. U.S. Office of Management and Budget, *Review and Possible Limited Revision of OMB's Statistical Policy Directive on Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity*, 81 Fed. Reg. 67398-67401 (September 30, 2016) at:

<https://www.gpo.gov/fdsys/pkg/FR-2016-09-30/pdf/2016-23672.pdf> The OMB requested additional public comments on these proposed changes in March 2017. U.S. Office of Management and Budget, *Proposals from the Federal Interagency Working Group for Revision of the Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity*, 82 Fed. Reg. 12242-12247 (March 1, 2017) at:

<https://www.gpo.gov/fdsys/pkg/FR-2017-03-01/pdf/2017-03973.pdf>

³¹ Oregon Health Authority Office of Equity and Inclusion, *Race, Ethnicity, Language, and Disability Data Collection Standards* (2014), at:

<https://www.oregon.gov/oha/oei/policyprocedures/Race%20Ethnicity%20Language%20Disability%20Data%20Collection%20Standards.pdf>

³² <https://www.oregon.gov/oha/news/Pages/HST-%20ONE%20applicant%20portal%20implementation.aspx>

race and ethnicity data increased during 2016 with the transition to the ONE application (up to 17.5% for the 12-month rolling period ending June 2016).³³

There was discussion at several of the health equity consultations about how OHA, CCOs and community stakeholders could increase awareness about these demographic data categories and why it was important for Oregon Health Plan applicants/CCO members to answer those optional questions. There was discussion about strategies to improve the response rate to these optional questions, including additional education and training of enrollment assisters and eligibility workers, as well as general public education activities among racial and ethnic communities. There are several training curricula available about how best to ask about race and ethnicity in a health care setting.³⁴ There discussions during the consultations about how the CCOs, OHA Transformation Center, and OHA Office of Equity & Inclusion might support such strategies to improve this data collection.

At several of the health equity consultations, participants raised the issue of how to improve the accuracy of such data. For example, even if a CCO has been able to identify a member's household language when originally "missing," that data are not easily updated in OHA's health information systems. In OHA's enrollment files, this member demographic data come from their applications for the Oregon Health Plan (and now through the ONE system) and are not updated until there is a renewal application (usually annually). Every month, OHA uses these enrollment files to update the CCOs on who their current members are. However, since these OHA enrollment files are using the data from the applications, any updated member race, ethnicity, household language and disability data the CCO may now have is overridden by the OHA monthly enrollment file data. CCOs have to find a way to preserve, retrieve and use any updated data they may have received from their members, or from their providers about their members. This is a critical issue for CCOs because the monthly enrollment files also include member contact information such as mailing addresses and phone numbers, which often are quickly outdated because of the high degree of mobility among this population. This issue of outdated data in the enrollment files remains problematic for a variety of reasons, including the inability to correct or update member race, ethnicity, household language, disability and other demographic data.

At the health equity consultation with Health Share of Oregon, there was a discussion about the continuing challenges of meeting the needs of the 1,200 to 1,500 refugees who are resettling into the tri-county service area and may need more orientation and support using the U.S. health care system and other social support. Oregon Health Plan and OHA data do not identify which CCO members are refugees, so it sometimes is difficult for the CCO to address their unique needs. There was a discussion about other data sources and ways to anticipate who would be arriving as refugees in Oregon.³⁵

There also was a discussion about the household language data at each of the health equity consultations. Given the sizable percentage of "other/undetermined" and "missing" data for household language, most of the CCOs showed a gap between the

³³ Oregon's Health System Transformation CCO Metrics 2016 Mid-Year Update (January 2017), at: http://www.oregon.gov/oha/Metrics/Documents/2016_Mid-Year_Report.pdf

³⁴ Health Research and Education Trust toolkit at: <http://www.hretdisparities.org/Staf-4190.php> and America's Essential Hospitals training video at: <http://essentialhospitals.org/education/race-ethnicity-and-language/>

³⁵ For example, the State Department publishes data on anticipated refugee arrivals to each state. Refugee Processing Center Admissions Data, at: <http://www.wrapsnet.org/admissions-and-arrivals/>

reported numbers of Hispanic/Latino members and the numbers of members from Spanish-speaking households, which is the most common household language after English. Accordingly, any of the data on the incentive measures stratified by household language are likely to be under-reporting the results for Spanish-speaking members. Nevertheless, the percentage of CCO members from Spanish-speaking households ranged from 15.3% for PacificSource Columbia Gorge to 2.4% for AllCare CCO. In terms of numbers of members, Health Share of Oregon had 24,227 members from Spanish-speaking households, followed by Willamette Valley Community Health with 15,110 members from Spanish-speaking households, and FamilyCare with 8,824 members from Spanish-speaking households.

Four CCOs (Health Share of Oregon, FamilyCare, Willamette Valley Community Health and Trillium Community Health Plan) had sufficient numbers of members speaking household languages in addition to English and Spanish for analysis:

Health Share of Oregon

Household language July 2014–June 2015	English	Spanish	Russian	Vietnamese	Cantonese	Somali	Arabic	Burmese	Karen	Nepali
Members = 283,721	150,790	24,227	4,603	2,955	1,452	1,277	958	425	329	339
% members	53.2%	8.5%	1.6%	1.0%	0.5%	0.4%	0.3%	0.2%	0.1%	0.1%

Household language July 2014–June 2015	Farsi	Romanian	Korean	Hmong	Cambodian	Bosnian	Swahili	Other languages (<100 for any language)	Other/undetermined	Missing
Members = 283,721	288	277	259	190	161	127	120	1,011	78,324	15,579
% members	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%	0.4%	27.6%	5.5%

FamilyCare

Household language July 2014–June 2015	English	Spanish	Russian	Vietnamese	Somali	Cantonese	Arabic	Other languages (<100 for any language)	Other/undetermined	Missing
Members = 156,999	77,514	8,824	1,394	808	390	387	209	707	52,865	13,901
% members	49.4%	5.6%	0.9%	0.5%	0.3%	0.3%	0.1%	0.5%	33.7%	8.9%

Willamette Valley Community Health

Household language July 2014–June 2015	English	Spanish	Russian	Somali	Vietnamese	Cantonese, Mandarin, Other Chinese, Tao Chiew	Other languages (<30 for any language)	Other/undetermined	Missing
Members = 120,617	66,446	15,110	653	110	96	51	154	32,160	5,837
% members	55.1%	12.5%	0.5%	0.1%	0.1%	0.0%	0.1%	26.7%	4.8%

Trillium Community Health Plan

Household language July 2014–June 2015	English	Spanish	Vietnamese	Cantonese	Other languages (<30 for any language)	Other/undetermined	Missing
Members = 108,682	68,710	2,772	56	41	100	30,741	6,262
% members	63.2%	2.6%	0.1%	0.0%	0.1%	28.3%	5.8%

Source: OHA Office of Health Analytics

While the participants at the health equity consultations appropriately understood that the primary languages spoken by their members are English and Spanish, at least for these four CCOs, language assistance services need to be available in additional languages. Russian was the next most common household language: Health Share of Oregon had 4,603 members from Russian-speaking households, FamilyCare had 1,394 members from Russian-speaking households, and Willamette Valley Community Health had 653 members from Russian-speaking households. Health Share of Oregon also had 2,955 members from Vietnamese-speaking households, FamilyCare had 808 members from Vietnamese-speaking households, Willamette Valley Community Health had 96 members from Vietnamese-speaking households, and Trillium Community Health Plan had 56 members from Vietnamese-speaking households. Health Share of Oregon also had 1,277 members from Somali-speaking households, FamilyCare had 390 members from Somali-speaking households, and Willamette Valley Community Health had 110 members from Somali-speaking households.

After the disability data were added to the materials for the health equity consultations, many participants commented that this was the first time they looked at, or thought about, their member data stratified by disability status in the context of performance measure, quality improvement or health equity.³⁶ There were questions asked at the consultations about the source of the definition of disability (noted above). The OHA Office of Equity and Inclusion has developed a broader definition of disability, based on

³⁶ A good resource is the book: Russell, M. Beyond Ramps: Disability at the End of the Social Contract (1998).

the definition the U.S. Census Bureau and U.S. Department of Labor³⁷ uses that will eventually be implemented throughout OHA programs, including the Oregon Health Plan.³⁸ The percentage of members with disability ranged from 9.2% for AllCare CCO to 3.8% for InterCommunity Health Network CCO. The number of members with disability ranged from 22,071 for Health Share of Oregon to 717 for PacificSource Columbia Gorge.

Participants at several health equity consultations asked questions about the availability of data about the sexual orientation and gender identity of their CCO members because they have increased their awareness of lesbian, gay, bisexual and transgender health issues. Beginning in 2016, sexual orientation and gender identity data are being collected by all Federally Qualified Health Centers in the Uniform Data System.³⁹ Although it may take some time for FQHCs that are CCO providers in Oregon to collect enough of this data from their patients for meaningful analysis, this would a starting point for obtaining such data. The 2015 federal requirements for certified electronic health records (EHRs) require the capacity to collect sexual orientation and gender identity data.⁴⁰ CCO primary care providers who have been recognized as patient-centered primary care homes are likely to be using federally certified EHRs. While it will take some time for all EHR vendors to upgrade their EHR products and for individual providers to collect these data in those EHRs, this will be another source of data about member sexual orientation and gender identity. There also is sexual orientation data collected as part of the Oregon Healthy Teens Survey, generally available by county.⁴¹ There are resources available on how best to collect sexual orientation and gender identity data in clinical settings.⁴²

There also were discussions at several health equity consultations about differences in population and community demographic characteristics within any CCO service area, both across multiple counties and within any county. These differences also reflect the diverse geographic typologies and population densities across Oregon (rural, urban, coastal, mountain, desert, etc.). While CCO member health care quality data are not generally available stratified by these geographic characteristics, CCOs could “geocode” their member data by ZIP code of residence using publicly available data (e.g., data from

³⁷ U.S. Department of Labor Bureau of Labor Statistics, Labor Force Statistics for Current Population Survey, at: http://www.bls.gov/cps/cpsdisability_faq.htm#Identified

³⁸ Oregon Health Authority Office of Equity and Inclusion, Race, Ethnicity, Language, and Disability Data Collection Standards (2014), at: <https://www.oregon.gov/oha/oei/policyprocedures/Race%20Ethnicity%20Language%20Disability%20Data%20Collection%20Standards.pdf>

³⁹ U.S. Department of Health and Human Services Health Services and Resources Administration, Program Assistance Letter 2016-02: Approved Uniform Data System Changes for Calendar 2016 (2016), at: <http://bphc.hrsa.gov/datareporting/pdf/pal201602.pdf>

⁴⁰ U.S. Department of Health and Human Services Office of National Coordinator for Health Information Technology, *2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications*; Final Rule, 80 Fed. Reg. 62602-62759 (October 16, 2015), at: <https://www.gpo.gov/fdsys/pkg/FR-2015-10-16/pdf/2015-25597.pdf>

⁴¹ <https://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/Pages/index.aspx>

⁴² Fenway Institute, *How to Gather Data on Sexual Orientation and Gender Identity in Clinical Settings* (2012), at: http://www.fenwayhealth.org/site/DocServer/Policy_Brief_HowtoGather..._v3_01.09.12.pdf?docID=9142

the Census and the American Community Survey). There also are other useful data sources that focus on rural health.⁴³

These discussions about member demographic data at the health equity consultations highlighted the unevenness of knowledge about the sources and meanings of the demographic data categories being used (but interest in learning), and the need for additional strategies and support to continuously improve the completeness, accuracy and use of such data.

⁴³ <http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/publications/index.cfm>

Section 4: Health equity opportunities from CCO incentive measure data

CCOs are required to report their performance on numerous health care quality measures to ensure that OHA is meeting the requirements of its obligations under the Medicaid section 1115 waiver and State Innovation Model grant.⁴⁴ CCOs also are eligible for pay-for-performance or incentive payments for achieving improvement targets for performance on a subset of these quality measures.⁴⁵ These incentive quality measures are determined by a Metrics and Scoring Committee, staffed by the OHA Office of Health Analytics, with participation from many of the CCOs.⁴⁶ To earn their full incentive payments, CCOs had to have at least 60% of their members enrolled in a patient-centered primary care home, and then meet improvement targets on at least 12 of the other 17 incentive quality measures.

CCO Incentive Measures	2013	2014	2015	2016	2017
Adolescent well-care visits	x	x	x	x	x
Alcohol or other substance misuse screening (SBIRT)	x	x	x	x	1
Ambulatory care: emergency department visits (per 1,000 mm)	x	x	x	x	x
CAHPS composite: access to care	x	x	x	x	x
CAHPS composite: satisfaction with care	x	x	x	x	x
Childhood immunization status				x	x
Cigarette smoking prevalence				x	x
Colorectal cancer screening	x	x	x	x	x
Controlling high blood pressure	x	x	x	x	x
Dental sealants			x	x	x
Depression screening and follow-up plan	x	x	x	x	x
Developmental screening (0-36 months)	x	x	x	x	x
Early elective delivery	x	x			
Diabetes: HbA1c poor control	x	x	x	x	x
Effective contraceptive use			x	x	x
Electronic health record adoption	x	x	x		
Follow-up after hospitalization for mental illness	x	x	x	x	x
Follow-up for children prescribed ADHD medication	x	x			
Health assessments within 60 days for children in DHS custody	x	x	x	x	x
Patient centered primary care home enrollment	x	x	x	x	x
Timeliness of prenatal care	x	x	x	x	x

In 2015, 15 of the 16 CCOs received their full incentive payments, totaling more than \$166 million (Cascade Health Alliance only met its improvement targets on nine of 17

⁴⁴ Under the section 1115 waiver, OHA reports statewide performance on 33 quality measures. <https://www.oregon.gov/oha/OHPB/docs/cco-metrics.pdf>

⁴⁵ OHA also has a challenge pool of any funds remaining after incentive measure funds are distributed (assuming that not all CCOs qualify for all the potential incentive measure funds available). In 2016, CCOs could earn additional challenge pool payments for meeting the improvement targets for four of the incentive quality measures: SBIRT, developmental screening, depression screening and follow-up, and diabetes control. All CCOs received payments from the \$1.2 million challenge pool.

⁴⁶ Several of these measures have been changed from year to year. For 2016, two measures were added (childhood immunization status and cigarette smoking prevalence) and one measure (electronic health record adoption) was dropped. <http://www.oregon.gov/oha/analytics/CCOData/CCO%20Incentive%20Measures%20and%20changes%20since%202013.pdf> The claims-based SBIRT measure has been removed as a CCO incentive measure for 2017; an EHR-based SBIRT measure will be developed during 2017 and reinstated as an incentive measure for 2018.

incentive quality measures and only received 60% of its potential incentive payment).⁴⁷ A summary of early performance on the CCO quality measures stratified by member race and ethnicity and reported in the 2015 midpoint evaluation follows:

Table ES.1. Summary of summative evaluation results by outcome measure

Measure	Changed after the Introduction of CCOs	Associated with the stage of CCO transformation activities ^a	Race/Ethnicity differences changed after the introduction of CCOs ^b
Improving primary care for all populations			
Developmental screening by 36 months	--	√	--
At least six well-child visits in the first 15 months of life	√+	√	√Blacks
Child and adolescent preventive care visit (age 12 months through 19 years)	--	--	√Asians
Adolescent well-care visit (age 12 through 21 years)	--	√	√Asians
Adult preventive care visit (age 18 through 64 years)	--	√	√Asians
Cervical cancer screening (age 21 through 64 years)	√+	--	√AI/AN
Ensuring appropriate care in appropriate places			
Total ED and ambulatory care visits	--	√	--
Total ED visits	--	√	--
Total ambulatory care visits	--	√	--
Improving behavioral and physical health coordination			
Total ED and ambulatory care visits for mental health/psychiatric care	--	--	--
Total ED visits for mental health/psychiatric care	--	--	√Blacks and Pacific Islanders
Total ambulatory care visits for mental health/psychiatric care	--	--	--
Follow-up within seven days after hospitalization for mental illness (age 6 through 64 years)	--	--	--
Reducing preventable hospitalizations			
Total number of inpatient admissions	--	√	--
PQI acute care composite measure	--	--	√Blacks
PQI chronic care composite measure	--	--	--
PQI 01: Diabetes short-term complication admission rate (age 18 through 64 years)	--	--	--
PQI 05: Chronic obstructive pulmonary disease or asthma admission rate (age 40 through 64 years)	--	--	--
PQI 08: Congestive heart failure admission rate (age 18 through 64 years)	--	--	--
PQI 15: Adult asthma admission rate (age 18 through 30 years)	--	--	--
Addressing discrete health issues (diabetes care)			
LDL-C screening (age 18 through 64 years)	--	--	--
Hemoglobin A1c testing (age 18 through 64 years)	--	--	--

^a Tested for a statistically significant difference between the three CCOs that had progressed the most with their transformation activities relative to the three CCOs in the earliest stages of their activities.

^b Tested for a statistically significant difference between the each racial/ethnic minority group and white enrollees.

√ = A statistically significant association. √+ = A positive association with the introduction of CCOs. √- = A negative association with the introduction of CCOs; -- = no statistically significant association was found.

AI/AN = American Indian/Alaskan Native. CCO = Coordinated Care Organization; ED = emergency department; LDL-C = low-density lipoprotein cholesterol; PQI = prevention quality indicator

⁴⁷ Oregon's Health System Transformation: CCO Metrics 2015 Final Report (June 2016), at: http://www.oregon.gov/oha/Metrics/Documents/2015_performance_report.pdf

Mathematica Policy Research found:

The results related to variations by race/ethnicity also indicate that the introduction of CCOs may be associated with improved parity in some outcome measures for some subgroups, such as improvements in potentially preventable hospital admissions for chronic conditions among Black enrollees, wellness care for Asian enrollees, and cervical cancer screening for American Indian/Alaska Native women. Even though we did not observe widespread reductions in racial/ethnic disparities immediately after CCOs were introduced to the Medicaid program, we also did not detect growing disparities.⁴⁸

While there is potential for CCOs to reduce racial and ethnic disparities in the quality measures, statewide data show that racial and ethnic disparities in health care access and outcomes continue to persist among CCO members:

- Hispanic/Latina women are less likely to have timely prenatal care.
- American Indian children are less likely to receive developmental screening.
- Hawaiian/Pacific Islander children are less likely to receive immunizations.
- Children with disabilities and American Indian and Hawaiian/Pacific Islander children are less likely to receive dental sealants.
- Adolescents of color and from households speaking languages other than English are less likely to receive adolescent well-care.
- Latinos/Hispanics are less likely to receive colorectal cancer screening
- American Indians have the highest rates of smoking.
- Asian Americans are less likely to receive screening for alcohol and substance misuse.
- Asian American women at risk of unintended pregnancy are less likely to have effective contraception use.
- American Indians, African Americans/Blacks, and individuals with disabilities have higher rates of emergency department use.⁴⁹

While recognizing that CCOs are responsible for reporting their performance on many quality measures, the technical assistance approach used for these health equity consultations was to highlight the 18 incentive quality measures used for 2016. This helped focus the discussions on a finite set of measures. It was noted that a focus on the incentive measures accomplished several simultaneous purposes: any improvement in reducing apparent disparities and improving CCO performance would result in direct and immediate financial reward for the CCO, improvements in health care and health status for CCO members, and evidence at the statewide level that advancements in quality improvement and health equity for diverse CCO members are feasible and achievable as part of Oregon's health system transformation. This was described as a win-win-win.

⁴⁸ Mathematica Policy Research, Midpoint Evaluation of Oregon's Medicaid Section 1115 Demonstration: Mid-2012 Through Mid-2014 (2015), page xiv, at: <https://www.oregon.gov/oha/OHPB/Documents/Final%20Report%20for%20the%20Midpoint%20Evaluation%20%204-30-2015.pdf>

⁴⁹ Oregon's Health System Transformation CCO Metrics 2015 Mid-Year Update (January 2016), at: <http://www.oregon.gov/oha/Metrics/Documents/2015%20Mid-Year%20Report%20-%20Jan%202016.pdf>; Oregon's Health System Transformation: CCO Metrics 2015 Final Report (June 2016), at: http://www.oregon.gov/oha/Metrics/Documents/2015_performance_report.pdf; and Oregon's Health System Transformation: CCO Metrics 2016 Mid-Year Report (January 2017), at: http://www.oregon.gov/oha/Metrics/Documents/2016_Mid-Year_Report.pdf

Accordingly, the health equity consultations used statewide and CCO-specific measure performance data on the 2016 incentive quality measures as the focus of discussions about potential health equity opportunities. When the consultations began in March 2016, the most recent available statewide and CCO-specific data about performance on most of these incentive measures were for the 12-month rolling period of July 2014 through June 2015. These statewide and CCO-specific data had just been published in January 2016 (there usually is a six-month lag in publishing mid-year or end-of-year data).⁵⁰ Each CCO had access to its own data for this period of time stratified by race, ethnicity, household language and disability; however, these data had not yet been made publicly available or published. The OHA Office of Health Analytics first publicly reported these data at a Metrics and Scoring Committee meeting in June 2016.⁵¹

As discussed later in this section, for some of the incentive measures (where CCO-specific data were not available), data from January 2015–December 2015 (rather than July 2014–June 2015) were available and used during the health equity consultations. In addition, data from the 2014 Medicaid Behavioral Risk Factor Surveillance System (BRFSS) survey (which oversampled to generate CCO-specific data)⁵², the 2015 and 2016 Consumer Assessment of Health Providers and Systems (CAHPS) survey (which includes CCO-specific data)⁵³, and local health department data about access to prenatal care (from 2012-2014)⁵⁴ also were reviewed and used in the analyses for the health equity consultations.

Statewide and CCO-specific data were compiled for each CCO and shared during the health equity consultations using the following color-coding:

High quality performance	Apparent disparities by race/ethnicity, household language or disability	Quality improvement opportunities
<p>+Average performance of all CCOs is <i>above</i> statewide benchmark.</p> <p>+Individual CCO performance is <i>above</i> average performance of all CCOs.</p> <p>+No tests of statistical significance were applied.</p>	<p>+Performance of CCO members from a racial/ethnic group, household language or disability statewide is <i>below</i> performance of all CCO members statewide.</p> <p>+Performance of CCO members from a racial/ethnic group, household language or disability is <i>below</i> performance of all members from that CCO.</p> <p>+No tests of statistical significance were applied.</p>	<p>+Average performance of all CCOs is <i>below</i> statewide benchmark.</p> <p>+Individual CCO performance is <i>below</i> average performance of all CCOs.</p> <p>+No tests of statistical significance were applied.</p>

⁵⁰ Oregon’s Health System Transformation CCO Metrics 2015 Mid-Year Update (January 2016), at: <http://www.oregon.gov/oha/Metrics/Documents/2015%20Mid-Year%20Report%20-%20Jan%202016.pdf>

⁵¹ <http://www.oregon.gov/oha/analytics/MetricsDocs/Measures%20by%20Race.%20Ethnicity.%20CCO.pdf>

⁵² 2014 Medicaid Behavioral Risk Factor Surveillance System (MBRFSS) Survey Report of Results (2016), at: <http://www.oregon.gov/oha/analytics/MBRFSS%20Docs/2014%20MBRFSS%20Report.pdf>

⁵³ CAHPS 5.0 Medicaid Survey Banner Book Report (June 2016), at: <http://www.oregon.gov/oha/analytics/Pages/CAHPS.aspx>

⁵⁴ Birth Data, Demographic Characteristics of Mother by Race/Ethnicity, 2012-2014, Oregon Public Health Division, at: <https://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/birth/Pages/demog.aspx>

At each consultation, there was an acknowledgement of the incompleteness and limitations of the available data. Consistent with the policy and practice of the OHA Office of Health Analytics, all data in cells with less than 30 members were suppressed for privacy and reliability. It also was emphasized that any differences in performance among racial, ethnic, household language, and disability groups were only for this specific period of performance (July 2014–June 2015), without any analysis of trend data. Finally, there was clarification that the differences shown were raw differences, with no tests of statistical significance applied.

At several of the health equity consultations, some CCOs had reviewed and shared either more updated data on these incentive measures or data stratified by other member demographic characteristics (by county of residence, urban vs. rural, etc.). In most cases, the updated or more detailed data confirmed the absence of disparities by race, ethnicity or household language. However, in some cases, the data identified potential disparities by geography. All CCOs were encouraged to continue monitoring and analyzing their own data stratified by member demographic characteristics to continue to identify their specific opportunities to advance health equity.

The remainder of this section provides an overview and summarizes the discussion about each of the 18 incentive measures reviewed and discussed at the health equity consultations.

CCO-specific performance data stratified by race, ethnicity, household language and disability were not available for all 18 incentive measures. For example, for the incentive measure that reports the percentage of members assigned to providers who have been recognized as patient-centered primary care homes, no data are available that stratifies that percentage by member race, ethnicity, household language or disability.

Patient-centered primary care home enrollment⁵⁵

Goal = 100%⁵⁶

The statewide percentage of CCO members enrolled in patient-centered primary care homes (PCPCHs) at the end of 2015 was 87.5%, with the highest performing CCO achieving 99.9% enrollment and the lowest performing CCO enrolling 73.5% of its members.⁵⁷

⁵⁵[http://www.oregon.gov/oha/analytics/CCODData/Patient%20Centered%20Primary%20Care%20Home%20\(PCPCH\)%20Enrollment%20-%202016%20\(revised%20Nov%202015\).pdf](http://www.oregon.gov/oha/analytics/CCODData/Patient%20Centered%20Primary%20Care%20Home%20(PCPCH)%20Enrollment%20-%202016%20(revised%20Nov%202015).pdf)

⁵⁶ Although the improvement target is 100%, incentive payments were available on a sliding scale to CCOs who enrolled at least 60% of their members in PCPCHs. All the CCOs met this improvement target of 60% enrollment in 2015.

⁵⁷ Since there were no stratified data available for this measure and data were available for the 12-month rolling period of January 2015–December 2015, this later data were used in the health equity consultations.

\$ PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT

Patient-centered primary care home enrollment

Percentage of CCO members who were enrolled in a recognized patient-centered primary care home (PCPCH).

2015 data (n=906,584)

Statewide change since 2014: **+8%**

Number of CCOs that improved: **12**

Number of CCOs achieving benchmark: **all 16**

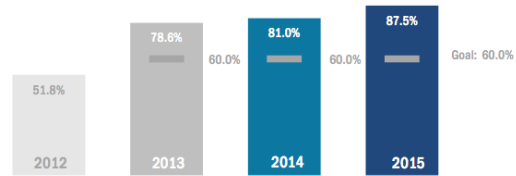
Enrollment in patient-centered primary care homes increased by 69 percent since 2012. This improvement is impressive considering that CCO enrollment has increased more than 70 percent due to Medicaid expansion (see graph at lower right).

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Results for this measure are not available by race and ethnicity.

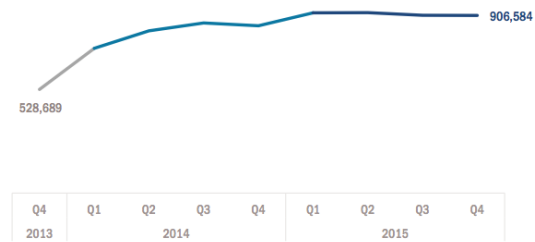
Statewide, patient-centered primary care home continues to increase.

Data source: CCO quarterly reporting



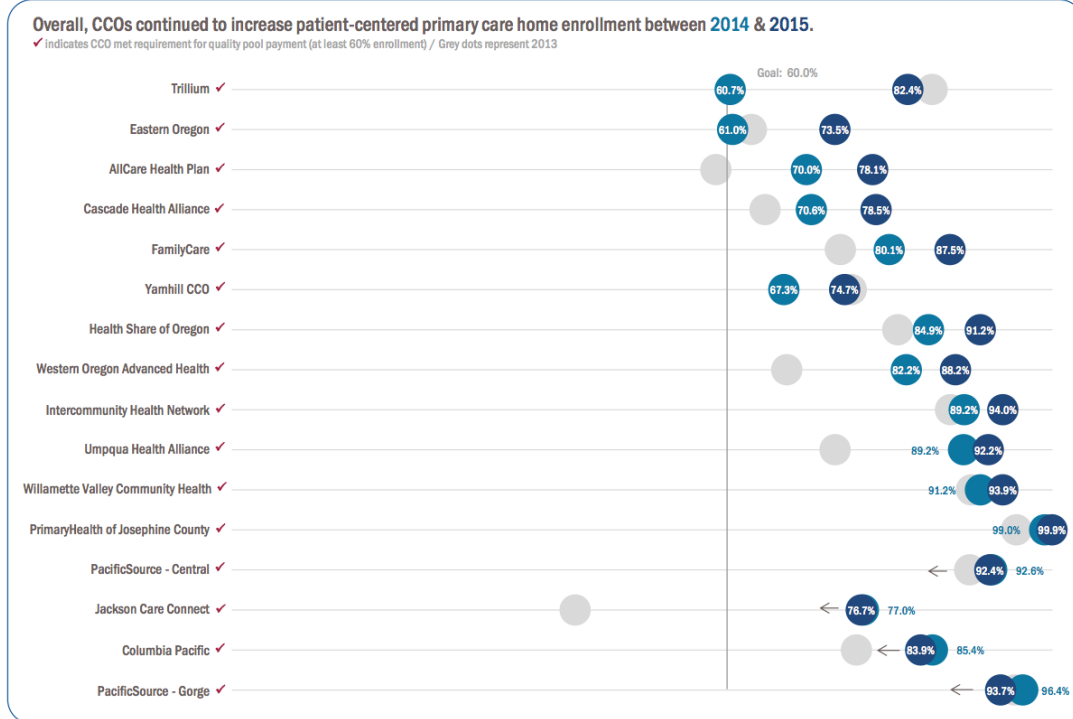
Total CCO enrollment increased 72 percent between 2013 and 2015.

87.9% of Medicaid members were enrolled in a CCO in December 2015.



None of the CCOs had stratified their data about members assigned to PCPCHs by race, ethnicity, household language or disability. However, enrollment in a PCPCH is a starting point for ensuring both access to, and consistent use of and follow-up with primary care. As a result, such analyses could support an intervention to advance health equity. For example, if a CCO's Hispanic/Latino members are less likely to be enrolled in PCPCHs, the CCO could focus and intensify its work with the providers for those Hispanic/Latino members to support them in becoming PCPCHs. This would result in both improvement on this incentive measure as well as improved care for those Hispanic/Latino members who would have access to more continuous and coordinated care.

PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT



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Below are statewide CCO performance data stratified by race and ethnicity for another seven of the 18 incentive measures for 2016.⁵⁸

- Childhood immunization status
- Cigarette smoking prevalence
- Colorectal cancer screening
- Controlling high blood pressure
- Depression screening and follow-up plan
- Diabetes HbA1c poor control
- Prenatal and postpartum care: timeliness of prenatal care.

Since these measures rely on data from medical records rather than administrative claims data, data by member demographics at the CCO-specific level are generally not available.

⁵⁸ The data used for these seven measures at the health equity consultations were for January 2015–December 2015. Updated data for the 12-month rolling period of July 2015–June 2016 became available in January 2017. Oregon’s Health System Transformation: CCO Metrics 2016 Mid-Year Report (January 2017), at: http://www.oregon.gov/oha/Metrics/Documents/2016_Mid-Year_Report.pdf Updated data for January 2016–December 2016 are expected to be available in June 2017.

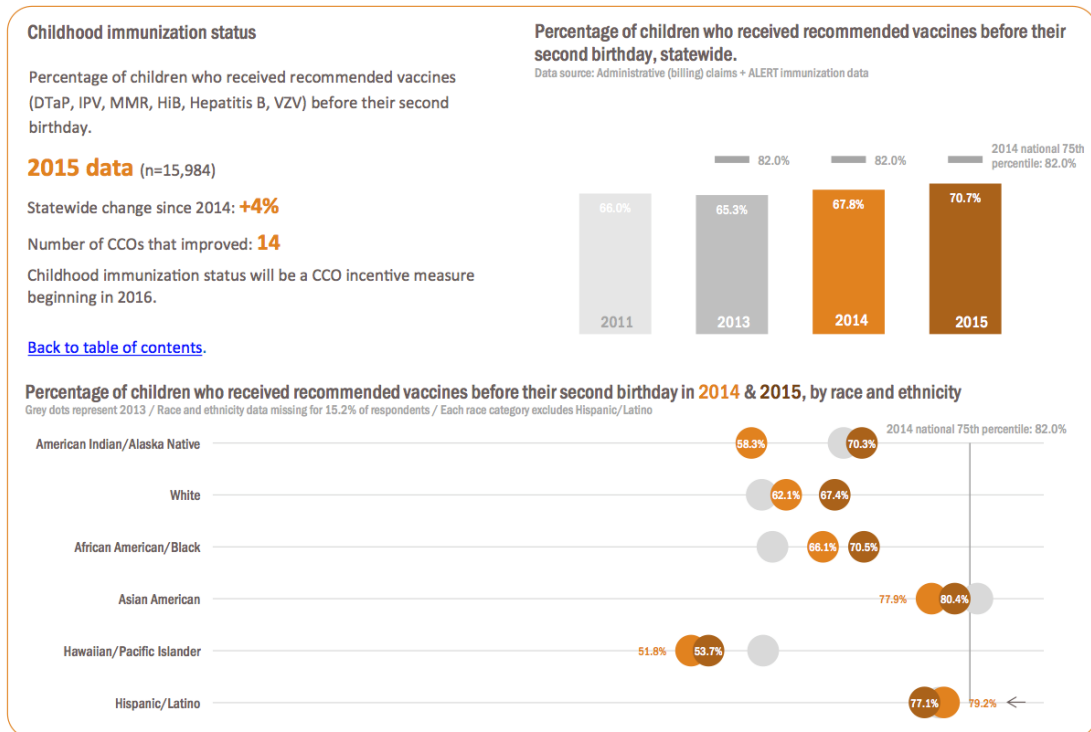
Childhood immunization status⁵⁹

2015 benchmark = 82%

2016 benchmark = 82% [new incentive measure for 2016]

While childhood immunization status had been one of the 33 quality measures reported to OHA, this was a new incentive measure for 2016. At the end of 2015, statewide CCO performance was 70.7%, with the highest performing CCO at 83.5% and the lowest performing CCO at 55.5%. That highest performing CCO (Cascade Health Alliance) was the only CCO above the 2015 benchmark.

CHILDHOOD IMMUNIZATION STATUS



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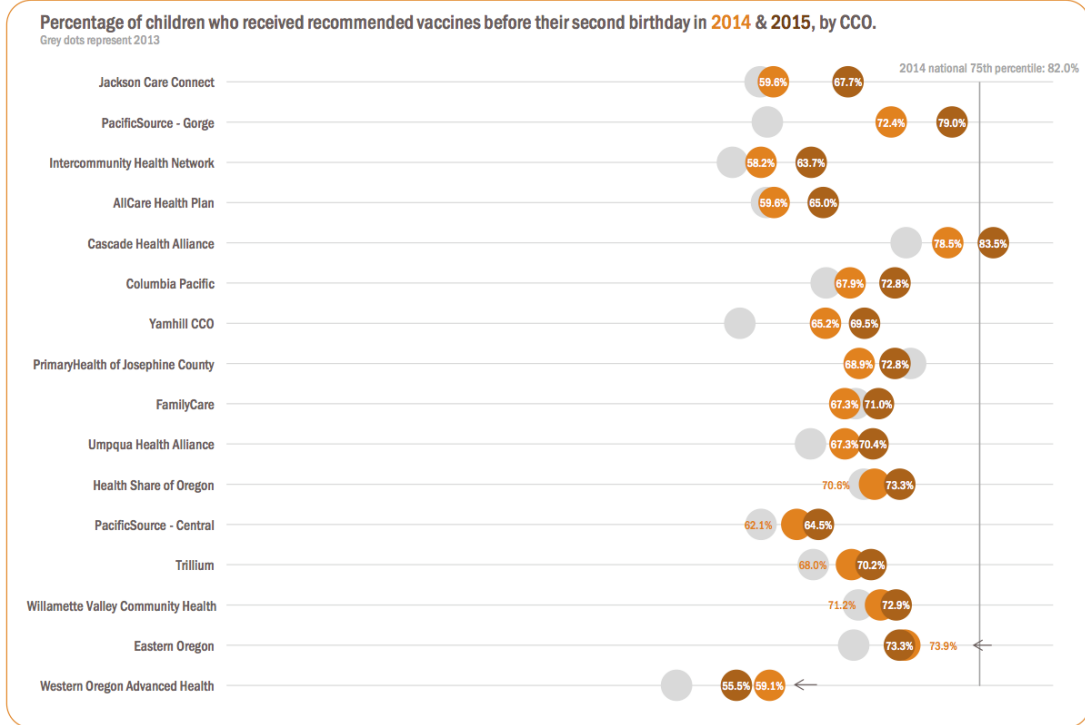
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The statewide data indicated a lower rate of childhood immunizations for Hawaiians/Pacific Islanders. For those CCOs with greater numbers of Hawaiian/Pacific Islander members, it would be important to identify whether there might be disparities in childhood immunization among their Hawaiian/Pacific Islander members.

⁵⁹ [http://www.oregon.gov/oha/analytics/CCOData/Childhood%20Immunization%20Status%20-%202016%20\(revised%20May%202016\).pdf](http://www.oregon.gov/oha/analytics/CCOData/Childhood%20Immunization%20Status%20-%202016%20(revised%20May%202016).pdf)

CHILDHOOD IMMUNIZATION STATUS



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In discussions of this measure at the health equity consultations, CCO participants also noted some of the challenges in documenting all immunizations any child may have received, especially if not provided by their primary care provider (e.g., by a local health department or school-based health center). In some areas, there is a higher rate of declining these immunizations for their children due to concerns about alleged linkages to autism, especially by White parents. In such cases, the racial and ethnic disparity of lower immunization rates may be among the White members. InterCommunity Health Network CCO is sponsoring two pilot projects related to this measure: one is with public health departments to learn more about the (negative) attitudes of residents about immunizations and one is with the Boys and Girls Clubs to promote immunizations among low-income and minority youth. The OHA Transformation Center has technical assistance resources to support improvements on the measure.⁶⁰

⁶⁰ <http://www.oregon.gov/oha/Transformation-Center/Pages/Resources-Metric.aspx>

Cigarette Smoking Prevalence⁶¹

2014 benchmark = 25% (lower is better)

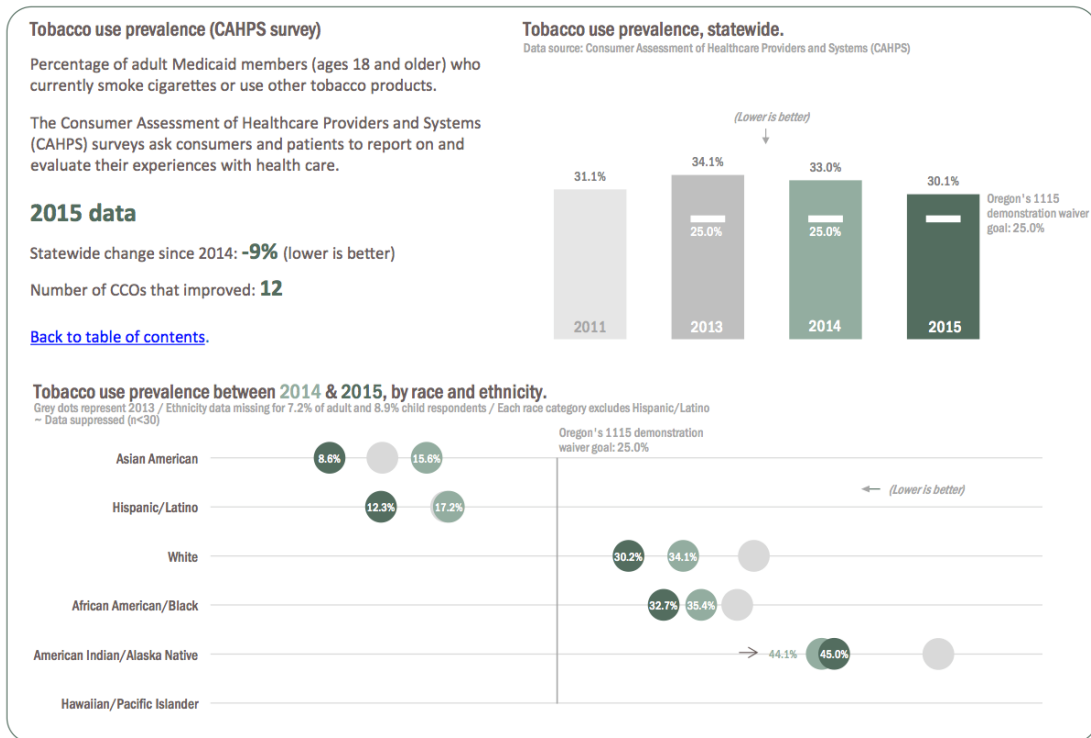
2015 benchmark = 25% (lower is better)

2016 cigarette smoking bundle [new incentive measure for 2016]

While tobacco use/cigarette smoking prevalence had also been one of the 33 quality measures being reported, it became part of a composite incentive measure beginning in 2016. The composite also includes the measurement of recommendation and referral to smoking cessation resources when smoking is identified.

Tobacco use/cigarette smoking prevalence data come from the Consumer Assessment of Health Providers and Systems (CAHPS) conducted annually. Data from the 2015 CAHPS were initially reviewed; when data from the 2016 CAHPS became available, they were then used in subsequent health equity consultations. In 2015, the statewide tobacco use prevalence among all CCOs was 30.1%, with the highest performing CCO (with the lowest tobacco use prevalence) at 21.7% and the lowest performing CCO (with the highest tobacco use prevalence) at 39.2%. At the end of 2015, only that highest performing CCO (PacificSource Columbia Gorge) had met the benchmark. The highest tobacco use/cigarette smoking prevalence was among American Indians, with slightly higher prevalence among African Americans/Blacks and Whites.

TOBACCO USE PREVALENCE (CAHPS SURVEY)



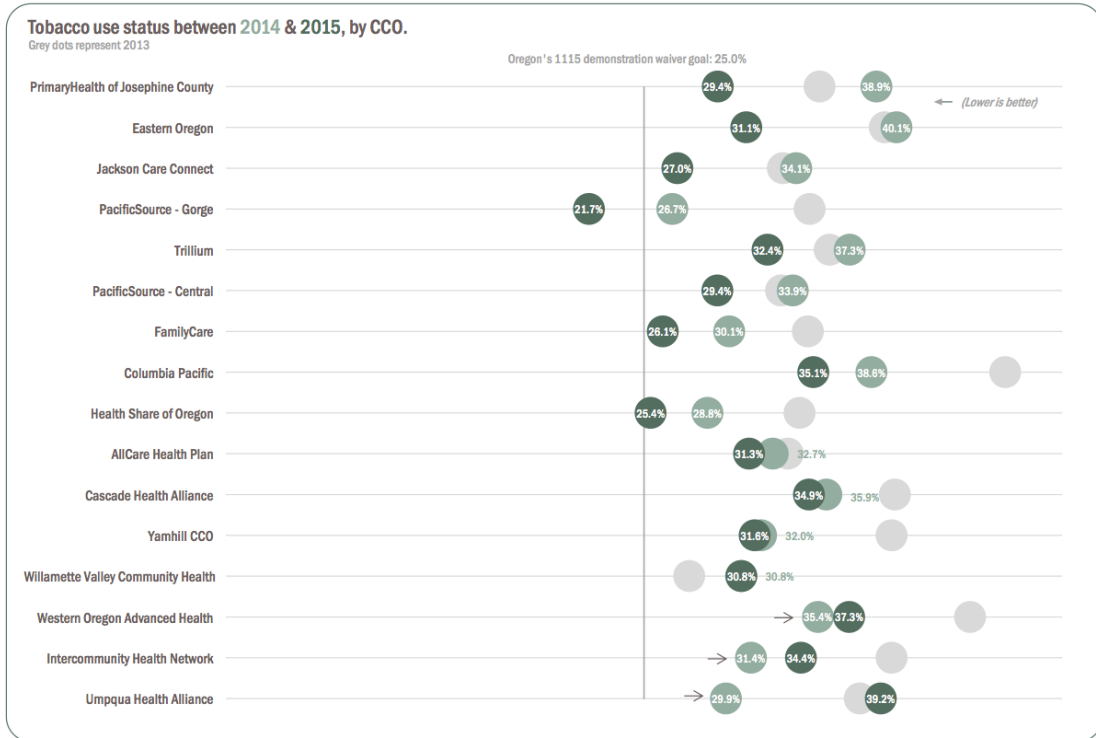
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⁶¹ [http://www.oregon.gov/oha/analytics/CCOData/Cigarette%20Smoking%20Prevalence%20Bundle%20-%202016%20\(revised%20May%202016\).pdf](http://www.oregon.gov/oha/analytics/CCOData/Cigarette%20Smoking%20Prevalence%20Bundle%20-%202016%20(revised%20May%202016).pdf)

TOBACCO USE PREVALENCE (CAHPS SURVEY)



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For comparison and trend data, Medicaid BRFSS data from 2014 also were reviewed at the health equity consultations. According to that survey, the statewide tobacco use prevalence among all CCOs was 29.3%, with the highest performing CCO (with the lowest tobacco use prevalence) at 22.7% and the lowest performing CCO (with the highest tobacco use prevalence) was 40.9%. These Medicaid BRFSS data also show higher prevalence among American Indians, African Americans/Blacks and Whites.

2014 Medicaid BRFSS current cigarette smoker by race and ethnicity[^]

State-wide	White	African American/Black	Hispanic/Latino	American Indian/Alaska Native	Asian American	Hawaiian/Pacific Islander
29.3	34.3	30.6	9.7	38.3	12.9	28.1

[^]Lower is better.

All these statewide data indicate a higher prevalence of tobacco use/cigarette smoking among American Indians. A participant from a tribal health clinic at the health equity consultation with Eastern Oregon CCO reported even higher rates of cigarette smoking among American Indians from his tribe. During the health equity consultations, there were discussions about the factors that might account for this higher prevalence among American Indians, including use of tobacco in cultural ceremonies, marketing practices by tobacco companies specifically focused on communities of color, and the relationship of tobacco use to mental health and substance use. There was discussion about the need for culturally appropriate interventions to reduce tobacco use/cigarette smoking

prevalence among American Indians, as well as strengthening relationships with local American Indian tribes while acknowledging and respecting tribal sovereignty. Tribal health clinics and local health departments were noted as potential partners to reach American Indian communities. The OHA Transformation Center has technical assistance resources to support improvements in tobacco cessation.⁶²

Colorectal cancer screening⁶³

2014 benchmark = 47%
2015 benchmark = 47%
2016 benchmark = TBD

In 2015, the statewide performance for colorectal cancer screening among all CCOs was 46.6% (almost at the benchmark), with the highest performing CCO at 52.7% and the lowest performing CCO at 36.0%. Ten of the CCOs were performing above the 2015 benchmark.

  **COLORECTAL CANCER SCREENING**

Colorectal cancer screening

Percent of adult members (ages 50-75) who had appropriate screening for colorectal cancer.

2015 data (n=6,506)

Statewide change since 2014: **+1%**

Number of CCOs that improved: **10**

Number of CCOs achieving benchmark or improvement target: **13**

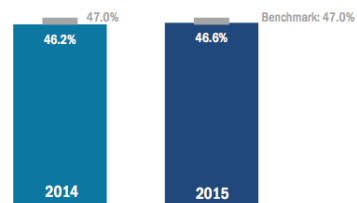
The measure specifications for colorectal cancer screening were updated in 2014 to use medical record data. Previously, rates were calculated using administrative (claims) data and were reported per 1,000 member months.

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Results for this measure are not available by race and ethnicity.

Percentage of adult members who had appropriate screening for colorectal cancer.

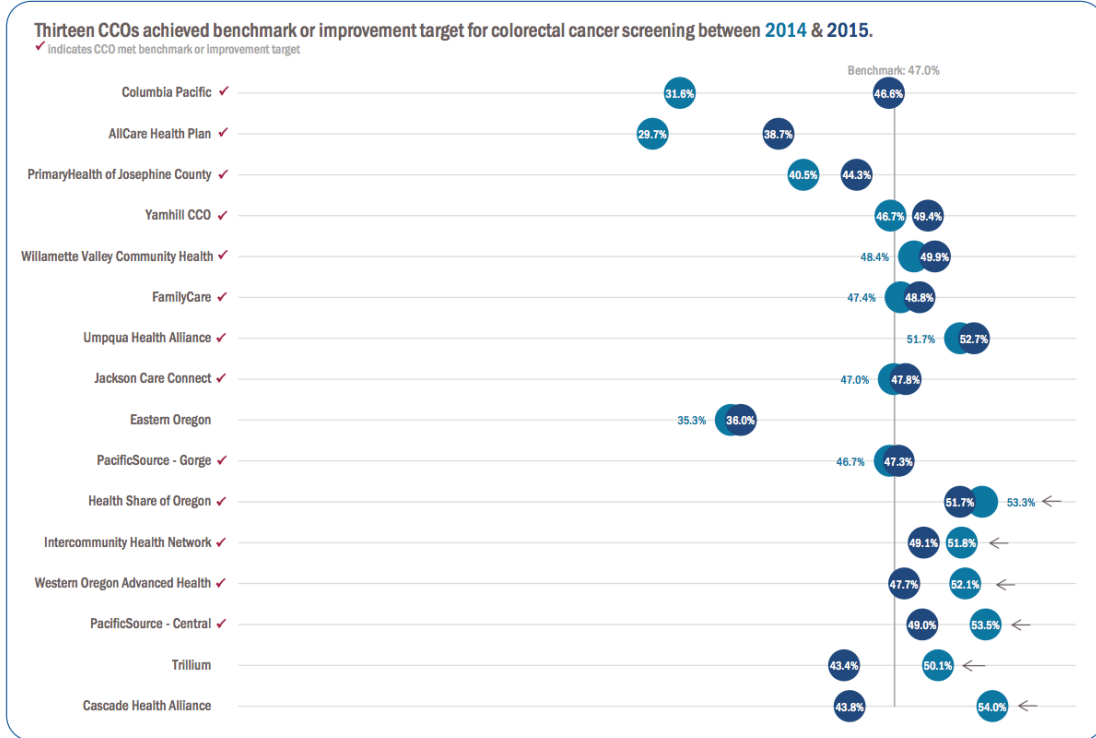
Data source: Administrative (billing) claims and medical record review
 Benchmark source: Metrics and Scoring Committee consensus



⁶² <http://www.oregon.gov/oha/Transformation-Center/Pages/Resources-Metric.aspx>

⁶³ [http://www.oregon.gov/oha/analytics/CCOData/Colorectal%20cancer%20screening%20-%202016%20\(revised%20Jan%202016\).pdf](http://www.oregon.gov/oha/analytics/CCOData/Colorectal%20cancer%20screening%20-%202016%20(revised%20Jan%202016).pdf)

\$ 📈 COLORECTAL CANCER SCREENING



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For comparison and trend data, Medicaid BRFSS data from 2014 indicated higher self-reported rates of colorectal cancer screening:

2014 Medicaid BRFSS current on colorectal cancer screening (ages 50–75) by race and ethnicity

State-wide	White	African American/Black	Hispanic/Latino	American Indian/Alaska Native	Asian American	Hawaiian/Pacific Islander
49.8	53.3	52.4	28.3	56.1	40.1	58.2

The Medicaid BRFSS data indicate there might be lower colorectal cancer screening rates for Hispanics/Latinos, and slightly lower for Asian Americans. The OHA Transformation Center has provided technical assistance to support improvement on this measure, including addressing potential disparities in screening rates among Hispanics/Latinos.⁶⁴ InterCommunity Health Network CCO has a pilot project to increase colorectal cancer screening among low-income, limited English proficient, migrant/seasonal workers, homeless and those in public housing; the CCO is still collecting the data from the project. Columbia Pacific CCO has prioritized improvements on this measure for its Hispanic/Latino members in its transformation plan.

During the discussions about this measure at the health equity consultations, several CCOs noted the challenge of documenting prior colorectal cancer screenings for

⁶⁴ <http://www.oregon.gov/oha/Transformation-Center/Pages/Resources-Metric.aspx>

populations (within the past 10 years) that have not had a regular or continuous health care provider, or when current providers are not yet using electronic health record systems that can document such screenings longitudinally. For example, one CCO conducted manual chart reviews for its Hispanic/Latino members on this measure and was able to confirm that disparities did not exist.

There also was some discussion about the barriers to improvement on this measure. The participants at the health equity consultation with Eastern Oregon CCO raised the “culture” of “cowboys and ranchers” that made it challenging to persuade men to obtain these colorectal cancer screenings.

Controlling high blood pressure⁶⁵

2014 benchmark = 64%

2015 benchmark = 64%

2016 benchmark = 69%

In 2015, the statewide performance for controlling high blood pressure among all CCOs was 64.7% (above the benchmark), with the highest performing CCO at 72.5%, and the lowest performing CCO at 52.2%. Ten of the CCOs were performing above the 2015 benchmark. This is one of the two clinical outcome measures among the incentive measures requiring documentation of clinical control of a specific diagnosed condition (the other is the diabetes control measure).

⁶⁵ [http://www.oregon.gov/oha/analytics/CCOData/Controlling%20Hypertension%20-%202016%20\(updated%20Aug%202016\).pdf](http://www.oregon.gov/oha/analytics/CCOData/Controlling%20Hypertension%20-%202016%20(updated%20Aug%202016).pdf)

  **CONTROLLING HIGH BLOOD PRESSURE**

Controlling high blood pressure

Percentage of adult patients (ages 18–85) with a diagnosis of hypertension (high blood pressure) whose condition was adequately controlled.

2015 data (n=140,420)

Statewide change since 2014: **0%**

Number of CCOs that improved: **11**

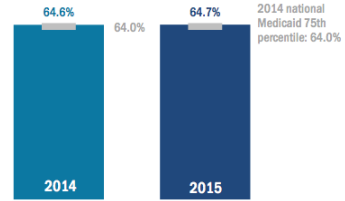
Number of CCOs achieving benchmark or improvement target: **11**

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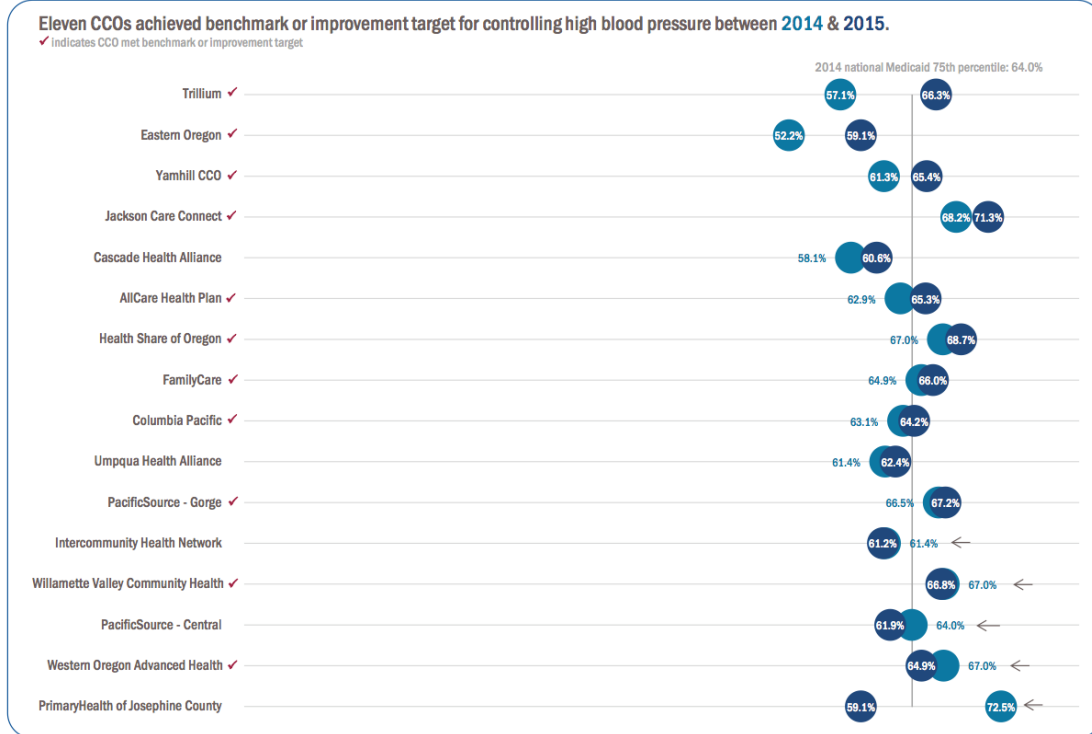
Results for this measure are not available by race and ethnicity.

Percentage of adults with high blood pressure whose condition was adequately controlled, statewide.

Data source: Electronic Health Records



CONTROLLING HIGH BLOOD PRESSURE



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Medicaid BRFSS data from 2014 were available about self-reported prevalence of high blood pressure (not about whether high blood pressure is clinically controlled):

2014 Medicaid BRFSS high blood pressure prevalence by race and ethnicity[^]

State-wide	White	African American/Black	Hispanic/Latino	American Indian/Alaska Native	Asian American	Hawaiian/Pacific Islander
28.3	30.8	32.7	18.3	31.0	29.2	28.1

[^]Lower is better.

In the Medicaid BRFSS data, there do not appear to be disparities in self-reported high blood pressure among racial and ethnic populations (and the self-reported prevalence is lowest among Hispanics/Latinos). As CCOs obtain more data about this measure stratified by member race, ethnicity, language, disability and other demographic characteristics (e.g., with improvements in extracting data from electronic health records), this may be a good measure to engage clinics and providers in a review and discussion about health equity. Health equity is a clinical outcome that all providers are more likely to monitor and feel that they can affect. At least one CCO, PacificSource Central Oregon, highlighted the need for more stratified data by member race and ethnicity on this measure in its transformation plan.

Depression screening and follow-up plan⁶⁶

2014 benchmark = 25%

2015 benchmark = 25%

2016 benchmark = 25% [2016 challenge pool measure]

In 2015, the statewide performance for depression screening and follow-up plans among all CCOs was 37.4% (above the benchmark), with the highest performing CCO at 62.8%, and the lowest performing CCO at 0.5%. Thirteen of the CCOs were performing above the 2015 benchmark on this measure.

  **DEPRESSION SCREENING AND FOLLOW-UP PLAN**

Depression screening and follow-up plan

Percentage of patients (ages 12 and older) who had appropriate screening and follow-up planning for depression.

Statewide, the percentage of adult patients who were screened for depression and had an appropriate follow-up plan increased.

Data source: Electronic Health Records
Benchmark source: Metrics and Scoring Committee consensus

2015 data (n=345,771)

Statewide change since 2014: **+34%**

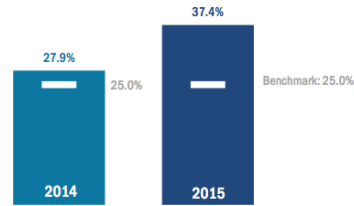
Number of CCOs that improved: **13**

Number of CCOs achieving benchmark or improvement target: **15**

The range in performance on this measure in part reflects the challenges of adopting and implementing electronic health record functionality that enables the reporting of all data elements required for this measure.

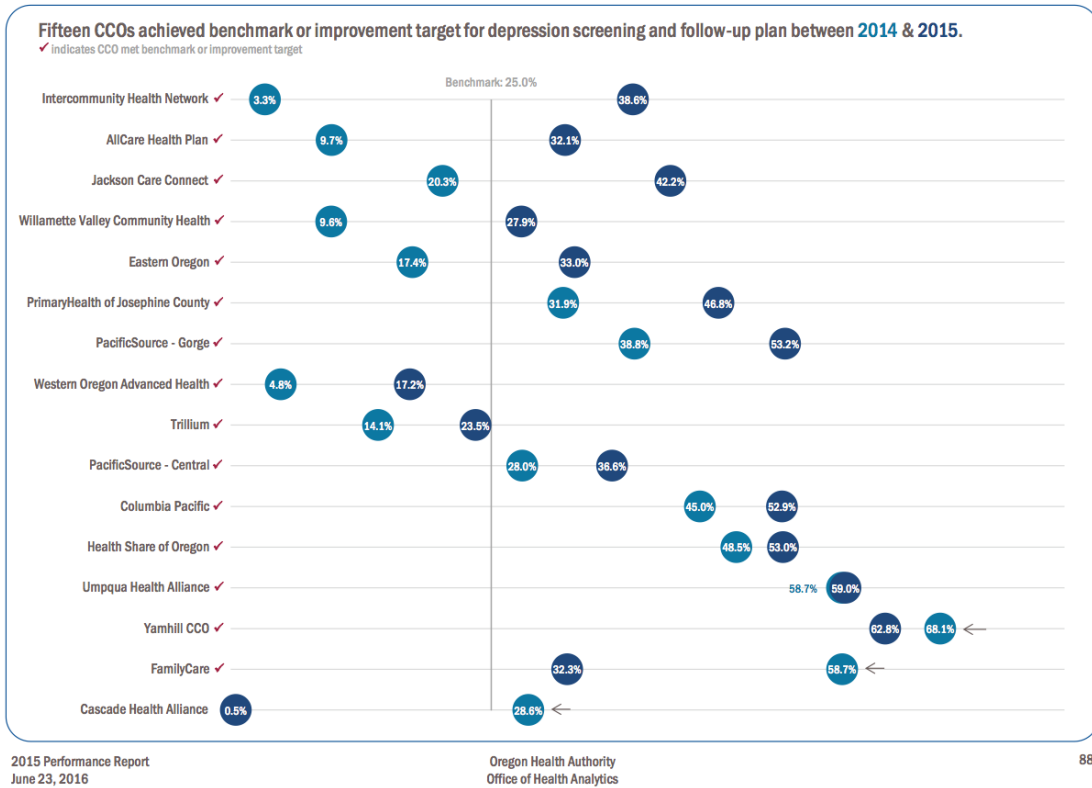
[Back to table of contents.](#)

Results for this measure are not available by race and ethnicity.



⁶⁶ [http://www.oregon.gov/oha/analytics/CCOData/Depression%20Screening%20-%202016%20\(revised%20Aug%202016\).pdf](http://www.oregon.gov/oha/analytics/CCOData/Depression%20Screening%20-%202016%20(revised%20Aug%202016).pdf)

DEPRESSION SCREENING AND FOLLOW-UP PLAN



Medicaid BRFSS data from 2014 were available about self-reported prevalence of depression (not about whether there has been screening and follow-up for depression):

2014 Medicaid BRFSS depression prevalence by race and ethnicity[^]

State-wide	White	African American/Black	Hispanic/Latino	American Indian/Alaska Native	Asian American	Hawaiian/Pacific Islander
36.8	42.2	30.1	20.4	40.7	12.9	18.9

[^]Lower is better.

In the Medicaid BRFSS data, there do not appear to be disparities in self-reported depression prevalence among racial and ethnic populations (with the self-reported prevalence lower than the statewide prevalence among Asian Americans, Hawaiians/Pacific Islanders, and Hispanics/Latinos but higher than the statewide prevalence among American Indians and Whites). PacificSource Columbia Gorge examined its internal data and found that Hispanics and Asians/Pacific Islanders had the lowest rates of behavioral health visits; there may be both cultural barriers to accessing and using behavioral health services as well as a lack of culturally appropriate providers for these members. PacificSource Central Oregon highlighted the need for more stratified data by member race and ethnicity on this measure in its transformation plan.

Diabetes: HbA1c poor control⁶⁷

2014 benchmark = 34% (lower is better)

2015 benchmark = 34% (lower is better)

2016 benchmark = 19% (lower is better) [2016 challenge pool measure]

Poor control of HbA1c among individuals with diabetes is the other clinical control measure. In 2015, the statewide performance among all CCOs was 26.7% (better than the benchmark), with the highest performing CCO at 11.4% (lower is better) and the lowest performing CCO at 33.9% (better than the benchmark). All of the CCOs were performing better than the 2015 benchmark.

DIABETES CARE: HbA1c POOR CONTROL

Diabetes care: HbA1c poor control

Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period. A lower score is better.

2015 data (n=53,620)

Statewide change since 2014: **+22%** (lower is better)

Number of CCOs that improved: **4**

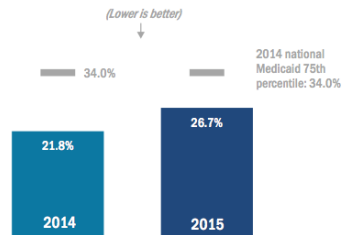
Number of CCOs achieving benchmark or improvement target: **all 16**

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Results for this measure are not available by race and ethnicity.

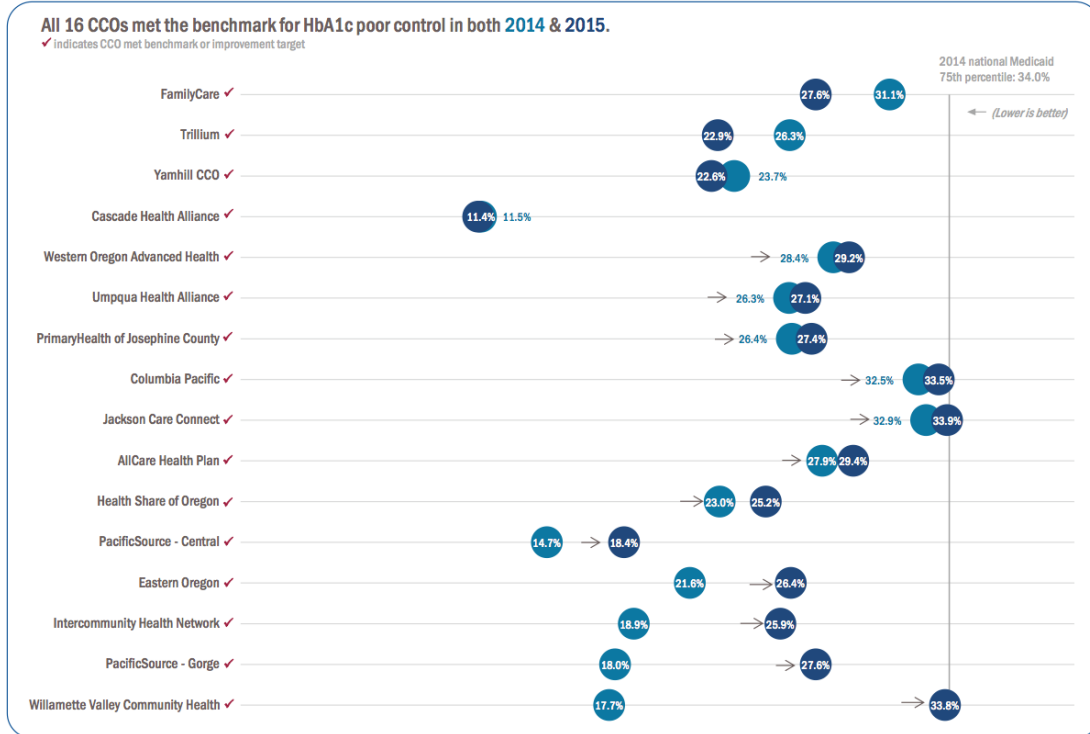
Statewide, the percentage of members with diabetes who had poor control of hemoglobin A1c has increased.

Data source: Electronic Health Records



⁶⁷ [http://www.oregon.gov/oha/analytics/CCODData/Diabetes%20HbA1c%20Poor%20Control%20-%202016%20\(updated%20Aug%202016\).pdf](http://www.oregon.gov/oha/analytics/CCODData/Diabetes%20HbA1c%20Poor%20Control%20-%202016%20(updated%20Aug%202016).pdf)

DIABETES CARE: HbA1c POOR CONTROL



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Medicaid BRFSS data are available about self-reported prevalence of diabetes (not about whether there the diabetes is clinically controlled):

2014 Medicaid BRFSS diabetes prevalence by race and ethnicity[^]

State-wide	White	African American/Black	Hispanic/Latino	American Indian/Alaska Native	Asian American	Hawaiian/Pacific Islander
11.6	11.6	14.2	12.3	12.5	13.0	22.1

[^]Lower is better.

In the Medicaid BRFSS data, the highest self-reported prevalence of diabetes is among Hawaiians/Pacific Islanders, nearly twice the statewide prevalence. For those CCOs with greater numbers of Hawaiian/Pacific Islander members, it would be important to identify whether there might be disparities in HbA1c control among their Hawaiian/Pacific Islander members with diabetes. As CCOs obtain more data about this measure stratified by member race, ethnicity, language, disability, and other demographic characteristics (e.g., with improvements in extracting data from electronic health records), this is another a good measure to engage clinics and providers in a review and discussion about health equity. Health equity t is a clinical outcome that all providers are more likely to monitor and feel that they can impact. Both PacificSource Columbia Gorge and PacificSource Central Oregon highlighted the need for improvement in diabetes control and self-management among American Indian and Hispanic/Latino members in their transformation plans.

Prenatal and postpartum care: Timeliness of prenatal care⁶⁸

2014 benchmark = 90%
2015 benchmark = 90%
2016 benchmark = 93%

Statewide, the CCO performance on this measure of timeliness of prenatal care was 84.7%, approaching the 2015 benchmark of 90%. The benchmark will increase to 93% for 2016. The highest performing CCO was at 92.3% and the lowest performing CCO was at 72.3%. Three CCOs (AllCare CCO, Eastern Oregon CCO and PacificSource Columbia Gorge) exceeded the 2015 benchmark.



PRENATAL AND POSTPARTUM CARE: TIMELINESS OF PRENATAL CARE

Timeliness of prenatal care

Percentage of pregnant women who received a prenatal care visit within the first trimester or within 42 days of enrollment in a CCO.

2015 data (n=5,724)

Statewide change since 2014: **+13%**

Number of CCOs that improved: **all 16**

Number of CCOs achieving benchmark or improvement target: **all 16**

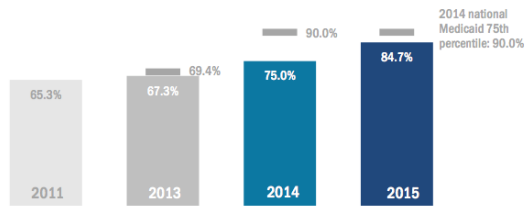
The measure specifications for timeliness of prenatal care were updated beginning in 2014 to use medical record data. Previously, this measure used administrative data only; 2014 and 2015 results are thus not directly comparable to earlier years.

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Results for this measure are not available by race and ethnicity.

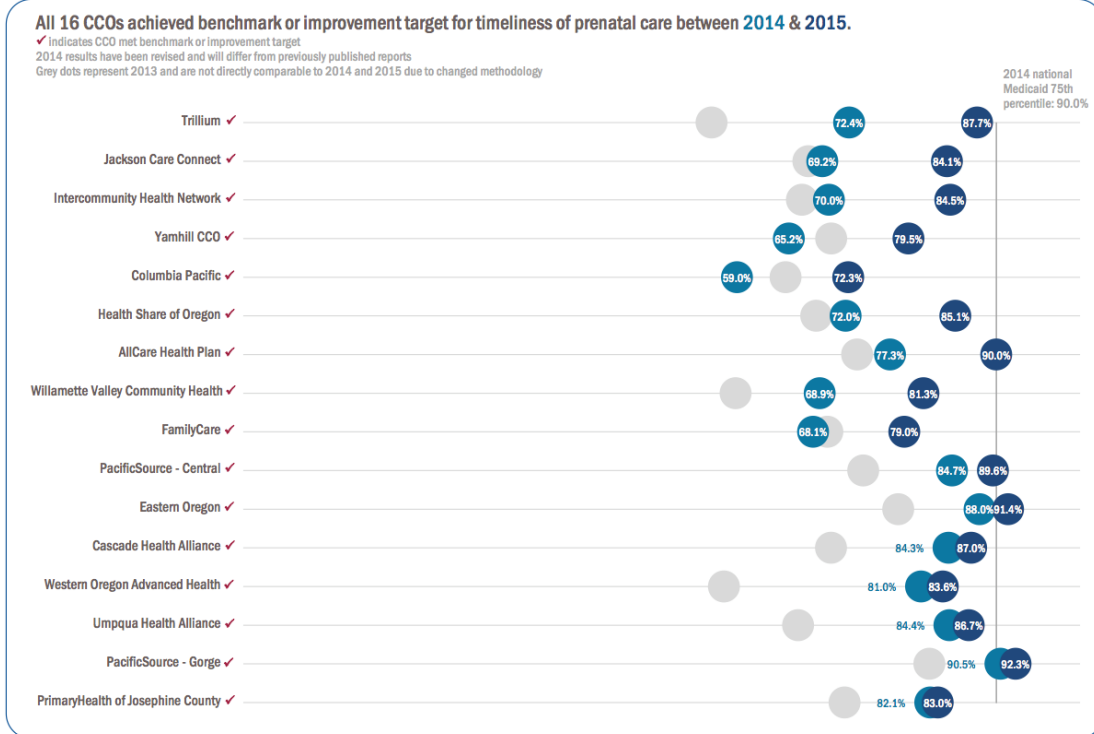
Timeliness of prenatal care, statewide.

Data source: Administrative (billing) claims and medical record review
2014 results have been revised and will differ from previously published reports
2014 and 2015 are not directly comparable to earlier years due to changed methodology



⁶⁸<http://www.oregon.gov/oha/analytics/CCOData/Timeliness%20of%20Prenatal%20and%20Postpartum%20Care%20-%20202016.pdf>

PRENATAL AND POSTPARTUM CARE: TIMELINESS OF PRENATAL CARE



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Local health department data about prenatal care from 2012 to 2014 were reviewed and shared with each CCO for their counties served. Since Medicaid provides health insurance coverage for a large percentage of births in each county, such local health department data are a strong proxy data source.

Start of prenatal care in first trimester 2012–2014

	All births in county	White	African American/ Black	Hispanic/ Latino	American Indian/ Alaska Native	Asian American	Hawaiian/ Pacific Islander
Baker County	75.0	75.8	***	***	***	***	N/A
Benton County	79.8	81.4	***	73.7	***	82.7	***
Clackamas County	78.6	80.1	70.4	70.2	84.7	79.9	43.3
Clatsop County	75.2	77.2	***	68.2	***	***	***
Columbia County	76.7	77.8	***	72.2	***	***	***
Coos County	76.8	78.5	***	68.4	73.1	75.8	***
Crook County	68.3	69.4	***	64.7	***	***	***
Curry County	72.0	72.5	***	73.3	***	***	***
Deschutes County	79.9	80.9	***	77.4	54.8	84.8	***

	All Births in County	White	African American/ Black	Hispanic/ Latino	American Indian/ Alaska Native	Asian American	Hawaiian/ Pacific Islander
Douglas County	80.4	80.7	***	77.9	78.8	78.8	***
Gilliam County	81.4	83.7	N/A	***	N/A	***	***
Grant County	64.8	67.1	N/A	***	***	***	N/A
Harney County	73.9	76.6	N/A	***	***	N/A	***
Hood River County	80.5	79.8	***	81.2	***	***	***
Jackson County	76.0	76.8	63.9	75.7	61.0	84.8	***
Jefferson County	68.7	69.3	***	69.3	64.1	***	***
Josephine County	77.2	78.5	***	71.8	62.5	73.3	***
Klamath County	78.5	81.0	***	74.0	63.6	***	***
Lake County	65.8	66.5	N/A	***	***	***	N/A
Lane County	76.6	77.6	72.6	72.0	70.1	74.5	64.5
Lincoln County	74.1	77.1	***	68.4	71.4	***	***
Linn County	79.4	80.5	***	73.5	***	75.6	***
Malheur County	61.7	72.3	***	49.5	***	***	***
Marion County	74.9	79.1	59.2	71.0	63.5	77.2	35.3
Morrow County	69.4	73.7	***	65.7	***	***	N/A
Multnomah County	76.3	79.4	65.9	73.2	65.0	74.6	37.4
Polk County	78.6	81.0	***	70.2	80.0	75.0	***
Sherman County	85.4	85.4	N/A	***	***	N/A	N/A
Tillamook County	73.6	76.0	***	64.4	***	***	***
Umatilla County	72.5	75.9	***	69.1	66.0	74.3	***
Union County	83.0	84.9	***	73.2	***	***	***
Wallowa County	81.0	81.8	N/A	***	***	***	N/A
Wasco County	80.5	81.3	***	82.4	62.9	***	***
Washington County	77.0	82.5	62.4	64.3	65.4	80.4	42.4
Wheeler County	76.7	***	N/A	***	N/A	N/A	***
Yamhill County	81.9	84.3	***	74.9	85.4	78.0	***

***Less than 30 births

Based on these data, there are lower rates of timely prenatal care among Hispanic/Latina women in almost all counties and among Hawaiian/Pacific Islander, American Indian, Asian American and African American/Black women in counties where data are available. In Hood River County, the rate was slightly lower for White women compared with Hispanic/Latina women.

At the health equity consultations, there were discussions about culturally and linguistically appropriate strategies to improve CCO performance on this measure, especially since there may be cultural barriers to accessing or using prenatal care.⁶⁹ Ensuring that family planning and prenatal care programs, services, and educational materials are available in Spanish would be an example of an effective intervention for Hispanic/Latina members. Another starting point would be ensuring that Hispanic/Latina and other women of color are assigned and established with patient-centered primary care homes where they have a regular source of care and can discuss family planning issues. At other consultations, there were discussions about working with other partners on improving timely access to prenatal care, including local health departments, Planned Parenthood clinics, and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) partners. Two CCOs, Cascade Health Alliance and Columbia Pacific CCO, had prioritized improvements in prenatal care in their transformation plan objectives.

Since stratified race, ethnicity, household language and disability data were not available at the CCO-level for the incentive measures discussed above, the discussion at the health equity consultations focused on the remaining 10 of 18 incentive measures:

- *Adolescent well-care visits*
- *Alcohol or other substance misuse screening (SBIRT), all ages 12+*
- *Ambulatory care: emergency department visits per 1,000 member months*
- *CAHPS composite: access to care*
- *CAHPS composite: satisfaction with care*
- *Dental sealants on permanent molars for children all ages 6–14*
- *Developmental screening in the first 36 months of life*
- *Effective contraceptive use among women at risk of unintended pregnancy*
- *Follow-up after hospitalization for mental illness*
- *Mental, physical and dental health assessments within 60 days for children in DHS custody*

The following are data on these incentive measures statewide for each of the CCOs for July 2014–June 2015:⁷⁰

⁶⁹ At several of the health equity consultations, there were discussions about not getting credit for initial assessments, conducted by nurses and other providers, that do not meet the strict criteria for the measure.

⁷⁰ Oregon's Health System Transformation CCO Metrics 2015 Mid-Year Update (January 2016), at: <http://www.oregon.gov/oha/Metrics/Documents/2015%20Mid-Year%20Report%20-%20Jan%202016.pdf> The CCO-specific data, stratified by race, ethnicity, household language and disability, were published by the OHA Office of Health Analytics in June 2016: <http://www.oregon.gov/oha/analytics/MetricsDocs/Measures%20by%20Race,%20Ethnicity,%20CCO.pdf> As noted above, updated data for the 12-month rolling period of July 2015-June 2016 became available in January 2017: Oregon's Health System Transformation: CCO Metrics 2016 Mid-Year Report (January 2017), at: http://www.oregon.gov/oha/Metrics/Documents/2016_Mid-Year_Report.pdf Updated data for January 2016-December 2016 are expected to be available in June 2017.

Adolescent well-care visits⁷¹

2014 benchmark = 57.6%

2015 benchmark = 62.0%

2016 benchmark = 61.9%

For the period July 2014–June 2015, the performance by all CCOs on adolescent well-care visits was 32.0%, well below the benchmark. The highest performing CCO was 46.2% and the lowest performing CCO was at 22.3%. At mid-year, none of the CCOs were meeting the 2015 benchmark. The statewide data show there were lower rates of adolescent well-care visits for Hawaiians/Pacific Islanders, Whites and American Indians. On the other hand, the rate was higher among adolescents with disabilities (perhaps because adolescents with disabilities are more likely to have more frequent medical visits where the well-care visit can be accomplished and documented).

ADOLESCENT WELL-CARE VISITS

Adolescent well-care visits

Measure description: Percentage of adolescents and young adults (ages 12-21) who had at least one well-care visit during the measurement year.

Purpose: Youth who can easily access preventive health services are more likely to be healthy and able to reach milestones such as high school graduation and entry into the work force, higher education, or military service.

mid-2015 data

Statewide change since 2014: **0%**

Number of CCOs that improved: **10**

Racial and ethnic groups experiencing improvement:

- ✓ White
- ✓ African American / Black

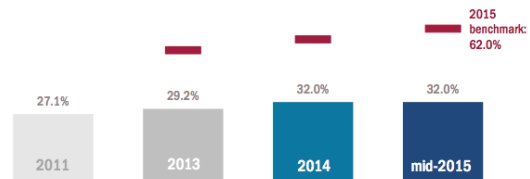
Statewide, the percentage of adolescents who had at least one well-care visit remains well below the benchmark. Barriers to improvement may include providers performing acute care visits when a patient would benefit from comprehensive well care; changes in recommendations for clinical care; and concerns about confidentiality for sensitive services.

See pages 97 and 103 for results stratified by members with and without disability and mental health diagnoses.

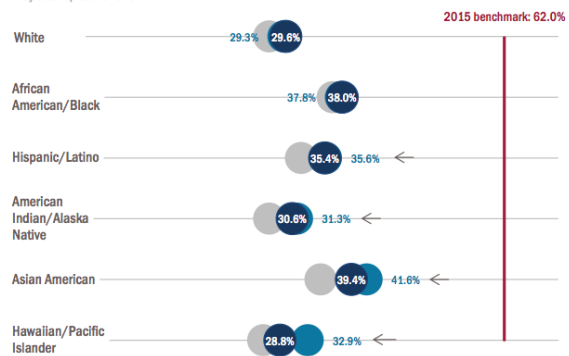
About these data

- N=139,396
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid 75th percentile (administrative data only)
- Race and ethnicity data missing for 11.9% of respondents
- Each race category excludes Hispanic/Latino
- 2014 benchmark: 57.6%

Statewide, the percentage of adolescents receiving well-care visits remained steady between 2014 and mid-2015.

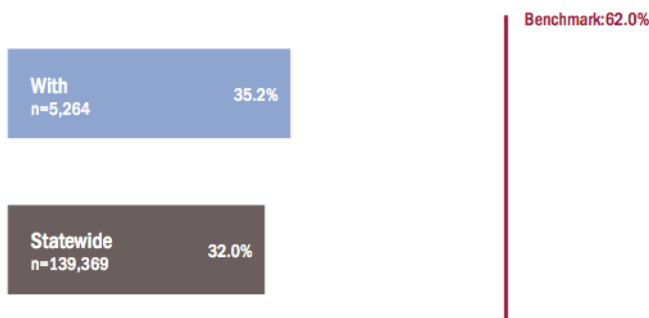


The percentage of Hawaiian / Pacific Islander adolescents receiving well-care visits declined between 2014 and mid-2015.

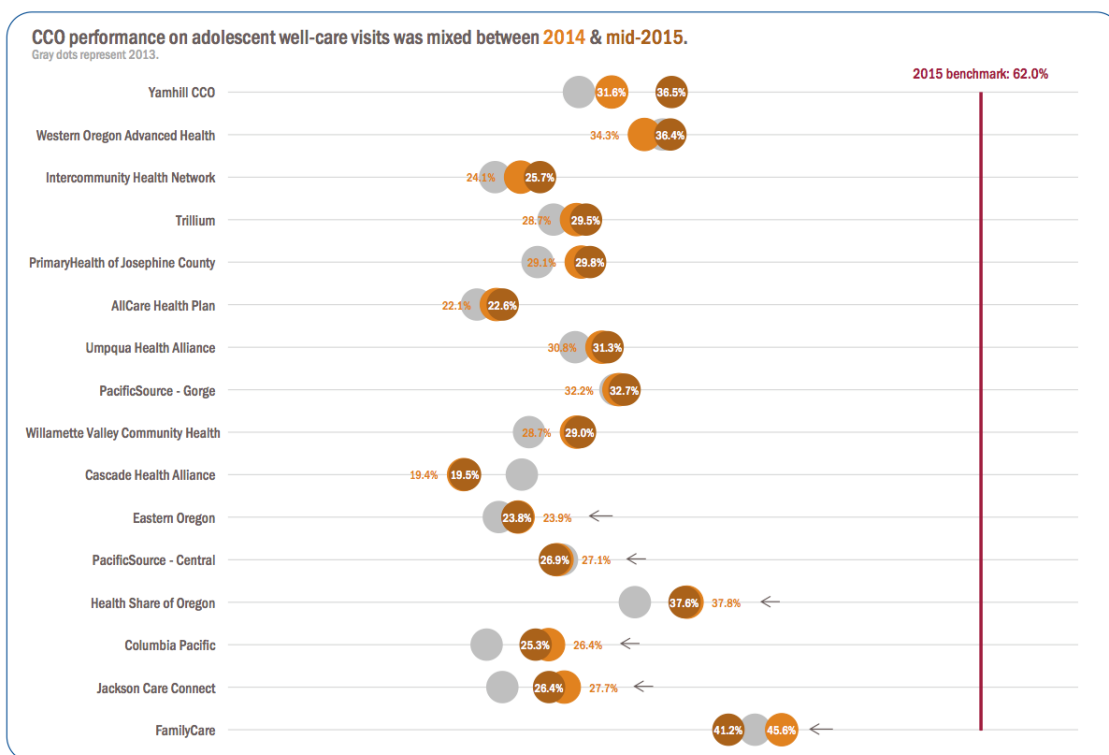


⁷¹ [http://www.oregon.gov/oha/analytics/CCOData/Adolescent%20Well%20Care%20Visits%20-%202016%20\(revised%20Jan%202016\).pdf](http://www.oregon.gov/oha/analytics/CCOData/Adolescent%20Well%20Care%20Visits%20-%202016%20(revised%20Jan%202016).pdf)

Adolescent well-care visits were higher among members with disability compared with statewide.



ADOLESCENT WELL-CARE VISITS

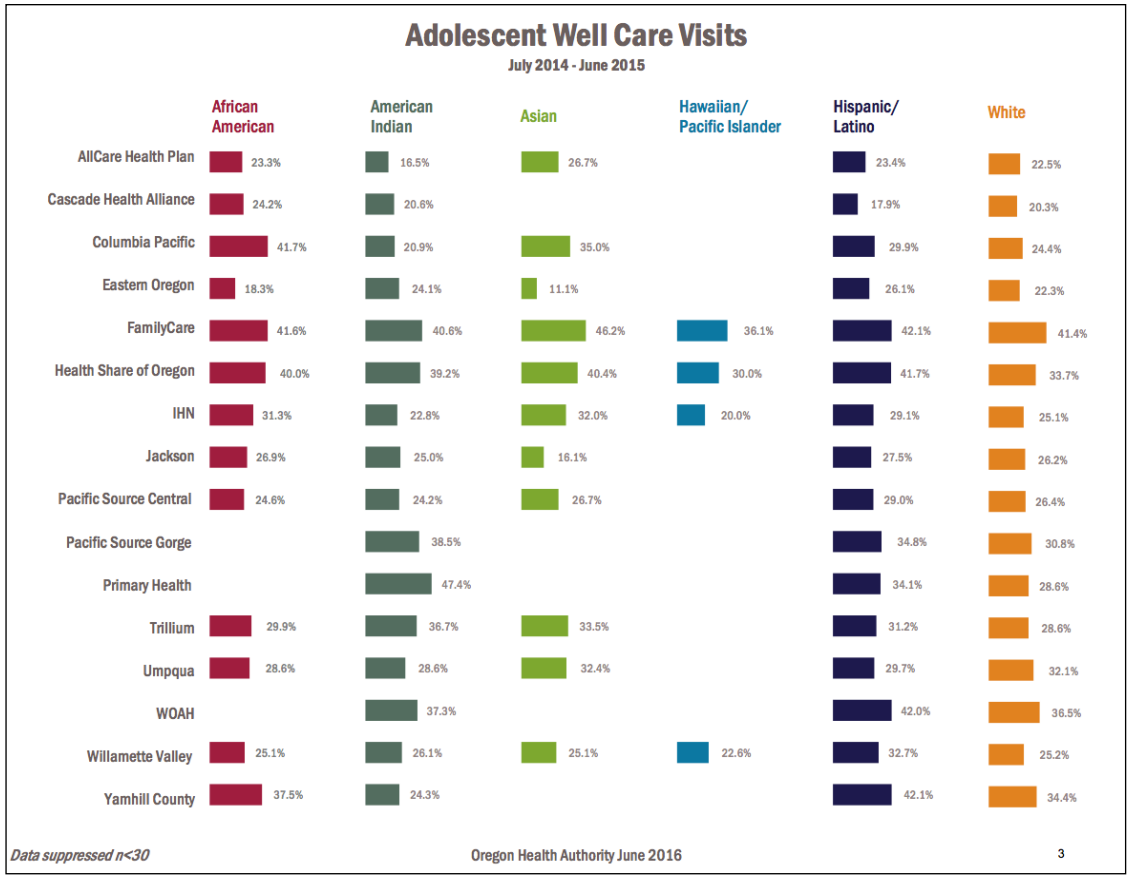


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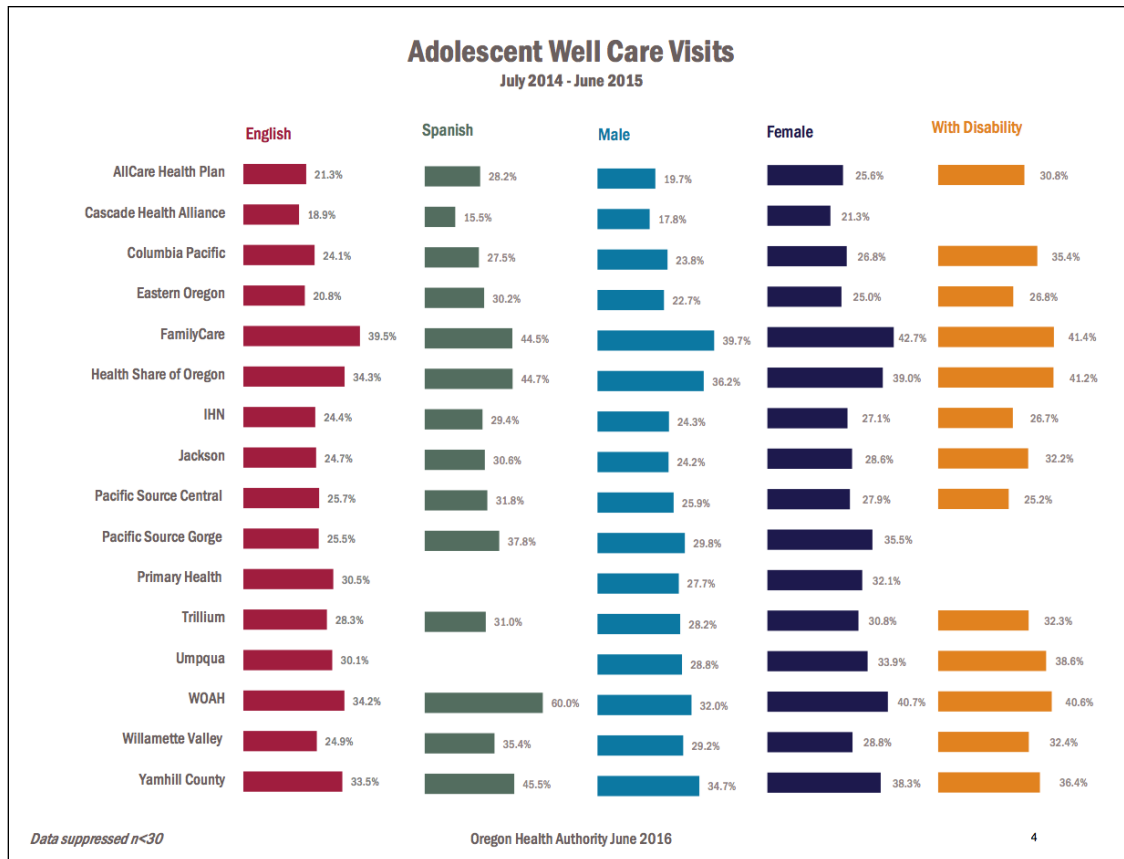
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Stratified data for each CCO were analyzed and discussed at each health equity consultation. The statewide data and CCO-specific data indicate there may be lower rates of well-care visits among Hawaiian/Pacific Islander, White and American Indian adolescents and, for some CCOs, among Hispanic/Latino and Asian American adolescents and adolescents with disabilities. For CCOs with sufficient numbers of members speaking languages other than English and Spanish, there were lower rates for adolescents from households speaking Russian, Farsi, Burmese, Karen, Nepali and Somali.



At the health equity consultations, there were discussions about culturally and linguistically appropriate strategies to improve CCO performance on this measure. For example, a CCO could identify which providers were assigned to their adolescent Hawaiian/Pacific Islander, White and American Indian members or to members speaking the languages noted above, and work with those providers to support adolescent well-care visits. For example, the American Indian members may be in areas where there are fewer providers; it is not known whether some would qualify for Indian Health Services from tribal providers. The languages noted are those primarily spoken by refugee populations so this might also be a good opportunity to ensure that there is adequate understanding of the U.S. health care system by those refugee members, and how to access health care services. The OHA Transformation Center has technical assistance resources available to support improvements on this measure.⁷²

⁷² <http://www.oregon.gov/oha/Transformation-Center/Pages/Resources-Metric.aspx>



Alcohol or other substance misuse screening (SBIRT), all ages 12+⁷³

2014 benchmark = 13%

2015 benchmark = 12%

2016 benchmark = 12% [2016 challenge pool measure]

By mid-2015, the performance by all CCOs on alcohol and other substance misuse screening was 8.4%, still below the benchmark. The highest performing CCO was 16.0% and the lowest performing CCO was at 0.3%. Three of the CCOs (Willamette Valley Community Health, PacificSource Columbia Gorge and Umpqua Health Alliance) were meeting the 2015 benchmark. The statewide data showed the lowest rates of screening among Asian Americans. There also is data available comparing the rate of screening among CCO members with and without a disability.

CCO-specific data indicate that there may be lower rates of SBIRT among Asian Americans, American Indians, Hawaiians/Pacific Islanders and members with disabilities (data not shown). For some CCOs, there were lower rates among African Americans/Blacks and Hispanics/Latinos. For CCOs with sufficient numbers of members speaking languages other than English, there were potential disparities for members from households speaking Spanish, Cantonese, Somali, Russian, Vietnamese, Arabic,

⁷³ [http://www.oregon.gov/oha/analytics/CCODData/Alcohol%20and%20Drug%20Misuse%20\(SBIRT\)%20-%202016%20\(revised%20Aug%202016\).pdf](http://www.oregon.gov/oha/analytics/CCODData/Alcohol%20and%20Drug%20Misuse%20(SBIRT)%20-%202016%20(revised%20Aug%202016).pdf)

Burmese, Karen, Nepali, Farsi, Romanian, Korean, Hmong, Cambodian, Bosnian and Swahili.

ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (ALL AGES)

Alcohol or other substance misuse screening (SBIRT) (all ages)

Measure description: The SBIRT measure, or Screening, Brief Intervention, and Referral to Treatment, measures the percentage of members (ages 12 and older) who had appropriate screening and intervention for alcohol or other substance abuse.

Purpose: By offering a simple but effective screening for alcohol or drug abuse during an office visit, providers can help patients get the care and information they need to stay healthy. If risky drinking or drug use is detected, a brief intervention, and in some cases referral to additional treatment, helps the patient recover more quickly and avoid serious health problems.

mid-2015 data

Statewide change since 2014: **+31%**

Number of CCOs that improved: **13**

All racial and ethnic groups experienced improvement.

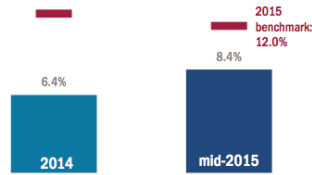
Adolescents age 12-17 were added to the SBIRT measure in 2015. Results are stratified by age groups for reporting and monitoring purposes (see pages 10-13). Incentive payments are based on all ages combined.

See pages 95, 101 and 105 for results stratified by members with and without disability, mental health diagnoses, and severe and persistent mental illness.

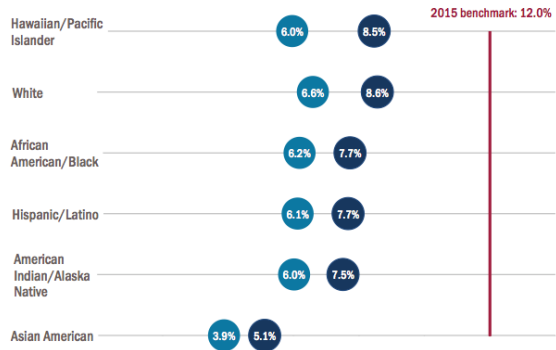
About these data

- N=500,524
- Data source: Administrative (billing) claims
- Benchmark source: Metrics and Scoring Committee consensus
- Race and ethnicity data missing for 11.5% of respondents
- Each race category excludes Hispanic/Latino
- 2014 benchmark: 13%
- 2014 results have been updated to include adolescents and will differ from previously published 2014 SBIRT results. 2011-2013 have not been recalculated; results published in earlier reports are not comparable.

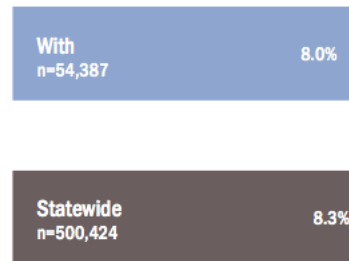
Statewide, screening for alcohol or other substance misuse for all ages has increased.



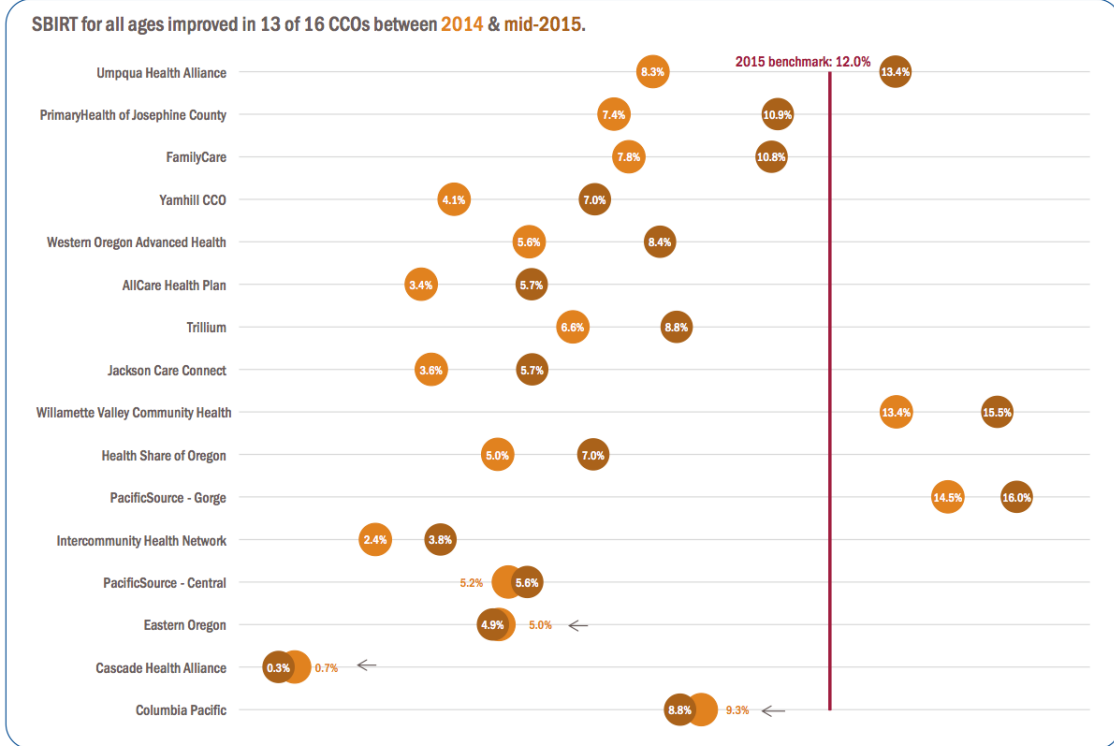
SBIRT for all ages between 2014 & mid-2015, by race and ethnicity.



Screening, brief intervention, and referral to treatment (SBIRT) for members (ages 12+) with disability compared with statewide.



ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (ALL AGES)



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At the health equity consultations, there were discussions about culturally and linguistically appropriate strategies to improve CCO performance on this measure. For example, ensuring that the SBIRT screening tools are available in member languages would be a first step to ensure culturally and linguistically appropriate services. At one health equity consultation, the CCO participants thought that performance on this measure for its Hispanic/Latino members was better because the clinic that primarily served its Hispanic/Latino members had bilingual staff that could administer the SBIRT in Spanish.

Stigma and cultural barriers (for both CCO members and providers) about discussions about discussing alcohol and substance misuse would have to be addressed. For example, a Chinese American provider may not feel it would be culturally appropriate to ask an older Chinese American member about alcohol and substance misuse. There were discussions at the health equity consultations about how such screenings could be incorporated into more general conversations about preventive services rather than focusing primarily or directly on the SBIRT.

Ambulatory care: Emergency department visits Per 1,000 member months⁷⁴

⁷⁴ [http://www.oregon.gov/oha/analytics/CCODData/Ambulatory%20Care%20-%20Outpatient%20and%20Emergency%20Dept%20Utilization%20-%202016%20\(revised%20Aug%202016\).pdf](http://www.oregon.gov/oha/analytics/CCODData/Ambulatory%20Care%20-%20Outpatient%20and%20Emergency%20Dept%20Utilization%20-%202016%20(revised%20Aug%202016).pdf)

2014 benchmark = 44.6 (lower is better)
2015 benchmark = 39.4 (lower is better)
2016 benchmark = 39.8 (lower is better)

The performance by all CCOs on the rate of emergency department visits for July 2014–June 2015 was 47.0 per 1,000 member months, falling short of the benchmark for 2015 (lower is better). However, this is one of the quality measures in which CCOs as a whole have steadily improved. The best performing CCO was at 33.4 per 1,000 member months and the worst performing CCO was at 62.4 per 1,000 member months. Three of the CCOs (PrimaryHealth, Cascade Health Alliance and AllCare CCO) were meeting the 2015 benchmark. The statewide data showed the highest rates of use among African Americans/Blacks, American Indians and Whites (lower is better). There also were data available comparing the rate of emergency department use among CCO members with and without a disability, which showed a much higher rate for members with a disability.

AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION

Ambulatory care: emergency department utilization

Measure description: Rate of patient visits to an emergency department. Rates are reported per 1,000 member months and a lower number suggests more appropriate use of this care.

Purpose: Emergency departments are sometimes used for problems that could have been treated at a doctor's office or urgent care clinic. Reducing inappropriate emergency department use can help to save costs and improve the health care experience for patients

mid-2015 data

Statewide change since 2014: **-0.6%** (lower is better)

Number of CCOs that improved: **9**

Racial and ethnic groups experiencing improvement:

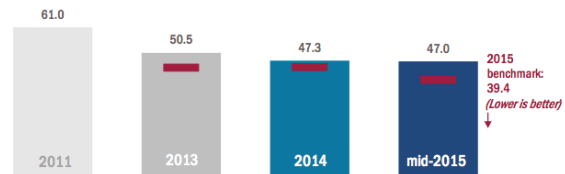
- ✓ African American / Black
- ✓ White

See pages 94, 99, and 104 for results stratified by members with- and without disability and mental health diagnoses.

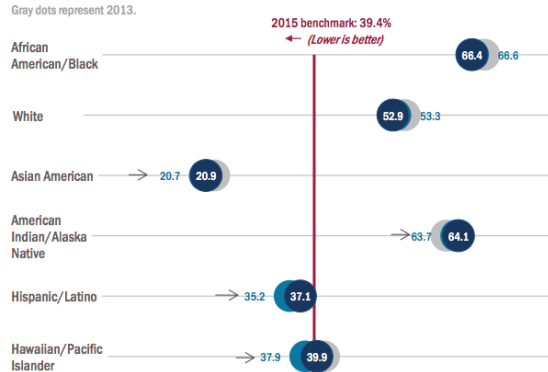
About these data:

- N= 10,644,736 member months
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid 90th percentile
- Race and ethnicity data missing for 12.6% of respondents
- Each race category excludes Hispanic/Latino
- 2014 benchmark: 44.6

Statewide, emergency department utilization remained steady between 2014 and mid-2015.

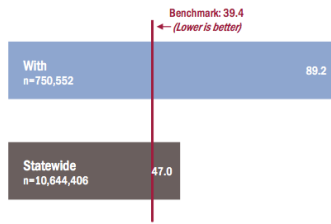


Emergency department utilization was lowest among Asian American members in both 2014 & mid-2015.



MEASURES BY DISABILITY

Emergency department utilization among members with disability compared with statewide.



Mid-2015 data

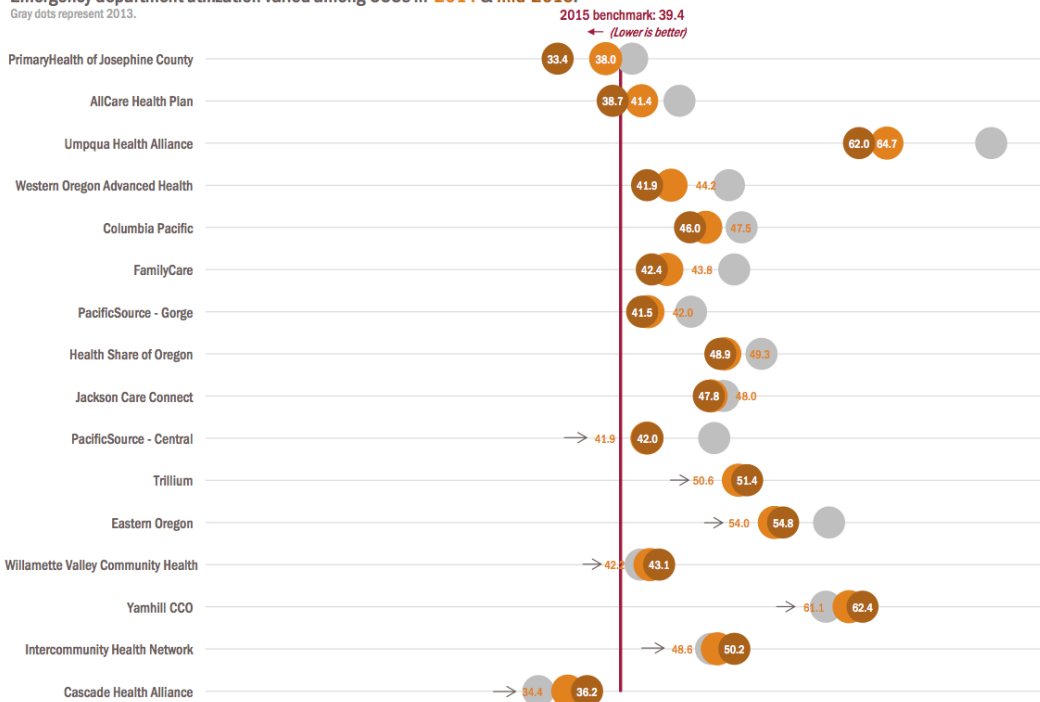
Members with disability have higher rates of emergency department utilization, which mirrors national data (lower rates are better).

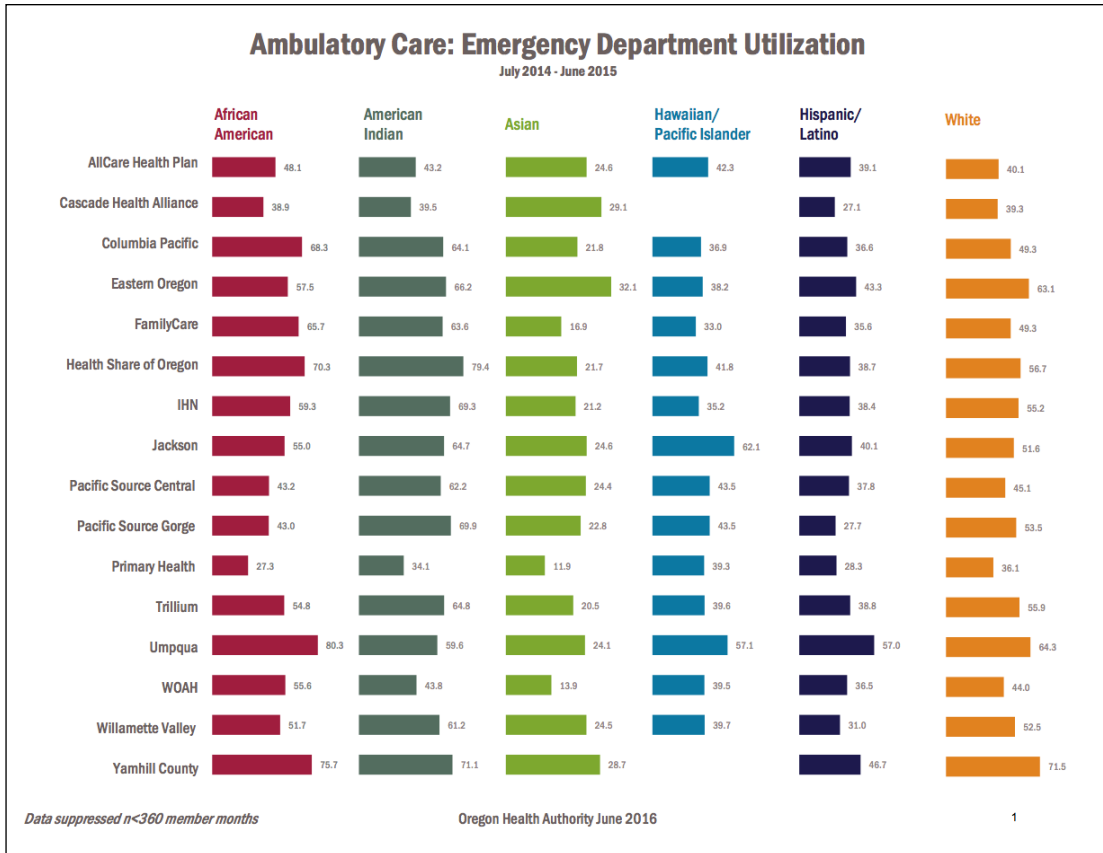
Members with disability are more likely to receive timely follow-up (within 7 days) after hospitalization for mental illness than statewide. Timely follow-up after hospitalization can reduce the duration of disability and, for certain conditions, the likelihood of re-hospitalization.

AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION

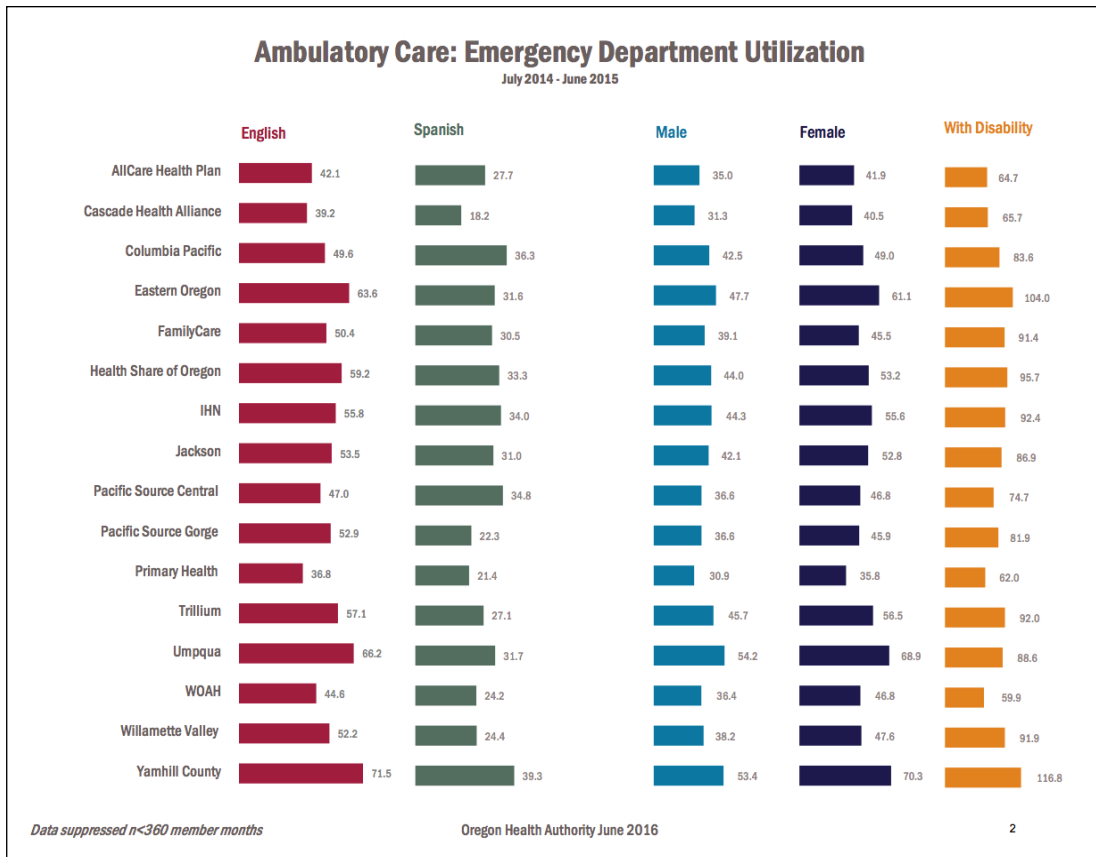
Emergency department utilization varied among CCOs in 2014 & mid-2015.

Gray dots represent 2013.





Both statewide data and CCO-specific data indicate there may be higher rates of emergency department use among American Indians, African Americans/ Blacks and members with disabilities. At some CCOs, emergency department utilization rates were higher for Hawaiians/Pacific Islanders and Whites. For those CCOs with more linguistically diverse members, there also were higher utilization rates among members from Bosnian- and Nepali-speaking households. At the health equity consultations, there were discussions about culturally and linguistically appropriate strategies to improve CCO performance on this measure.

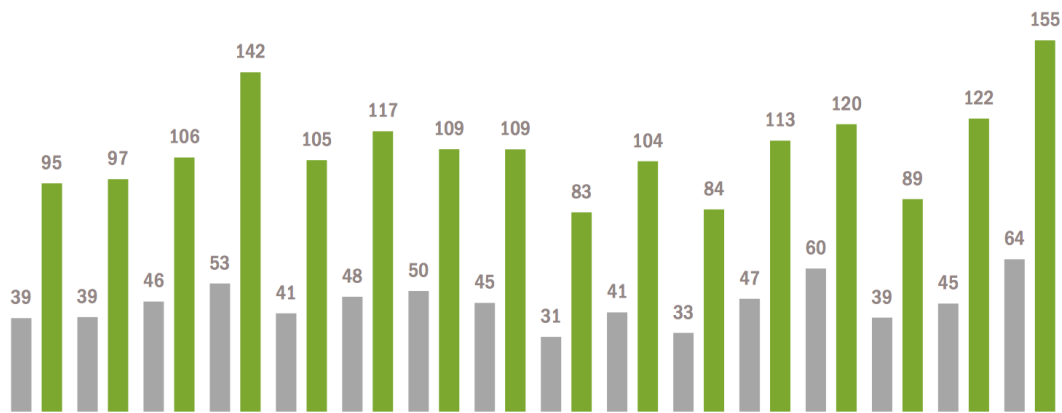


For example, ensuring that American Indian and African American/Black CCO members are assigned to patient-centered primary care homes (PCPCHs), and that those PCPCH providers have actually engaged those members with at least one ambulatory visit in the past year, would be a good starting point. Many Oregon Health Plan members, especially those who enrolled through the expanded Medicaid program beginning in 2014, have not had a regular or continuous source of care and are used to going to the emergency department when they have an urgent health care need. They may not understand the concept of a PCPCH or know about telephonic advice services or other after-hours services. Providing an orientation to the concept of a PCPCH, sharing information about available services and answering member questions about how to access health care are all responsibilities for any PCPCH, but especially important for members who end up going to the emergency department unnecessarily.

Most CCOs do not have significant numbers of members with a disability, but emergency department use is higher for members with disability at every CCO, sometimes nearly two times higher. For members with a disability, it would be important to examine access to primary and urgent care, especially after-hours and on weekends. When an individual with a disability has a medical need — e.g., shoulder pain for someone using one’s arms to operate a wheelchair — it may be more acute and urgent than a comparable injury to an individual without a disability. At the InterCommunity Health Network CCO, there was a discussion about a recent assessment about the barriers to physical access to health care facilities for persons with disabilities. Such assessments can also identify issues for improvement and compliance with disability access laws.

Throughout 2016, the OHA Metrics and Scoring Committee examined the potential development of an additional incentive measure focused specifically on health equity. The committee also considered requiring improvement goals based on stratification of existing incentive measures by race and ethnicity or other member demographic characteristics. The committee considered several options and reviewed stratified incentive measure data, similar to the reviews of the data conducted during these health equity consultations. Ultimately, the Committee focused on disparities at all the CCOs in emergency department use for members with severe and persistent mental illness. In January 2017, the committee adopted a new incentive measure for 2018, with all CCOs required to measure (and reduce) emergency department use for members with severe and persistent mental illness.

ED utilization among members with SPMI compared with members overall in each CCO (mid-2016)



For each pair of bars: gray = all CCO members; green = CCO members with severe and persistent mental illness⁷⁵

An additional proposal to develop a disparities reduction goal in emergency department use for a second population experiencing disparities (such as a racial or ethnic population) was ultimately not adopted by the committee.⁷⁶ Hopefully, the discussions at the health equity consultations will be useful to the CCOs as they develop and implement this new incentive measure and integrate disparities reduction into future goals and objectives.

The next two measures are composite measures derived from the CAHPS surveys, with separate surveys for adults and for children. These data are for January–December 2015.⁷⁷

⁷⁵ <http://www.oregon.gov/oha/analytics/MetricsDocs/Equity-proposal-Jan-2017.pdf>

⁷⁶ OHA Metrics and Scoring Committee Minutes, January 20, 2017, at: <http://www.oregon.gov/oha/analytics/MetricsDocs/January-2017-minutes.pdf>

⁷⁷ Subsequent health equity consultations used updated data from the 2016 CAHPS.

CAHPS composite: Access to care⁷⁸

2015 benchmark = 87.2%

2016 benchmark = 86.7%

The 2015 statewide performance by all CCOs on the CAHPS composite measure for access to care was at 83.8%, approaching the benchmark of 87.2%. Scores were slightly higher for children compared to adults. Two CCOs (Jackson Care Connect and PrimaryHealth) met or exceeded the benchmark. Statewide, Asian American adults and Asian American children reported the least access to care.

 **ACCESS TO CARE (CAHPS SURVEY)**

Access to care (CAHPS survey)

Percentage of members (adults and children) who received appointments and care when they needed them.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

2015 data

Statewide change since 2014: **+1%**

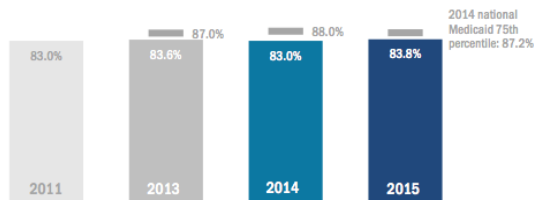
Number of CCOs that improved: **10**

Number of CCOs achieving benchmark or improvement target: **6**

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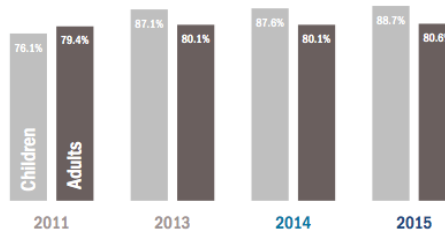
Statewide, access to care has increased slightly.

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)



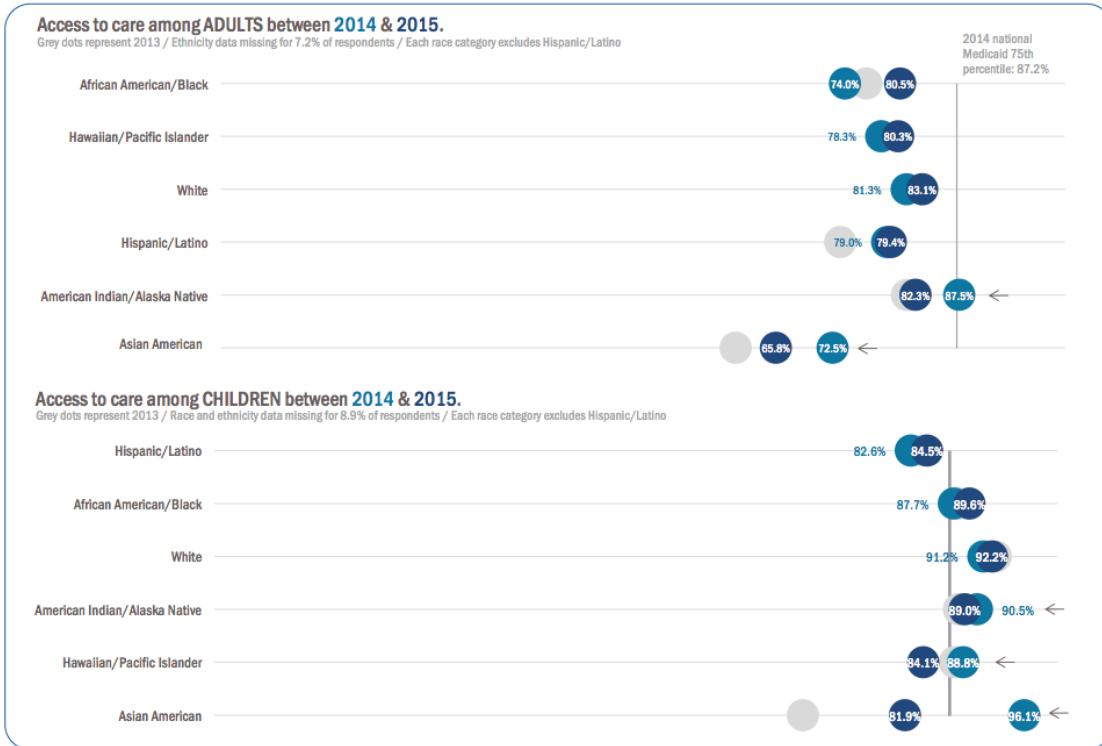
Access to care among children and adults, statewide.

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)



⁷⁸ [http://www.oregon.gov/oha/analytics/CCODData/CAHPS%20Composite%20-%20Access%20to%20Care%20-%202016%20\(revised%20Oct%202016\).pdf](http://www.oregon.gov/oha/analytics/CCODData/CAHPS%20Composite%20-%20Access%20to%20Care%20-%202016%20(revised%20Oct%202016).pdf)

 **ACCESS TO CARE (CAHPS SURVEY)**



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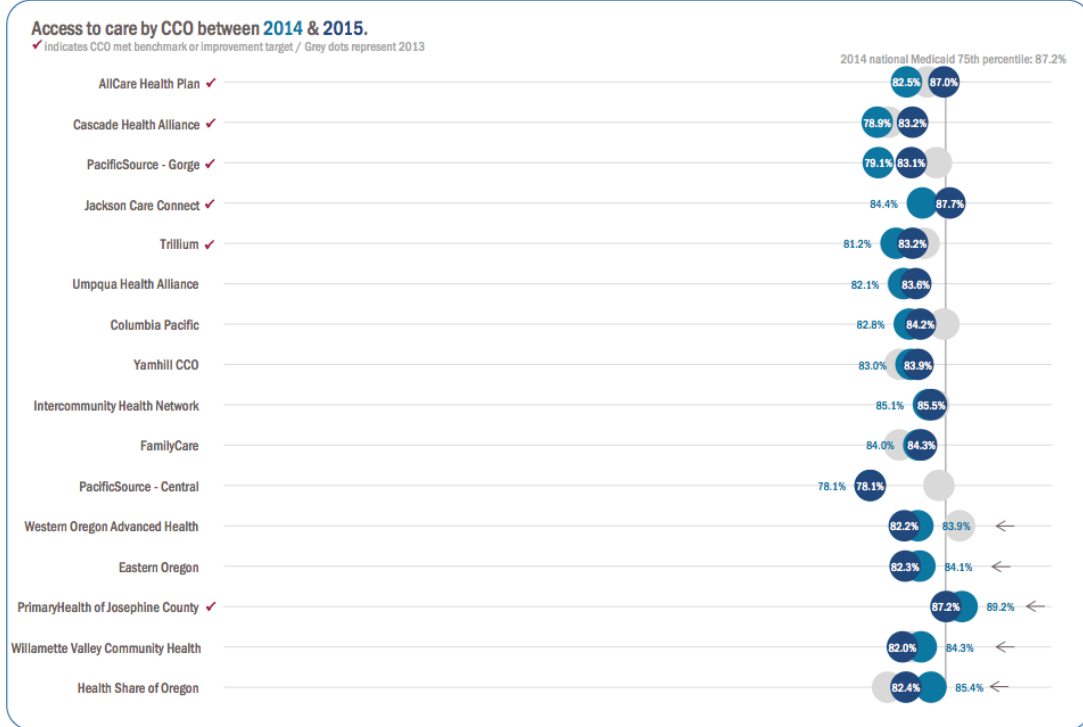
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At the health equity consultations, statewide and CCO-specific data on both the composite access to care scores and the four CAHPS survey items (two for adults, two for children) were shared and discussed.⁷⁹ At the individual CCO level, very limited data were available stratified by race and ethnicity (usually only for Whites and Hispanics/Latinos), and that data had little variation (slightly lower performance reported by Hispanic/Latino members on some items).

⁷⁹ These questions from the CAHPS 5.0H Questionnaire were: Adult Q4: In the last 6 months, when you needed care right away, how often did you get care as soon as you needed? (combined responses for Always and Usually); Adult Q6: In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed? (combined responses for Always and Usually); Child Q4: In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed? (combined responses for Always and Usually); and Child Q6: In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed? (combined responses for Always and Usually)


ACCESS TO CARE (CAHPS SURVEY)



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There were discussions at the health equity consultations about the need for additional data about member experiences of care. At the health equity consultation with PacificSource Columbia Gorge, one participant reported that Providence Hood River had recently sent out 2,500 hospital patient surveys and only received 13 responses in Spanish, which are insufficient to adequately measure the experience of Spanish-speaking patients. There also was discussion about how many of these patient and consumer surveys are written at a high health literacy level and are difficult for individuals with lower health literacy to respond to. Finally, there was a discussion of potential additional or alternate methods to measure CCO member care experiences.⁸⁰

CAHPS composite: Satisfaction with care⁸¹

2015 benchmark = 89.6%

2016 benchmark = 89.2%

CCOs also generally perform well on the CAHPS composite measure for satisfaction with care, with overall performance at 85.4%, approaching the benchmark of 89.6% for 2015. There was less variation in performance among adults compared to children. Although none of the CCOs exceeded the 2015 benchmark, even the lowest performing CCO had a composite score of 80.2%.

⁸⁰ The Metrics and Scoring Committee have been reviewing the utility of the CAHPS surveys for measuring patient experiences of care, and whether there might be alternate measures available.

⁸¹ <http://www.oregon.gov/oha/analytics/MetricsDocs/CAHPS-Survey-Findings-2015.pdf>

⁸¹ <http://www.oregon.gov/oha/analytics/CCOData/CAHPS%20Composite%20-%20Satisfaction%20with%20Care%20-%202016.pdf>

 **SATISFACTION WITH CARE (CAHPS SURVEY)**

Satisfaction with care (CAHPS survey)

Percentage of members (adults and children) who received needed information or help and thought they were treated with courtesy and respect by their health plan's customer service staff.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

2015 data

Statewide change since 2014: **+1%**

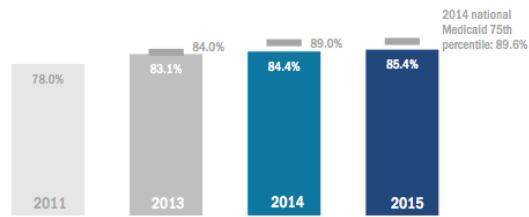
Number of CCOs that improved: **11**

Number of CCOs achieving benchmark or improvement target: **8**

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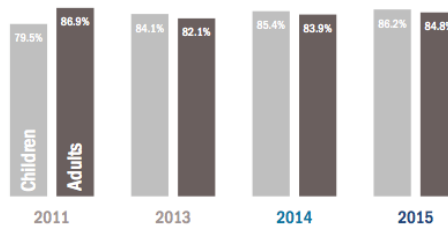
Statwide, satisfaction with care increased slightly in 2015.

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)



Satisfaction with care among children and adults, statewide.

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)



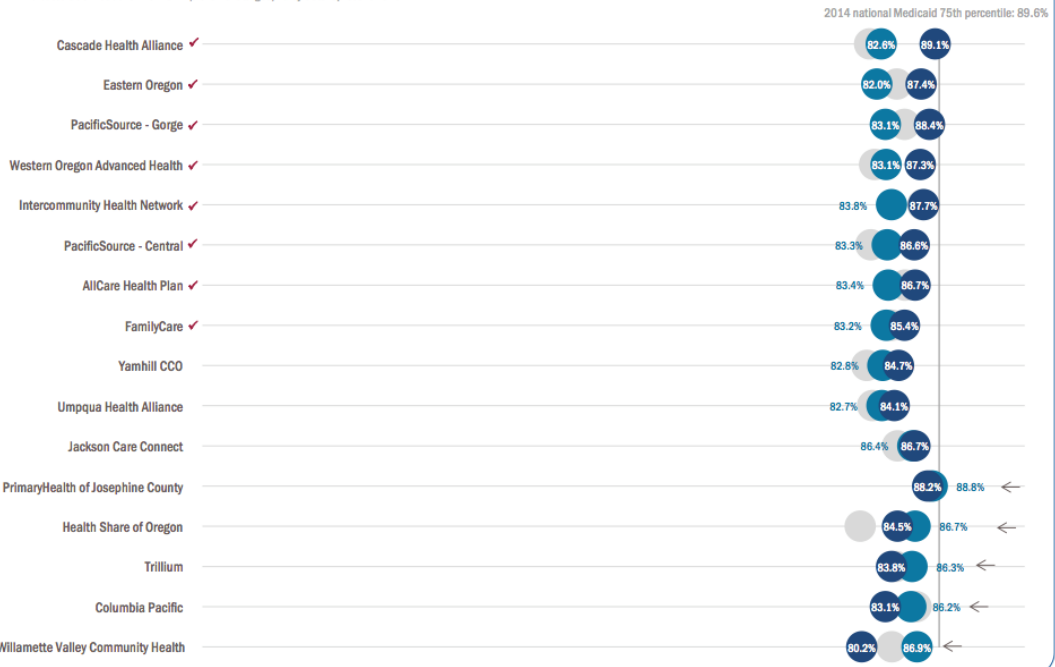
At the health equity consultations, statewide and CCO-specific data on both the composite satisfaction with care scores and the four CAHPS survey items (two for adults, two for children) were shared and discussed.⁸² Like the CAHPS access measure, at the individual CCO level, very limited data were available stratified by race and ethnicity (usually only for Whites and Hispanics/Latinos), and that data had little variation (slightly lower performance reported by Hispanic/Latino members on some items).

⁸² These questions from the CAHPS 5.0H Questionnaire were: Adult Q31: In the last 6 months, how often did your health plan's customer service give you the information or help you needed? (combined responses for Always and Usually); Adult Q32: In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect? (combined responses for Always and Usually); Child Q50: In the last 6 months, how often did customer service at your child's health plan give you the information or help you needed? (Combined responses for Always and Usually); and Child Q51: In the last 6 months, how often did customer service staff at your child's health plan treat you with courtesy and respect? (combined responses for Always and Usually)

   **SATISFACTION WITH CARE (CAHPS SURVEY)**

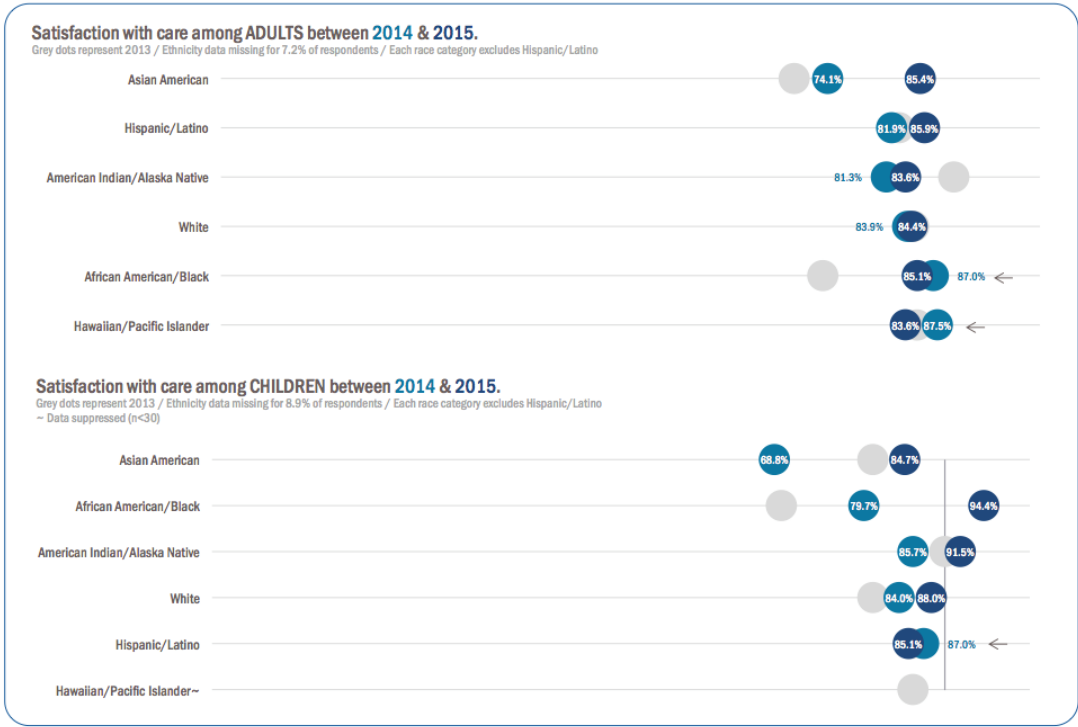
Eight CCOs achieved their improvement target for satisfaction with care CCO between 2014 & 2015.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2013



Although there was slightly greater satisfaction of care reported by African American/Black and American Indian children, most of the scores were in the 83–88% range.

 **SATISFACTION WITH CARE (CAHPS SURVEY)**



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Dental sealants on permanent molars for children, all ages 6–14⁸³
2015 benchmark = 20%
2016 benchmark = 20%

For July 2014–June 2015, 14.3% of CCO members ages 6–14 statewide had received dental sealants. This is the only incentive measure related to oral health. In mid-2015, none of the CCOs had met the 2015 benchmark of 20%. The rate of dental sealants among American Indian, Hawaiian/Pacific Islander and White children was lower than the statewide average. The rate also was lower among children with a disability.

⁸³ [http://www.oregon.gov/oha/analytics/CCODData/Dental%20Sealants%20-%202016%20\(revised%20Mar%202016\).pdf](http://www.oregon.gov/oha/analytics/CCODData/Dental%20Sealants%20-%202016%20(revised%20Mar%202016).pdf)

§ DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN - ALL AGES (6-14)

Dental sealants on permanent molars for children (all ages)

Measure description: Percentage of children ages 6-14 who received a dental sealant during the measurement year.

Purpose: Dental sealants are a widely recognized tool used to prevent tooth decay. Childhood tooth decay causes needless pain and infection, and can affect a child's nutrition and academic performance.

mid-2015 data

Statewide change since 2014: **+28%**

Number of CCOs that improved: **all 16**

All racial and ethnic groups experienced improvement.

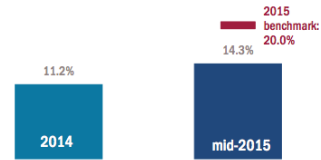
Dental sealants is a new incentive measure beginning in 2015. Results are stratified by age groups (see pages 46-49) for reporting and monitoring purposes only. Incentive payments are based on all ages combined.

See pages 96 and 102 for results stratified by members with- and without disability and mental health diagnoses.

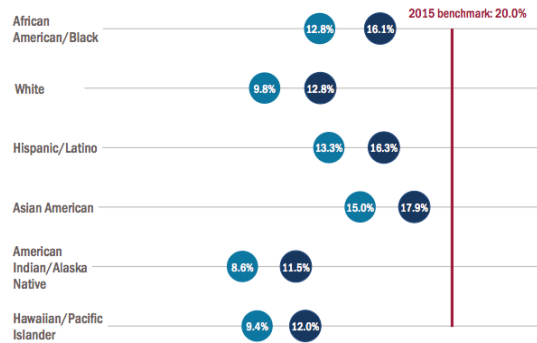
About these data:

- N=149,048
- Data source: Administrative (billing) claims
- Benchmark source: Metrics and Scoring Committee consensus
- Race and ethnicity data missing for 10.3% of respondents
- Each race category excludes Hispanic/Latino
- 2011 and 2013 results are not available for this measure

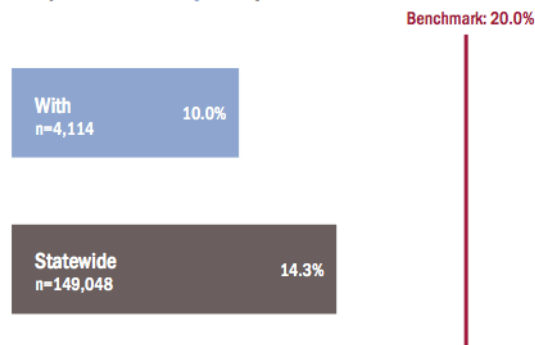
Statewide, the percentage of children ages 6-14 who received dental sealants has increased.



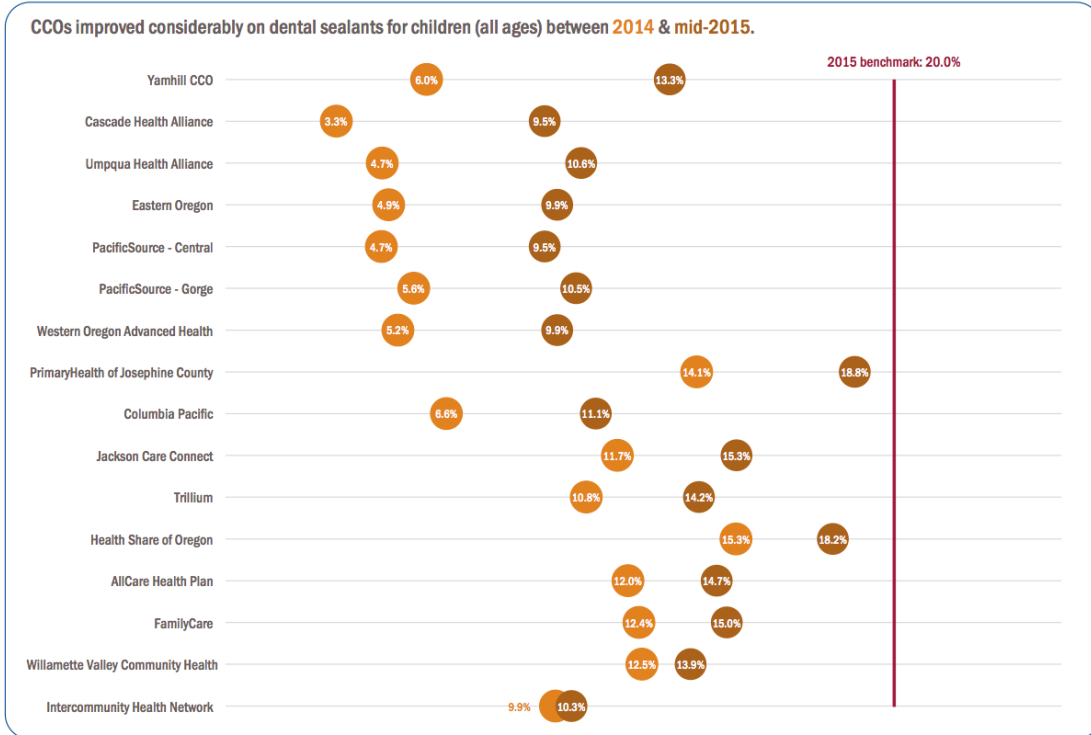
Asian American children ages 6-14 received dental sealants more frequently than other races and ethnicities in both 2014 & mid-2015.



Dental sealants on permanent molars for children all ages (6-14) with disability compared with statewide.



§ DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN - ALL AGES (6-14)

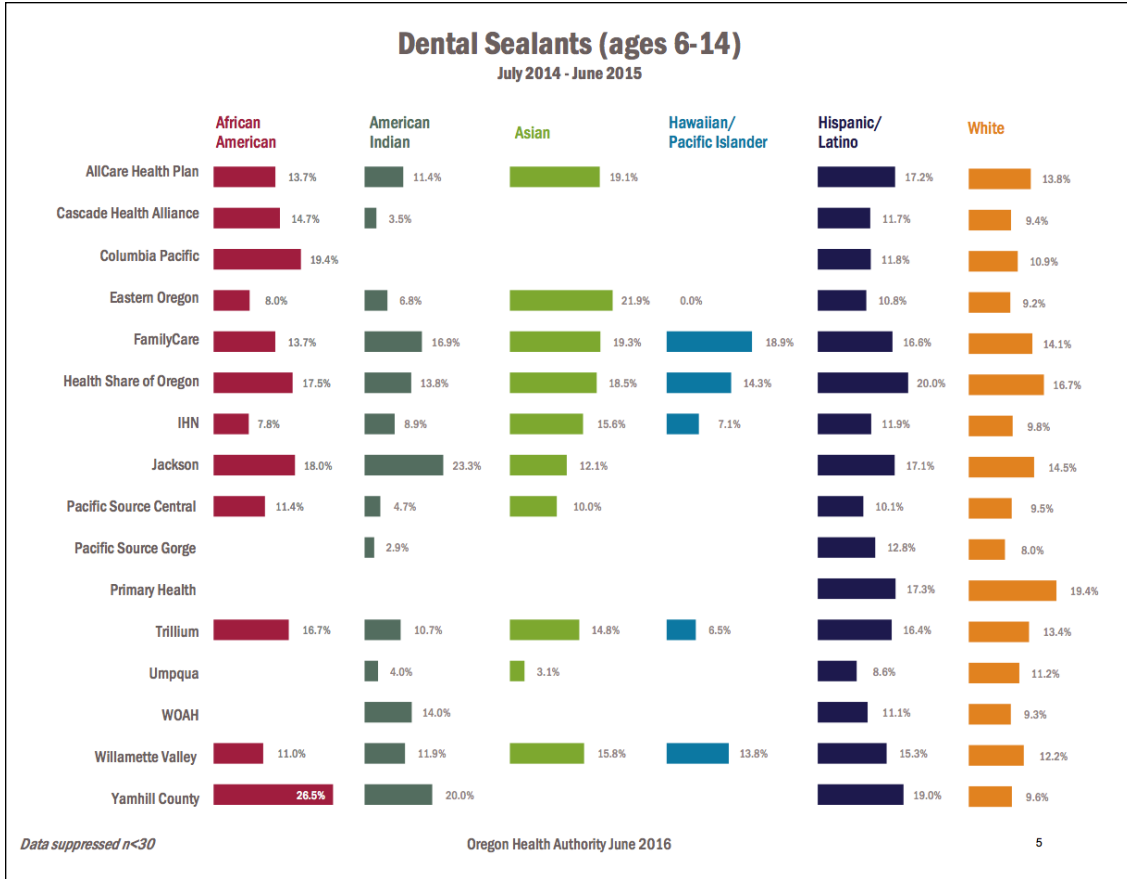


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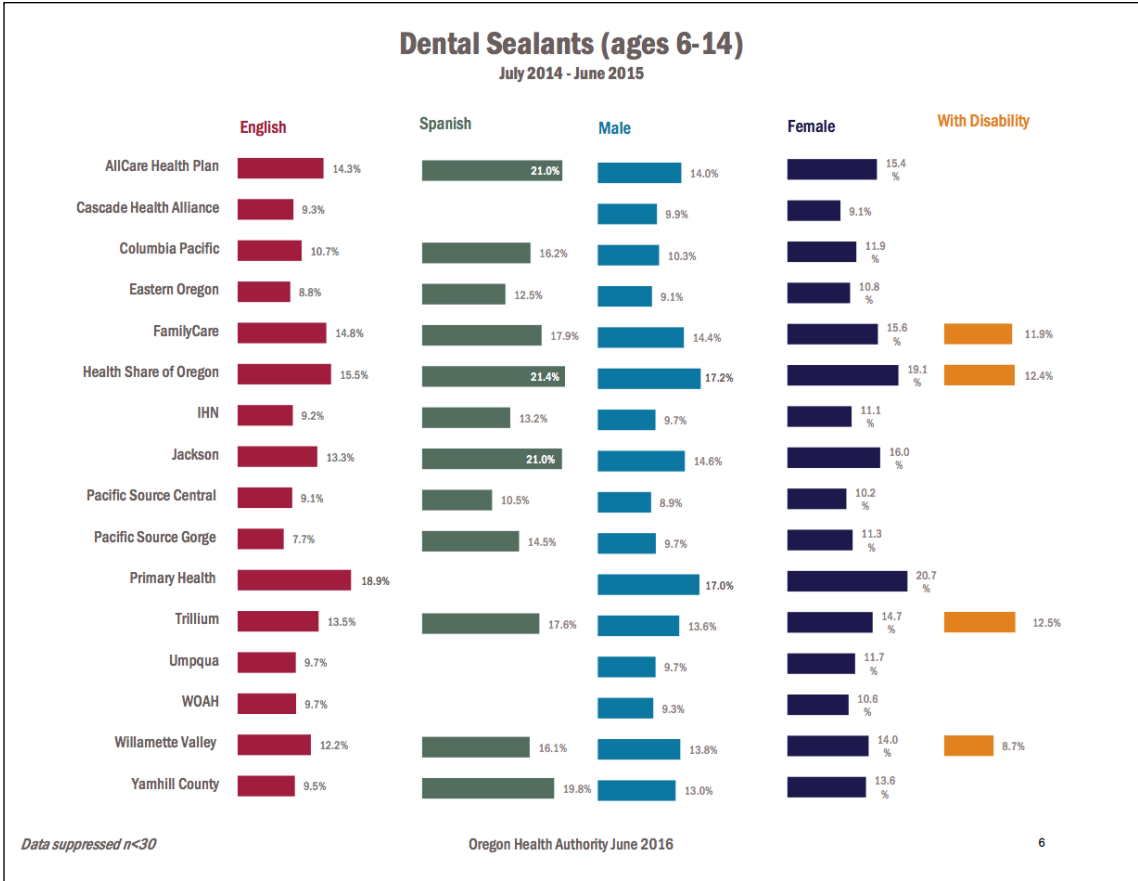
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Both statewide data and CCO-specific data indicate there may be lower rates of dental sealants among American Indian, Hawaiian/Pacific Islander and White children, and among children with disabilities. For some CCOs, the rates of dental sealants were lower among African American/Black and Asian American children.



At the health equity consultations, there were discussions about culturally and linguistically appropriate strategies to improve CCO performance on this measure. For example, CCOs could review their information on American Indian, Hawaiian/Pacific Islander and White children, and children with disabilities to ensure they have been assigned and established with dental providers. Providers for children with disabilities may be focused on other health issues and not highlighting the need for these oral health services. There may also be geographic and other gaps in the dental provider network that could be addressed. In some regions, there are oral health coalitions that are important partners and could have discussions about opportunities to advance health equity. Many CCOs rely on school-based health programs for dental sealants; if so, a CCO could review whether school-based health programs are available in all geographic areas of that CCO's service area. If there are gaps, the CCO could work on developing and implementing alternate interventions to making the dental sealants available.



Finally, at some of the health equity consultations, it was noted this could be one of the preventive services incentive measures linked together for culturally and linguistically appropriate member outreach and communications (along with developmental screening, childhood immunizations, and adolescent well-visits) since they are all focused on children and youth, and communications are likely to go to parents and guardians. Messages that emphasized these screenings and preventive services as part of a schedule or series that would maintain and improve the health and well-being of their children and families would be an effective message for parents and guardians from many cultural backgrounds.

Developmental screening in the first 36 months of life⁸⁴
2015 benchmark = 50%
2016 benchmark = 50% [2016 challenge pool measure]

While the overall statewide rate of developmental screening was approaching the benchmark at 49.5%, the statewide data indicate that there may be lower rates among Hawaiian/Pacific Islander, American Indian and African American/Black children. Fortunately, children with disabilities seem to receive these developmental screenings at a higher rate than children overall. The highest performing CCO was at 76.3% and the lowest at 29.3%. Half of the CCOs exceeded the benchmark.

⁸⁴ [http://www.oregon.gov/oha/analytics/CCODData/Developmental%20Screening%20-%202016%20\(revised%20Mar%202016\).pdf](http://www.oregon.gov/oha/analytics/CCODData/Developmental%20Screening%20-%202016%20(revised%20Mar%202016).pdf)

DEVELOPMENTAL SCREENING IN THE FIRST 36 MONTHS OF LIFE

Developmental screening in the first 36 months of life

Measure description: Percentage of children who were screened for risks of developmental, behavioral and social delays using standardized screening tools in the 12 months preceding their first, second or third birthday.

Purpose: Early childhood screening helps find delays in development as early as possible, which leads to better health outcomes and reduced costs. Early developmental screening provides an opportunity to refer children to the appropriate specialty care before problems worsen. Often, developmental delays are not found until kindergarten or later -- well beyond the time when treatments are most helpful.

mid-2015 data

Statewide change since 2014: **+16%**

Number of CCOs that improved: **all 16**

All racial and ethnic groups experienced improvement.

Developmental screenings have improved each year, and more than doubled since 2011.

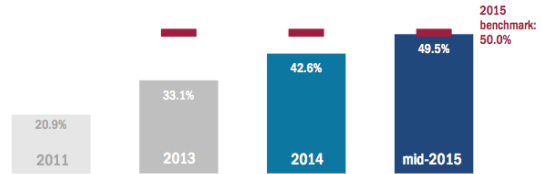
Examples of interventions CCOs have taken to improve developmental screening include provider training, collaborating with early learning hubs, and developing alternate payment methodologies for providers to incentivize increased screening.

See pages 93 and 98 for results stratified by members with and without disability and mental health diagnoses.

About these data:

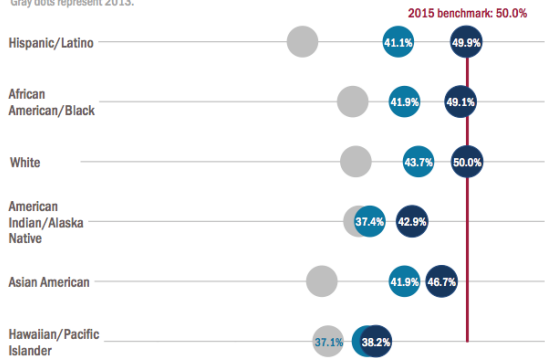
- N= 54,190
- Data source: Administrative (billing) claims
- Benchmark source: Metrics and Scoring Committee consensus
- Race and ethnicity data missing for 11.5% of respondents
- Each race category excludes Hispanic/Latino
- 2014 benchmark: 50.0%

Statewide, developmental screening continues to improve and is near the benchmark as of mid-2015.

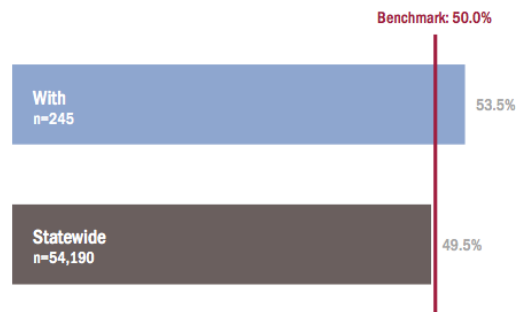


Developmental screening improved for all races and ethnicities between 2014 & mid-2015.

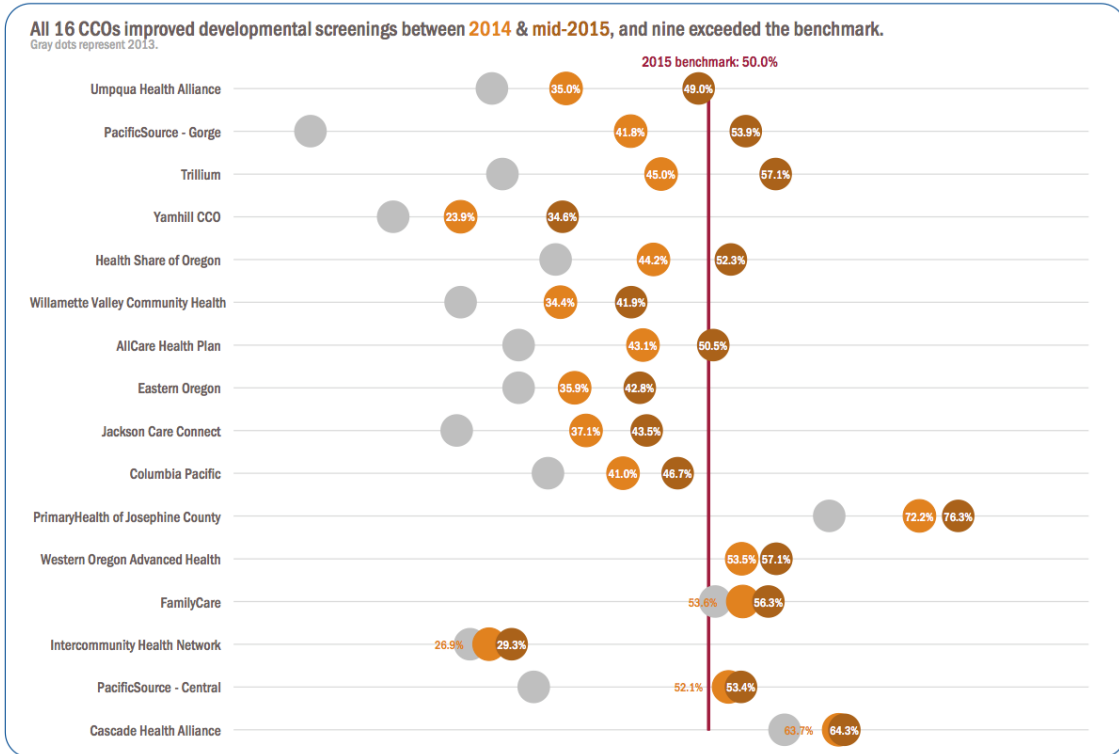
Gray dots represent 2013.



Children with disability received development screenings during the first 36 months of life more frequently than statewide.



DEVELOPMENTAL SCREENING IN THE FIRST 36 MONTHS OF LIFE



2015 Mid-Year Performance Report
January 20, 2016

Oregon Health Authority
Office of Health Analytics

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The rates of developmental screening were also lower among children from Spanish, Burmese, Somali, Arabic, Vietnamese, Russian and Cantonese speaking households (data not shown).

At the health equity consultations, there were discussions about culturally and linguistically appropriate strategies to improve CCO performance on this measure. There also were discussions about how some CCOs may not be getting credit for all developmental screenings if early learning providers or school-based health providers conducted them. Collaboration with early learning hubs was suggested as a quality improvement strategy.

Effective contraceptive use among women at risk of unintended pregnancy⁸⁵
2014 benchmark = 50%
2015 benchmark = 50%
2016 benchmark = 50%

Among all CCOs, effective contraception use among women was at 34% for July 2014–June 2015, below the statewide benchmark of 50%. None of the CCOs had met the benchmark. Statewide data show the lowest rates of effective contraception use among Asian American women.

⁸⁵ [http://www.oregon.gov/oha/analytics/CCODData/Effective%20contraceptive%20use%20-%202016%20\(revised%20Aug%202016\).pdf](http://www.oregon.gov/oha/analytics/CCODData/Effective%20contraceptive%20use%20-%202016%20(revised%20Aug%202016).pdf)

§ **EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (AGES 18-50)**

Effective contraceptive use among women at risk of unintended pregnancy (ages 18-50)

Measure description: Percentage of adolescent (ages 15-17) and adult (15-17) women with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year: IUD, implant, contraception injection, contraceptive pills, sterilization, patch, ring, or diaphragm.

Purpose: See page 52.

mid-2015 data

Statewide change since 2014: **+2%**

Number of CCOs that improved: **9**

Racial and ethnic groups experiencing improvement:

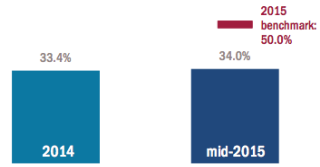
- ✓ Asian American
- ✓ American Indian / Alaska Native
- ✓ Hawaiian / Pacific Islander
- ✓ White
- ✓ Hispanic / Latino

Effective contraceptive use among women at risk of unintended pregnancy is a new incentive measure beginning in 2015.

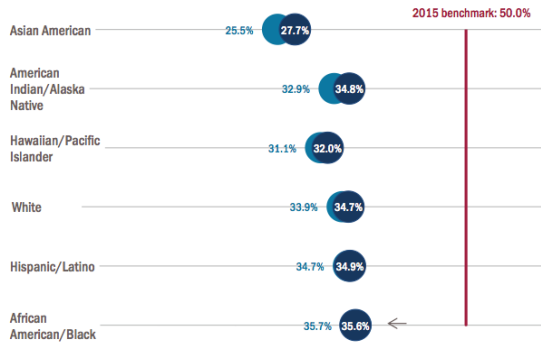
About these data:

- N=131,822
- Data source: Administrative (billing) claims
- Benchmark source: Metrics and Scoring Committee consensus
- Race and ethnicity data missing for 12.6% of respondents
- Each race category excludes Hispanic/Latino
- 2011 and 2013 results are not available for this measure

Statewide, effective contraceptive use among adults remained fairly steady between **2014** and **mid-2015**.



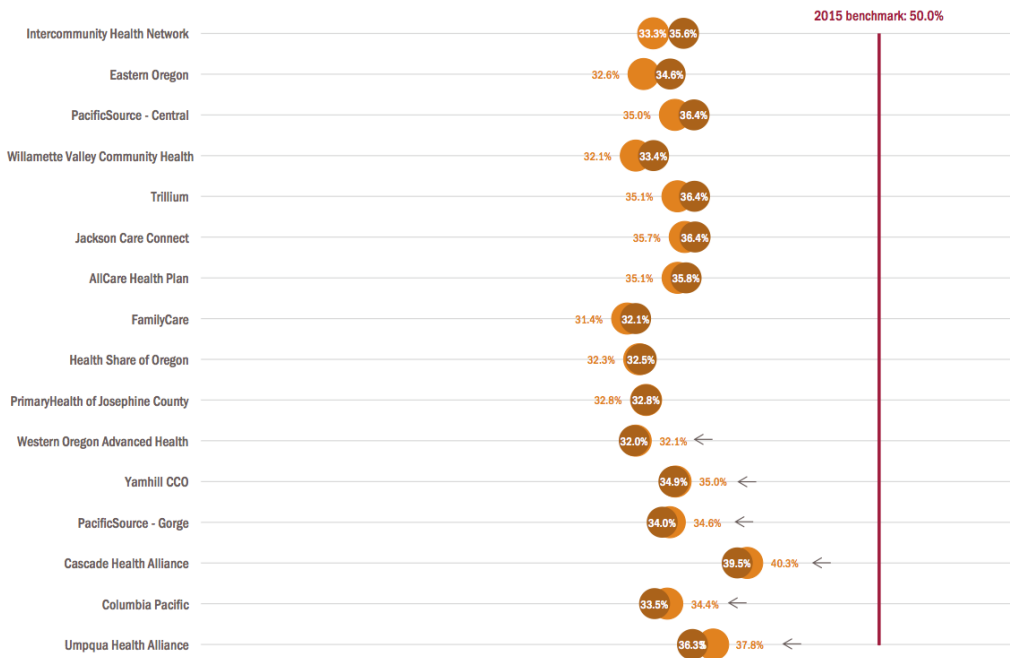
Effective contraceptive use increased among Asian American adults between **2014** & **mid-2015**, but remains lower than other groups.

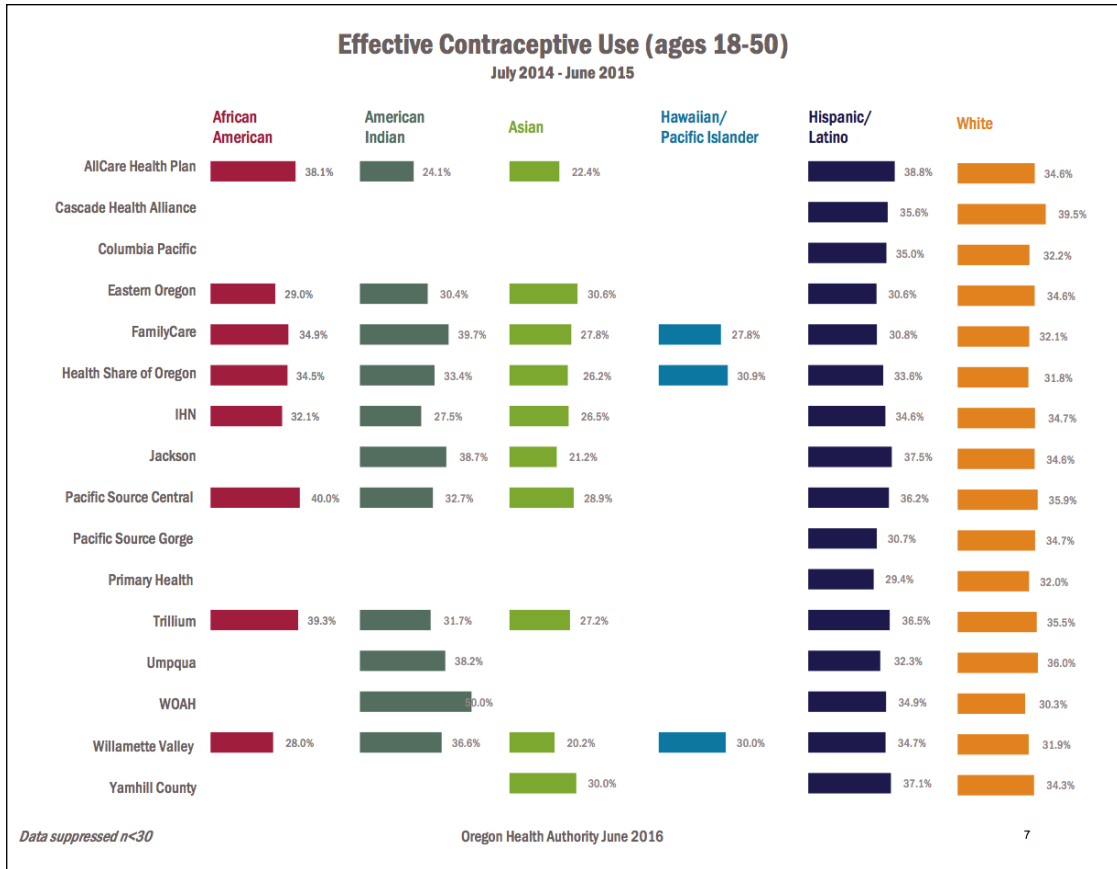




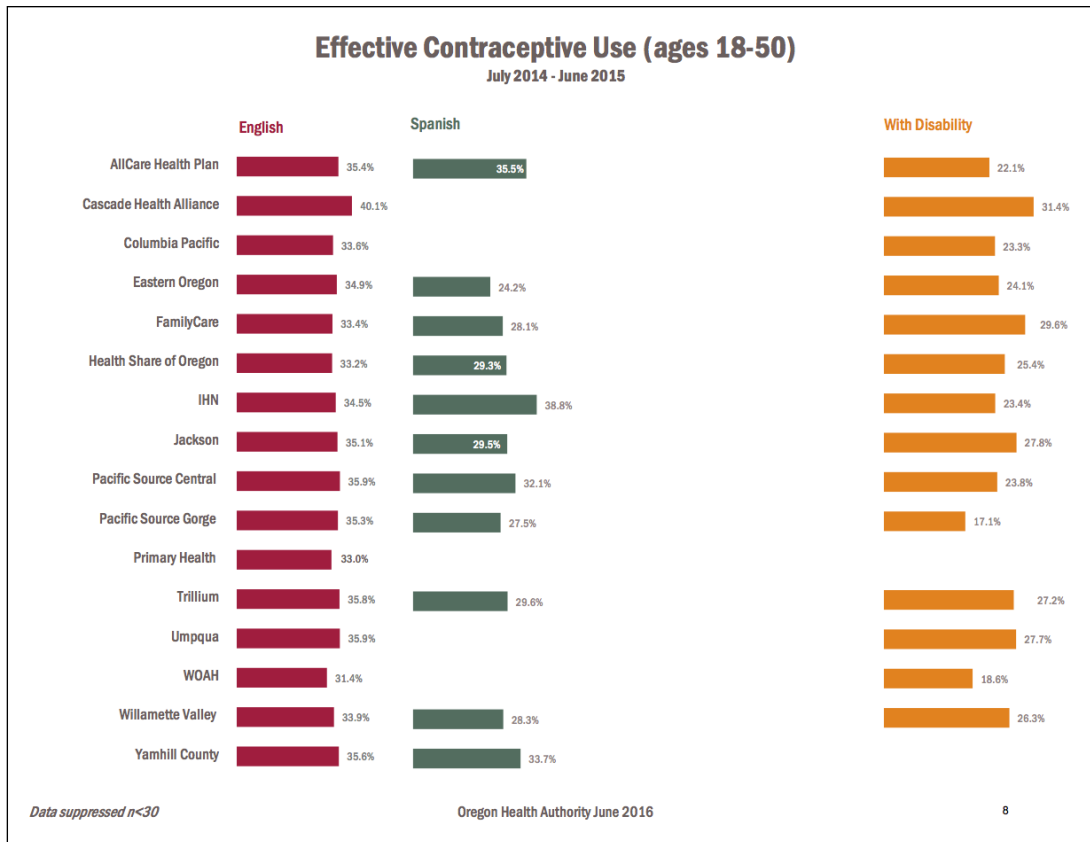
EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (AGES 18-50)

Effective contraceptive among adults age 18-50 in 2014 & mid-2015, by CCO.





Statewide and CCO-specific data indicate lower rates of effective contraception use among Asian American women and among women with disabilities. For some CCOs, the rates also were lower for Hawaiian/Pacific Islander, American Indian and Hispanic/Latina women. For CCOs where data were available, there also were lower rates of effective contraception use among women from households where Russian, Farsi, Vietnamese, Somali, Cantonese and Spanish were spoken.



Statewide Medicaid BRFSS data from 2014 indicate a slightly higher self-reported rate of effective contraception use but similar lower rates among Asian American, Hawaiian/Pacific Islander and African American/Black women.

2014 Medicaid BRFSS effective contraception use by race and ethnicity

State-wide	White	African American/Black	Hispanic/Latino		American Indian/Alaska Native	Asian American	Hawaiian/Pacific Islander
58.4	62.7	48.7	53.4		54.9	44.3	46.0

At the health equity consultations, there were discussions about culturally and linguistically appropriate strategies to improve CCO performance on this measure, especially since there may be cultural barriers in discussing contraception (for both women and their providers). Providers who serve members with disabilities may focus primarily on the individuals' disability and not think of the patient as sexually active and needing a discussion about unwanted pregnancy and contraception. Many CCOs and their providers have received training on asking the One Key Question ("Would you like to become pregnant in the next year?") as a way to engage in conversations about pregnancy and contraception.⁸⁶

⁸⁶ <http://www.onekeyquestion.org>

Follow-up after hospitalization for mental illness⁸⁷

2015 benchmark = 70.0%

2016 benchmark = 79.9%

The CCOs exceeded the 2015 benchmark for follow-up after hospitalization for mental illness, with a statewide rate of 72.6%. Seven CCOs exceeded the benchmark. Although the rates of follow-up were slightly lower for African Americans/ Blacks and Hispanics/ Latinos, they were in the 69% range, almost at the benchmark. Follow-up also was high for members with disabilities. For many CCOs, the denominator of how many members had been hospitalized for mental illness in the 12-month rolling period was so low that stratification by race, ethnicity, household language or disability would not be meaningful.

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Follow-up after hospitalization for mental illness

Measure description: Percentage of members (ages 6 and older) who received a follow-up visit with a health care provider within seven days of being discharged from the hospital for mental illness.

Purpose: Follow-up care is important to help members make progress and feel better after being in the hospital for mental illness. Additionally, research shows that follow-up care helps keep members from returning to the hospital, providing an important opportunity to reduce health care costs and improve health.

mid-2015 data

Statewide change since 2014: **+3%**

Number of CCOs that improved: **8** of 13 reported

Racial and ethnic groups experiencing improvement:

- ✓ African American / Black
- ✓ Asian American
- ✓ White

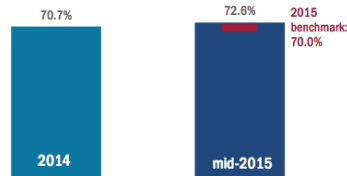
Beginning in 2015, follow-up visits on the day of discharge are included in this measure.

See pages 94 and 100 for results stratified by members with- and without disability and mental health diagnoses.

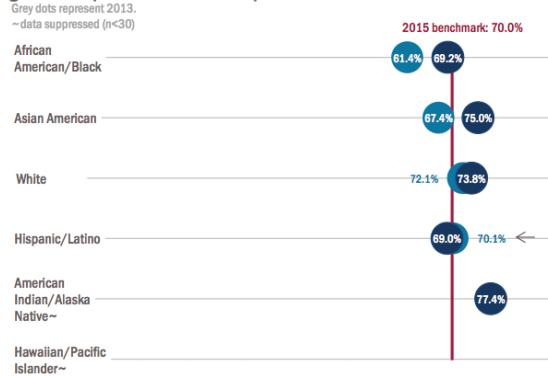
About these data:

- N = 3,043
- Data source: Administrative (billing) claims
- Benchmark source: national Medicaid 90th percentile
- Race and ethnicity data missing for 7.5% of respondents
- Each race category excludes Hispanic/Latino
- 2014 results have been updated to include same-day follow-up and thus will differ from previously published reports. Prior years are not comparable.

Statewide, follow-up after hospitalization for mental illness has increased slightly, and exceeds the benchmark.



African American/Black and Asian American members experienced the greatest improvement in follow-up care between 2014 & mid-2015.



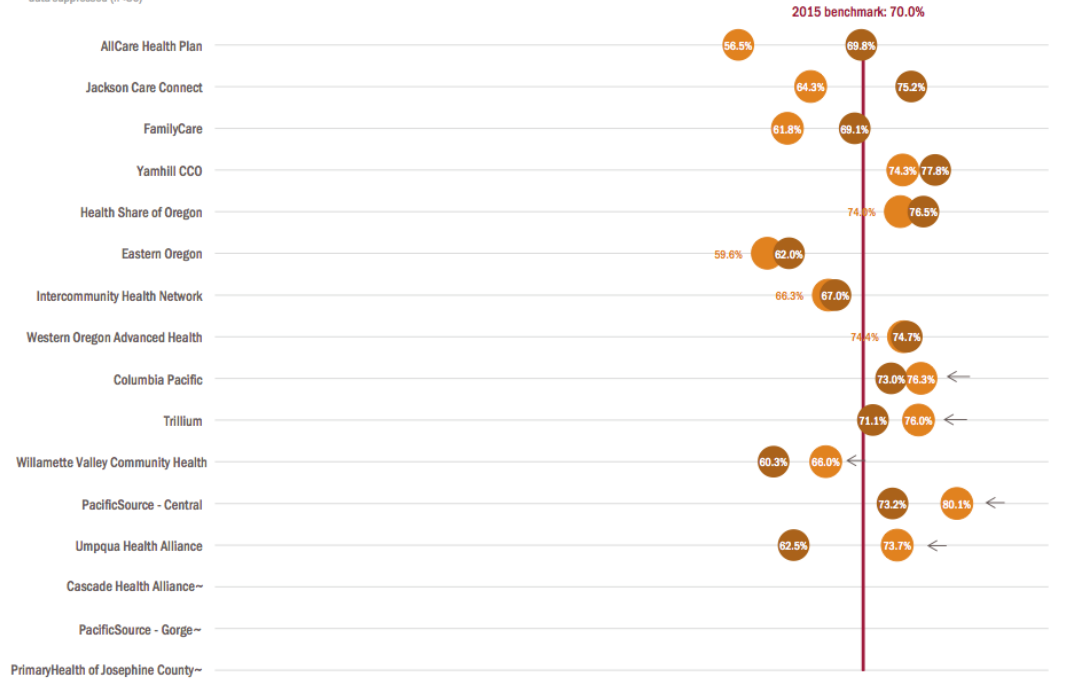
⁸⁷ [http://www.oregon.gov/oha/analytics/CCODData/Follow%20Up%20After%20Hospitalization%20for%20Mental%20Illness%20-%202016%20\(revised%20Aug%202016\).pdf](http://www.oregon.gov/oha/analytics/CCODData/Follow%20Up%20After%20Hospitalization%20for%20Mental%20Illness%20-%202016%20(revised%20Aug%202016).pdf)

Follow-up after hospitalization for mental illness for members with disability compared with statewide.



FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

CCO performance on follow-up after hospitalization was mixed between 2014 & mid-2015.
 - data suppressed (n<30)



Mental, physical and dental health assessments within 60 days for children in DHS custody⁸⁸

2015 benchmark = 90%

2016 benchmark = 90%

This incentive measure is focused on comprehensive health assessments for children in foster care. Statewide, there is room for improvement on this measure, with only 37.1% of these assessments completed. None of the CCOs met the benchmark of 90%. The rate of completed assessments is lowest among American Indian foster children, and is less than half the overall statewide rate among foster children with disabilities. CCOs should pay particular attention to these two foster children populations. However, for many CCOs, the denominator of how many members were in foster care during the twelve-month rolling period was so low that stratification by race, ethnicity, household language or disability was often not meaningful.

MENTAL, PHYSICAL, AND DENTAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY

Mental, physical, and dental health assessments within 60 days for children in DHS custody

Measure description: Percentage of children ages 4+ who received a mental, physical, and dental health assessment within 60 days of the state notifying CCOs that the children were placed into custody with the Department of Human Services (foster care). Physical and dental health assessments are required for children under age 4, but not mental health assessments.

Purpose: Children who have been placed in foster care should have their mental, physical, and dental health checked so that an appropriate care plan can be developed. Health assessments are a requirement for the foster program because of their importance to improving the health and well-being of a child in a trying situation.

mid-2015 data

Statewide change since 2014: **+33%**

Number of CCOs that improved: **11** of 12 reported

All racial and ethnic groups for whom data are reported experienced improvement.

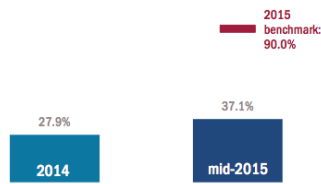
Dental health assessments have been added to this measure beginning in 2015. 2014 results have also been updated to reflect this change, and thus differ from previously published reports.

See pages 93 and 98 for results by members with- and without disability and mental health diagnoses.

About these data:

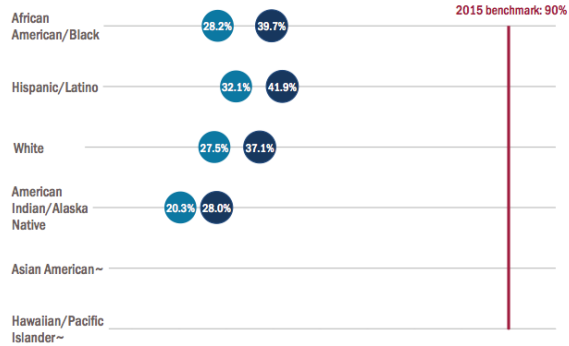
- N=1,574
- Data source: Administrative (billing) claims + ORKids
- Benchmark source: Metrics and Scoring Committee consensus
- Race and ethnicity data missing for 3.4% of respondents
- Each race category excludes Hispanic/Latino

Statewide, health assessments for children in DHS custody improved considerably between 2014 and mid-2015, but remain well below the benchmark.



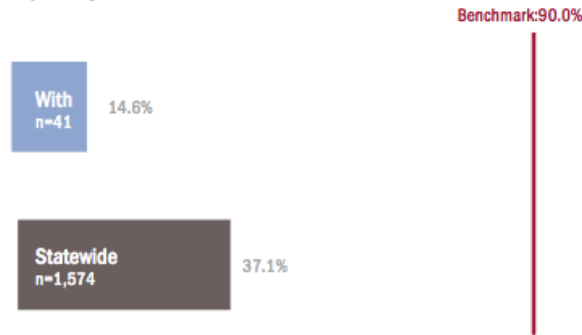
Health assessments for children in DHS custody between 2014 & mid-2015, by race and ethnicity.

~ data suppressed (n<30)



⁸⁸[http://www.oregon.gov/oha/analytics/CCOData/Assessments%20for%20Children%20in%20DHS%20Custody%20-%202016%20\(revised%20Aug%202016\).pdf](http://www.oregon.gov/oha/analytics/CCOData/Assessments%20for%20Children%20in%20DHS%20Custody%20-%202016%20(revised%20Aug%202016).pdf)

Children in DHS custody (foster care) with disability received mental, physical, and dental health assessments less frequently than statewide.



MENTAL, PHYSICAL, AND DENTAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY

Overall, CCOs improved on this measure between 2014 & mid-2015, but remain well below the benchmark.



Summary of data and discussions about incentive measures

While incentive measure data for each CCO stratified by member race, ethnicity, household language and disability were not available for all 18 of the 2016 incentive quality measures, there were sufficient examples where data were available, or statewide or other data could be used, to identify apparent disparities and opportunities for advancing health equity. Many participants noted this was the first time they had seen their incentive measure data stratified by race, ethnicity, household language and disability. This was particularly true for community stakeholders, such as members of

community advisory councils, who generally had not had the opportunity for such an in-depth review and discussion about the incentive measures. After data stratified by disability was added to the materials, there were many observations that this was the first time that data had been reviewed or thought about based on disability.

This review and the discussions at the health equity consultations did not attempt to make definitive findings about the existence of disparities. CCO participants were encouraged to ask more questions, look at other available data and continue to be inquisitive about opportunities for advancing health equity. However, it was emphasized that when an apparent disparity is identified at the CCO level and statewide and persisted over time, it is more likely the disparity really does exist and needs attention. Many participants expressed their appreciation for being able to see their own CCO-specific data and statewide data in these contexts.

The discussions at the health equity consultations also identified many potential culturally and linguistically appropriate approaches to improving CCO performance on the incentive measures and reducing any apparent disparities. It is hoped these health equity consultations provided encouragement to the CCOs and their stakeholders to continue analyzing their own data for opportunities to advance health equity.

Section 5: Health equity opportunities from CCO transformation plans

Many CCO transformation plan activities relate to health equity. As noted above in Section 1, three transformation areas (6, 7 and 8) directly relate to health equity:

- Assuring that communications, outreach and member engagement are tailored to cultural, health literacy and linguistic needs;
- Assuring that the culturally diverse needs of members are met (cultural competence training, provider composition reflects member diversity, certified traditional health workers' and traditional health workers' composition reflects member diversity); and
- Developing a quality improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care and outcomes.

In April 2016, the OHA Office of Health Analytics published all the measures and benchmarks compiled from the current 2015–2017 CCO transformation plans.⁸⁹ Based on a review of all these plans, here is a summary of the types of activities that the CCOs are implementing in transformation areas 6, 7 and 8 that support health equity:

Organizational support for health equity

- Three CCOs (AllCare CCO, FamilyCare and PacificSource Central Oregon) reference the U.S. Department of Health and Human Services Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services⁹⁰ to assess their organizational capabilities and activities.
- Only one CCO (FamilyCare) referenced a dedicated staff position working on health equity, e.g., health equity coordinator.
- Two CCOs (Health Share of Oregon and Trillium Community Health Plan) referenced a staff work group or committee working on health equity.
- One CCO (FamilyCare) referenced the development of a CCO health equity plan.
- Two CCOs (Health Share of Oregon and Columbia Pacific CCO) are adopting, reviewing, and/or revising their internal policies, procedures and work plans on culturally and linguistically appropriate services.
- Three CCOs (Cascade Health Alliance, Columbia Pacific CCO and PrimaryHealth) are supporting the adoption of cultural competency policies by the CCOs' clinics and network providers.
- Two CCOs (Columbia Pacific CCO and Jackson Care Connect) have included discussions of health equity on the agendas of meetings of their boards of directors.
- Two CCOs (Cascade Health Alliance and PrimaryHealth) are including discussions health equity in meetings with their clinics and providers, e.g., Clinical Advisory Panel, monthly clinic engagement meeting.

⁸⁹ http://www.oregon.gov/oha/analytics/MetricsDocs/CCO_Transformation_Plans_Handout.pdf These measures and benchmarks were available in each CCOs Transformation Plan but had not been compiled into a single document. <http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/Oregon-CCO-Transformation-Plans.aspx>

⁹⁰ <https://minorityhealth.hhs.gov/omh/browse.aspx?vl=2&vlid=53>

- Four CCOS (AllCare CCO, Jackson Care Connect, PrimaryHealth and Trillium Community Health Plan) referenced their participation in and support of regional health equity coalitions, including discussions about starting such organizations in Josephine County and in Lane County.

Health workforce diversity and inclusion of health care interpreters, community health workers and traditional health workers

- Six CCOs (AllCare CCO, FamilyCare, Jackson Care Connect, PacificSource Central Oregon, PacificSource Columbia Gorge and Trillium Community Health Plan) are reviewing and improving their own workforce recruitment and diversity policies, procedures and practices.
- Four CCOs (AllCare CCO, FamilyCare, PacificSource Columbia Gorge and Trillium Community Health Plan) are supporting workforce diversity at their clinics and network providers.
- Five CCOs (AllCare CCO, FamilyCare, PacificSource Central Oregon, PacificSource Columbia Gorge and Trillium Community Health Plan) are funding or supporting the hiring of certified health care interpreters as CCO staff and by their clinics and network providers.
- Six CCOs (AllCare CCO, Eastern Oregon CCO, Health Share of Oregon, InterCommunity Health Network CCO, Western Oregon Advanced Health and Yamhill Community Care Organization) are funding or supporting community health workers and traditional health workers to provide culturally and linguistically appropriate services to members.

Cultural competency training

- Nine CCOs (AllCare CCO, Eastern Oregon CCO, FamilyCare, Health Share of Oregon, InterCommunity Health Network CCO, PacificSource Central Oregon, Trillium Community Health Plan, Umpqua Health Alliance and Yamhill Community Care Organization) are providing trainings for their staff on topics including cultural competency, cultural diversity, cultural agility, health equity, health literacy and trauma-informed care.
- One CCO (Columbia Pacific CCO) provided a health equity training for its board of directors.
- Ten CCOs (AllCare CCO, Cascade Health Alliance, Eastern Oregon CCO, FamilyCare, Jackson Care Connect, PacificSource Central Oregon, PrimaryHealth, Willamette Valley Community Health, Western Oregon Advanced Health and Yamhill Community Care Organization) are providing cultural competency, cultural diversity and/or health equity trainings for their clinic and provider networks.
- Six CCOs (Columbia Pacific CCO, Eastern Oregon CCO, Jackson Care Connect, PrimaryHealth, Umpqua Health Alliance and Western Oregon Advanced Health) are providing trainings on trauma-informed care for their clinic and provider networks.
- Three CCOs (Columbia Pacific CCO, Eastern Oregon CCO and Jackson Care Connect) are developing assessments and materials to support the implementation of trauma-informed care by their clinics and providers.
- Four CCOs (Jackson Care Connect, PrimaryHealth, Western Oregon Advanced Health and Yamhill Community Care Organization) are providing trainings on health literacy for their clinic and provider networks.

- Three CCOs (FamilyCare, Umpqua Health Alliance and Western Oregon Advanced Health) are providing trainings on the culture of poverty for their clinic and provider networks.

Communications with diverse members

- One CCO (Columbia Pacific CCO) is reviewing and revising its member handbook and other member educational materials to include references to the availability of culturally and linguistically appropriate services.
- Two CCOs (FamilyCare and Jackson Care Connect) are using member meetings to deepen their engagement with diverse members.
- Two CCOs (PacificSource Central Oregon and PacificSource Columbia Gorge) are reviewing and improving information provided to members about language assistance services.
- Two CCOs (Columbia Pacific CCO and Trillium Community Health Plan) are reviewing member complaints and seeking member/community feedback about language assistance services.
- Eleven CCOs (Cascade Health Alliance, Columbia Pacific CCO, FamilyCare, Health Share of Oregon, InterCommunity Health Network CCO, Jackson Care Connect, PacificSource Central Oregon, PacificSource Columbia Gorge, Trillium Community Health Plan, Willamette Valley Community Health and Yamhill Community Care Organization) are reviewing and translating member materials into Spanish.
- Three CCOs (Columbia Pacific CCO, InterCommunity Health Network CCO and Trillium Community Health Plan) are specifically reviewing member materials in Spanish on their website.
- One CCO (FamilyCare) is reviewing and translating member materials into languages in addition to Spanish.
- Ten CCOs (Eastern Oregon CCO, FamilyCare, InterCommunity Health Network CCO, Jackson Care Connect, PacificSource Columbia Gorge, Trillium Community Health Plan, Umpqua Health Alliance, Willamette Valley Community Health, Western Oregon Advanced Health and Yamhill Community Care Organization) are reviewing and revising member materials for appropriate health literacy.
- Three CCOs (Eastern Oregon CCO, InterCommunity Health Network CCO and Trillium Community Health Plan) are specifically reviewing member materials on their website for appropriate health literacy.
- Two CCOs (InterCommunity Health Network CCO and Umpqua Health Alliance) are reviewing member materials to ensure access to persons with disabilities.

Quality improvement activities to reduce disparities

- Ten CCOs (Columbia Pacific CCO, Eastern Oregon CCO, FamilyCare, Health Share of Oregon, PacificSource Central Oregon, PacificSource Columbia Gorge, PrimaryHealth, Trillium Community Health Plan, Umpqua Health Alliance and Yamhill Community Care Organization) are analyzing, reporting and disseminating their quality performance measure data stratified by member demographic characteristics such as race, ethnicity, language, age, gender and disability.
- Four CCOs (Eastern Oregon CCO, FamilyCare, Western Oregon Advanced Health and Yamhill Community Care Organization) are analyzing their CAHPS

data to identify potential disparities in access and quality of care based on race, ethnicity and language.

- Three CCOs (Health Share of Oregon, PacificSource Central Oregon and Trillium Community Health Plan) are analyzing their data about complaints, grievances, and appeals to identify disparities by race, ethnicity, and language.
- Three CCOs (Jackson Care Connect, PacificSource Central Oregon, PacificSource Columbia Gorge) are supporting the capacity of their clinics and network providers to analyze their own quality performance data to identify disparities.
- CCOs have identified health disparities among their members based on race (e.g., American Indians/Alaska Natives), ethnicity (Hispanic/Latino), non-English-speaking/English language learners, persons with severe and persistent mental illness, foster youth, and members living in rural areas.
- All the CCOs are implementing and evaluating specific interventions to reduce identified disparities on quality measures; examples include interventions to improve prenatal care, developmental screenings for children, adolescent well-care visits, contraception use, drug and alcohol use, tobacco use, depression, diabetes, hypertension, colorectal cancer screening, dental exams, emergency department use, hospital discharges and medication management.
- Five CCOs (Columbia Pacific CCO, FamilyCare, Jackson Care Connect, PacificSource Central Oregon and PacificSource Columbia Gorge) are prioritizing disparities reduction interventions for their Latino members.
- Four CCOs (Cascade Health Alliance, Columbia Pacific CCO, Jackson Care Connect and PacificSource Central Oregon) are implementing disparities reduction interventions in Spanish.

While this summary of activities reflects an impressive amount and range of activities by all the CCOs, there are no activities that are conducted by all 16 CCOs. Even something as basic as providing ongoing staff training on how best to serve diverse member populations was not reported by all the CCOs. While many CCOs provided some type of training to their providers, the content and extent of such trainings varied widely across the CCOs. Only six CCOs reported activities to increase the diversity of their own staff and only four CCOs reported activities to examine and increase the diversity of their provider networks to reflect the demographic characteristics of members served. While OHA has supported traditional health workers and community health workers as part of health system transformation efforts, only six CCOs reported use of traditional health workers and community health workers. While many of the CCOs were implementing activities to improve the readability of member materials to address health literacy and the availability of translated member materials, few of these activities were systematic, with any specific goals or objectives (e.g., what percentage of materials would be at appropriate health literacy levels, or what percentage of materials would be available in Spanish or other languages). Only 10 CCOs reported activities to examine their own CCO-specific data to identify disparities, and only three reported efforts to support their providers in analyzing data at the provider level to identify disparities. The inconsistency in activities across the CCOs indicates that the CCOs could benefit from learning best practices from each other, and sharing examples and resources to avoid duplication.

As the health equity consultations were conducted with the CCOs, there were instances in which some CCO health equity activities had not been included or updated in the CCO transformation plans (and progress reports). For example, five CCOs (AllCare

CCO, FamilyCare, Health Share of Oregon, PacificSource Central Oregon and Trillium Community Health Plan) now have full- or part-time staff positions focused on health equity, but only one staff position (at FamilyCare) was specifically referenced in the transformation plans. Similarly, three CCOs (AllCare CCO, Health Share of Oregon and Trillium Community Health Plan) now have internal staff committees or work groups focused on health equity (and InterCommunity Health Network CCO has a Health Disparities Work Group that includes CCO staff, community advisory council members and other community stakeholders), but the transformation plans only reference two of them.

On the other hand, what is summarized above is based on the transformation plans and progress reports submitted by the CCOs. At the health equity consultations, some questions were raised about the current status of activities that had been reported by the CCO, including questions about some activities that had been reported but were not familiar to health equity consultation participants. These discussions highlighted the need for CCO-wide equity plans that integrated all the health equity-related activities at each CCO and establish specific, achievable goals and objectives shared and known among CCO staff and other stakeholders.

The discussions at the health equity consultations focused on the CCO activities, measures and benchmarks that CCOs reported for transformation areas 6, 7 and 8. As part of the discussions, the participants at the health equity consultations and technical assistance team identified additional opportunities for CCOs to advance health equity.

Transformation area 6: Assuring communications, outreach, member engagement and services are tailored to cultural, health literacy and linguistic needs

Health literacy

As part of their work on this transformation area, several CCOs are in the process of reviewing and improving their communications with members. For example, FamilyCare has a Member Engagement and Outreach Committee reviewing member materials for translations and for health literacy. InterCommunity Health Network CCO has evaluated all of its website pages and documents to ensure no higher than a sixth-grade reading level. Trillium Community Health Plan also conducts a plain language review for all its member materials.

This topic cuts across two transformation areas. Four CCOs had provided trainings on health literacy to their providers as part of transformation area 7. While health literacy should be addressed by all CCOs as part of their transformation plans, not all the CCOs had specific activities focused on health literacy. This would be an opportunity for CCOs to learn best practices from each other as they improve their organizational systems to meet the health literacy needs of diverse CCO members.

Language assistance services

It was noted during the health equity consultations that specific attention could be focused on ensuring the communication needs of members who speak languages other than English, and members with disability, are met. For example, all of Cascade Health Alliance's diabetes-related educational materials and its notices about denials, appeals and grievances are now available in Spanish. On the other hand, at several health equity

consultations, there were discussions about the increase in Russian-speaking members and the need for additional materials available in Russian.

Another example is InterCommunity Health Network CCO, which has a Communications and Marketing Workgroup working on revisions to its CCO website to better meet accessibility requirements for individuals with disabilities and individuals with limited English proficiency. It was recommended that the workgroup could prioritize changes to the CCO website pages and linked documents related to incentive measures where there may be disparities for members with disability, i.e., emergency department use, dental sealants and effective contraception use; and where there are apparent disparities for Hispanic/Latino members and Spanish-speaking members, i.e., SBIRT and timeliness of prenatal care. While each CCO would want to tailor its own member materials and websites, this is another area where there could be more proactive sharing of examples and best practices.

At many of the health equity consultations, there was discussion about language access policies and practices. While there was ready acknowledgement that language assistance services were required, there was uneven knowledge about what specific language assistance services were available, and how they were actually used by limited English proficient members or members with disabilities. For example, the participants at the health equity consultation with InterCommunity Health Network CCO were not sure about the details of the CCO-wide policy on interpreter services for members, i.e., how to ensure access to services. Similarly, participants at the health equity consultation with Columbia Pacific CCO noted that there have been some complaints about inadequate sign language interpretation services and that conducting a systematic review of the policies and practices for interpreter services and language access at clinics and hospitals would be useful. Although there probably were very few certified health care interpreters in the three counties served by Columbia Pacific CCO, it also might be useful to conduct an inventory of those interpreter resources. The patient advocates at the health equity consultation with PacificSource Columbia Gorge reported experiences with clients not being offered interpreter services, even at the hospital. PacificSource Columbia Gorge CCO staff noted that there are low rates of provider billings for interpreter services and it was suggested that the CCO might conduct more trainings and share more information about the availability of such language assistance services. While the provider services staff from Trillium Community Health Plan has regular and ongoing contact with its providers, there has not yet been a specific discussion about language assistance services with those providers.

Health care interpreters and bilingual staff

At several of the health equity consultations, there was discussion about the needs for access to training programs for health care interpreters so that they can meet OHA certification requirements.⁹¹ For example, AllCare CCO has been engaging in efforts to recruit individuals to attend the local health interpreter trainings (sponsored by the Southern Oregon Health Equity Coalition). At the health equity consultation, there were additional ideas brainstormed, including providing scholarships for the training. There also might be other activities to reach local students and youth to create interest and support in pursuing a career as a health interpreter; e.g., by hosting speakers from the state or national health care interpreter associations. There also were discussions about

⁹¹ <https://www.oregon.gov/oha/oei/Pages/hci-training.aspx>

strategies to support health care interpreter training during the health equity consultations with PacificSource Central Oregon and PacificSource Columbia Gorge.

At several health equity consultations, there were discussions about sign language interpreters for the deaf and hard of hearing. There was a need for more information about the process for training and certifying sign language interpreters, as well as how technologies such as video medical interpreting could meet these language assistance needs.

At the health equity consultation with Cascade Health Alliance, there was a discussion about whether there is language proficiency testing for its bilingual staff. Currently, the vice president, who is bilingual, has a conversation in Spanish with any job applicants expected to speak Spanish with members. It was noted that there are tools for more formal language proficiency testing that might be considered.⁹²

Member and community engagement

Few of the CCOs have explicitly focused their member engagement activities on specific racial and ethnic populations. Jackson Care Connect has had an AmericaCorps VISTA volunteer who has been conducting outreach with Spanish-speaking members and the Latino community. This volunteer also has worked with the local YMCA to adapt its wellness curriculum for Spanish-speaking families. Jackson Care Connect also conducts monthly member meetings; it was suggested that health equity topics could be discussed at these member meetings. At its health equity consultation, the participants from Jackson Care Connect shared their current plans for evaluating the CCO's community engagement programs and discussed how they could stratify the metrics to examine community engagement by race, ethnicity and language. Umpqua Health Alliance prepares and sends out regular member newsletters and health information alerts, which could be opportunities to discuss health equity topics.

During the health equity consultation with PacificSource Central Oregon, there was a discussion about continuing to learn that it takes time and trust to develop an effective working relationship with the American Indian tribes in its service area. For example, while there are American Indians participating in the CAC, they cannot represent the tribes or the tribal leadership. It was raised that OHA had a staff person acting as a liaison to all the American Indian tribes throughout the state and that it would be useful for OHA to re-engage with the CCOs and the tribes at that level. Participants at the health equity consultation with PacificSource Columbia Gorge highlighted the unique needs of migrant and seasonal fishers and gatherers from American Indian tribes in their region. There also was a discussion about strengthening relationships with local tribal health centers at the health equity consultations with Western Oregon Advanced Health and with Eastern Oregon CCO.

⁹² For example, see the tests available from the American Council on the Teaching of Foreign Languages at: <https://www.actfl.org/assessment-professional-development/assessments-the-actfl-testing-office> and the Clinician Cultural and Linguistic Assessment: <https://www.altalang.com/language-testing/ccla/>

Transformation area 7: Assuring that the culturally diverse needs of members are met (cultural competence training, provider composition reflects member diversity, certified traditional health workers and traditional health workers composition reflect member diversity)

Health workforce diversity

Four CCOs reported activities evaluating whether the composition of their provider networks reflected the diversity of their members, e.g., by collecting demographic information on providers (race, ethnicity, language).⁹³ During the health equity consultations with Cascade Health Alliance and PacificSource Columbia Gorge, it was confirmed that while provider directories list the languages spoken by the provider and/or office staff, such language proficiency is self-reported.⁹⁴ During the discussion with Cascade Health Alliance, it was noted there might be some improvements in the translations of clinic names into Spanish listed in the provider directory (not using a literal translation). PacificSource Columbia Gorge noted there currently is no way to match members who are identified as Spanish-speaking with Spanish-speaker providers; the auto-assignment process does not consider language assistance needs.

Some CCOs are conscious of diversity when recruiting for staff and providers. For example, PacificSource Central Oregon has had success engaging Latino students at Central Oregon Community College about pursuing careers in health; but it has been more challenging to engage American Indian students. During the health equity consultation with Jackson Care Connect, there was discussion about strategies that could increase health workforce diversity, including working with local employment development agencies that work with the Hispanic/Latino community, conducting recruitment at schools/community colleges with greater numbers of Hispanic/Latino students, and working with the OHSU School of Nursing diversity program. There was a discussion during the health equity consultation with PacificSource Columbia Gorge about reviewing human resource policies and practices for job-related requirements for bilingual positions (either as a preferred or required job qualification).

CCO staff and provider training

Almost all the CCOs have training activities related to cultural competency and equity; some limit the trainings to their own staff while others offer trainings to providers and, in a few cases, to other stakeholders in the community. Some of the CCOs are using external resources for cultural competency training. For example, some of the regional health equity coalitions have provided the trainings used by the CCOs. At one of the health equity consultations, there were questions about the status of the cultural

⁹³ Nerenz DR, Carreon R, Veselovskiy G. Collection of data on race/ethnicity and language proficiency of providers. *Am J Manag Care*. 2013;19(12):e408-e414

⁹⁴ California Health Care Foundation and Manatt Health, *Directory Assistance: Maintaining Reliable Provider Directories for Health Plan Shoppers* (2015), at: <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20D/PDF%20DirectoryAssistanceProvider.pdf>; California Senate Bill 137 requires provider directories to be updated quarterly with information including “non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter...if any, on the provider’s staff”: https://leginfo.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB137 (implementation by July 2017)

competency programs reviewed by the Office of Equity & Inclusion. The Office of Equity & Inclusion now maintains an online registration about the cultural competency continuing education programs it has reviewed and approved.⁹⁵

At least four CCOs (Yamhill Community Care Organization, AllCare CCO, Columbia Pacific CCO and PacificSource Central Oregon) have implemented or are developing staff training activities focused on health equity (see discussion of follow-up technical assistance in Section 7). For example, AllCare CCO's Health Equity and Inclusivity Action Team has re-kindled an organizational level dialogue about health equity; there is a plan to provide training to all staff (five hours), and to offer the training to external partners (five slots each month).

There were discussions at several of the health equity consultations about how CCO staff might benefit from more trainings on health equity. One CCO, Health Share of Oregon, has been implementing a comprehensive training and learning program on health equity for its entire staff. The staff training has been in phases, starting with foundational topics (shared language, developing a health equity lens, etc.), then showcasing community examples of culturally competent services, and now moving to skills-focused trainings (communications, interrupting microaggressions, etc.).

The content and topics of trainings for providers varied across the CCOs. Many of the CCOs have offered training on adverse childhood events (ACEs) and trauma-informed care. Providers have received some of these trainings well. There was discussion at one health equity consultation about how the trainings on ACEs and trauma-informed care could be more culturally specific and use examples that specifically address cultural competency. Other common topics for provider trainings were health literacy and the culture of poverty.

At several of the CCO consultations, it was noted that a lot of training topics had focused more on learning about the social determinants of health and community health, with less focus on health equity issues in the clinical context. There were discussions about how to bridge community and clinical health by highlighting issues such as preventive services. There was discussion at several of the health equity consultations of how trainings for providers could advance health equity by focusing on clinically relevant topics that would support improvements in the incentive measures and reduce apparent disparities. Several participants highlighted the importance of offering Continuing Medical Education credits for provider trainings. It also was noted that skills-based trainings (e.g. motivational interviewing, teach-back method), improving team-based care for diverse patient populations (e.g. training and delegating certain screening and health education tasks and reminders to medical assistants and other members of the care team/office staff), and the sharing of patient experiences may be effective training methods for providers.

As part of their follow-up to the health equity consultations, several CCOs (Trillium Community Health Plan, InterCommunity Health Network CCO and PacificSource Central Oregon) are refining their staff and provider training plans. Generally, most of the

⁹⁵ <http://www.oregon.gov/oha/oei/Pages/Cultural-Competence-Continuing-Education-Approval-Committee.aspx>

CCOs could benefit from clearer plans for their training activities, with more specific timelines and learning objectives.

The CCO clinical advisory panels (CAPs) are another setting where issues of health equity might be raised and discussed. Participants at the consultation with Columbia Pacific CCO felt that its CAP might be ready to engage in discussions directly on race and ethnicity and other socioeconomic issues. The participants at the health equity consultation with Jackson Care Connect noted that data about colorectal cancer screening, effective use of contraception and teen pregnancy had been presented and discussed at its CAP, and that its CAP was useful in identifying gaps and interventions that would work among the providers.

PrimaryHealth requested written policies and procedures addressing cultural competency issues from its providers and has collected responses from 26 providers. During the health equity consultation with PrimaryHealth, the CCO was encouraged to share these provider policies and procedures with other CCOs and provider networks.

One CCO, Columbia Pacific CCO, has provided training on health equity to its board of directors. Several other CCOs have discussed health equity with their governing boards. For example, AllCare CCO's executive leadership and board discussed the social determinants of health, especially the culture of poverty, at its most recent annual retreat. The participants at the health equity consultation with Jackson Care Connect shared that its board of directors network and quality committee have been interested in identifying high utilizers and high costs to focus on and that this could be a way to raise and discuss health equity issues.

Traditional health workers, community health workers and health care interpreters

Many of the CCOs have supported traditional health workers (THWs) and community health workers (CHWs), including hiring THWs as staff and providing financial support for THWs as members of primary care teams. For example, Yamhill Community Care Organization has been funding its CHWs from its financial reserves. Cascade Health Alliance is collaborating with one of its largest providers, Sky Lakes Medical Center, to support THWs who assist with transportation to medical appointments, medication management and tasks such as shopping. The THWs include a Spanish-speaker and a former Medicaid member. InterCommunity Health Network CCO supports at least five pilot projects that use THWs (focused on maternal health, health navigation and housing planning).

At several of the health equity consultations, there was discussion about the needs for access to training programs for THWs, including access to online trainings in areas where local in-person trainings are not available.⁹⁶

FamilyCare conducted inventory of THWs and CHWs in its geographic service area, whether certified or not, and found varying capacities among the community-based organizations with THWs and CHWs, especially to report on quality measures. The CCO is thinking about longer-term capacity and sustainability strategies and is partnering with Community Capacitation Center on a Spanish language training curriculum for CHWs.

⁹⁶ <https://www.oregon.gov/oha/oei/Pages/thw-approved.aspx>

Ideally, FamilyCare would want to work with THWs and CHWs to reach the unengaged, address disparities such as type 2 diabetes, and demonstrate results with strong evaluations. Health Share of Oregon has had ongoing discussions with the Oregon CHW Association about developing a business plan to function as a CHW “hub” to train and deploy CHWs and provide technical assistance to providers working with CHWs. There is still work to be done on payment/funding models but Providence and Kaiser are also involved in the discussions.

FamilyCare also has been working on developing a doula program with the Oregon Doula Association, International Center for Traditional Childbearing, and Black Parenting Initiative. Using doulas is a culturally appropriate intervention for the African American/Black community and the CCO is trying to develop a payment model that would support doulas. Health Share of Oregon also has been working on supporting doulas among communities of color and also would like to do more work to support peer substance use counselors as THWs.

It does not appear that any THW or CHW program has a specific focus on supporting improvements on the CCO incentive measures. For example, while PacificSource Central Oregon has been supporting behavioral health coaches/CHWs in the PCPCH clinics, these care team members have not been asked to support improvements in the incentive quality measures or to specifically work on advancing health equity. Similarly, the InterCommunity Health Network CCO CHW/THW pilot has focused on reducing no-show rates and the integration of mental health and substance abuse services. Working with THWs and CHWs on the incentive measures may be another opportunity to leverage existing CCO programs to support culturally and linguistically appropriate approaches to improvements in incentive measure performance for diverse CCO members.

Transformation area 8: Developing a quality improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care and outcomes

Objectives and benchmarks

While each of the CCOs has established objectives and benchmarks for this transformation area, there is a wide range in specificity and focus among these quality improvement plans. During several of the health equity consultations, there was discussion about how some of these objectives and benchmarks might be refined to be more actionable and achievable. For example, Western Oregon Advanced Health was using improvements in school readiness as its benchmarks, which would be challenging to demonstrate both causation and improvement within one-year timeframes.

Staff positions and work groups

Five CCOs have staff positions (full- or part-time) focused on health equity. Health Share of Oregon has a chief equity and engagement officer and a health equity project manager. FamilyCare has a health equity coordinator. Trillium Community Health Plan has a health equity officer. PacificSource Central Oregon has a health equity coordinator, and AllCare CCO has a project manager on equity). Two CCOs (Jackson Care Connect and Yamhill Community Care Organization) are using AmeriCorps VISTA volunteers to support their work on health equity.

Several CCOs have staff teams focused on health equity (Health Share of Oregon has a Cultural Competence and Health Equity Workgroup and a Disparities Analytics and Reporting Team, Trillium Community Health Plan has a Diversity and Health Equity Committee, and AllCare CCO has a Health Equity and Inclusivity Action Team). InterCommunity Health Network CCO supports a Health Equity Workgroup with primarily external stakeholders as members. Several additional teams were assigned or formed at CCOs as follow-up to these health equity consultations.

Feedback from diverse members

The CCOs also have developed various ways to collect feedback from their members about disparities. AllCare CCO worked with its CAP to develop and add a question on its provider satisfaction survey that asked, “Do you feel that you were treated differently from other patients because of any of the following? (insurance type, race, gender, age, LGBTQ, language, disability, other)”. There has been only one “yes” response in first 100 or so responses, and it was because of insurance type. There was discussion at the health equity consultation about how best to collect additional information about the experience of care from their members that would be inclusive of the experiences of their diverse members.

At the health equity consultation with PacificSource Columbia Gorge, there was a discussion about the low response rates to member and patient surveys and methods to increase patient engagement and receive member feedback, including patient advisory councils, focus groups and town halls. The participants at the consultations reported that they have received feedback from Spanish-speaking members that they prefer Spanish-speaking providers and a central place to obtain information and have their questions answered in Spanish.

Health Share of Oregon has been reviewing its grievances and appeals data for health equity opportunities. Both the quality improvement and compliance staff view grievances and appeals as opportunities for improvement and are conscious of under-utilization/under-reporting (e.g., most grievances and appeals are filed by English-speaking members). There do not seem to be any good benchmarks for the number of and types of responses to grievances and appeals (is less better?) and Health Share of Oregon wondered whether OHA provides guidance about benchmarks or convenes stakeholders to discuss appropriate benchmarks. Health Share of Oregon also noted that OHA also could do more to ensure translations of notices and communications to members and make arrangements for interpreters during appeals.

Effective interventions to reduce disparities

There was discussion at some of the health equity consultations about what types of interventions have proven effective at reducing disparities. Compilations of effective disparities reduction intervention were shared.⁹⁷ PacificSource Columbia Gorge provided information on its current self-management programs, which include programs in Spanish and ones culturally responsive to Hispanic/Latino members; however, the CCO does not yet have programs that are specifically responsive to American Indian members. These health equity consultations also highlighted the opportunities to

⁹⁷ National Committee for Quality Assurance, Recognizing Innovation in Multicultural Health Care Awards, at: <http://www.ncqa.org/hedis-quality-measurement/research/health-care-disparities>; University of Chicago School of Medicine, Finding Answers, at: <http://www.solvingdisparities.org>

develop quality improvement plans focused on existing incentive measures that also would reduce racial, ethnic and linguistic disparities.

The three other transformation areas indirectly related to health equity also were discussed during the health equity consultations:

- *Implementation of patient-centered primary care homes*
- *Encouraging electronic health records and health information exchange*
- *Developing a community health needs assessment and a community health improvement plan.*

Transformation area 2: Continuing implementation and development of patient-centered primary care homes

Overall, CCOs have made significant progress in supporting their clinics to become recognized as patient-centered primary care homes (PCPCHs)(statewide, the percentage of members assigned to PCPCHs increased to 87% by end of 2015). One of the common themes discussed during the health equity consultations was how these PCPCHs could be important partners in advancing health equity. When incentive measure performance data indicated there might be disparities for certain CCO members by race, ethnicity, household language or disability, a first intervention would be to identify whether those members were assigned to and actually receiving care from PCPCHs. If not, then working to get those members assigned and beginning to receive care from PCPCHs would help address issues such as making sure that preventive screenings were being conducted.

On the other hand, it would be expected that CCO members from certain racial, ethnic and household language groups would be more likely to be enrolled with certain clinics; i.e., Spanish-speaking members are more likely to seek care from clinics with Spanish-speaking providers. The CCO also could analyze whether members from certain racial, ethnic and household language groups were assigned to clinics that had PCPCH recognition. If not, then the CCO might focus additional support for those clinics in becoming recognized as PCPCHs.

For those CCOs that were providing technical assistance and other support for clinics in becoming recognized as PCPCHs, there was discussion about the elements in the recognition standards that support health equity. As a clinic reviews and improves workflows and processes of care to meet the PCPCH recognition standards, a CCO could highlight these health equity elements and provide specific technical assistance to ensure that those elements are met. For example, a CCO could provide technical assistance on documenting patient demographic data, including race, ethnicity and primary language, in the member's electronic health record. Having such patient demographic data in the electronic health record would facilitate the electronic sharing of quality data that included those member demographics for stratification and analyses.

As another example, a CCO could provide specific technical assistance to ensure that the clinic seeking PCPCH recognition has a language access policy in place for members with limited English proficiency. Such a language access policy could include something as simple as ensuring that the phone number and dialing instructions to access a telephonic health care interpreter are prominently displayed on or near the

telephone in each exam room, and that all providers and their clinical teams are familiar and trained on how to access telephonic health care interpreters.

At least one CCO has a PCPCH learning collaborative to provide support to its clinics in maintaining their recognition as PCPCHs. This learning collaborative might be an opportunity to present and discuss data on disparities with clinics and providers. For example, the next meeting of one learning collaborative was going to include a discussion of the effective contraception use measure, where there may be some apparent disparities. InterCommunity Health Network CCO is sponsoring a project focused on pediatric medical homes, including ensuring high performance on the developmental screening, childhood immunization and SBIRT incentive measures. There may be opportunities to advance health equity through a focus on how diverse children are doing on these measures.

Transformation area 5: Developing a plan for encouraging electronic health records, health information exchange and meaningful use

One of the significant limitations for CCOs in supporting quality improvement is their continued reliance on their providers to obtain comprehensive and updated clinical data about CCO members. Accordingly, another transformation area supports the continued adoption of electronic health records and the increased electronic exchange of health information. During the health equity consultations, there were frequent discussions about how many of these electronic health record systems and health information exchange efforts have been delayed or stalled.

At the health equity consultation with Cascade Health Alliance, there was discussion about the general challenges in implementing electronic health records among the CCO's providers. It was not known whether the providers had been documenting member race, ethnicity and language in the EHRs, or if providers know how to report quality data stratified by member race, ethnicity and language. The CCO noted that local provider adoption had now coalesced on two EHR systems, which would make training and technical assistance on these EHR functionalities more feasible. Another CCO has an EHR user group that could be a venue to discuss some of these demographic data issues.

Several of the CCOs (AllCare CCO, Cascade Health Alliance, Jackson Care Connect, PacificSource Columbia Gorge, PacificSource Central Oregon and PrimaryHealth) are using the Jefferson Health Information Exchange (HIE). However, none of these CCOs using the Jefferson HIE were aware whether its patient health information includes patient race, ethnicity, language, and disability; this would be an important source of data to identify potential disparities. As users and customers of the Jefferson HIE, these CCOs could create an expectation that such demographic data be included and available as part of the health information exchange.

The Emergency Department Information Exchange (EDIE) and PreManage⁹⁸ are electronic health information exchange resources supported by OHA that are being used by many CCOs (Columbia Pacific CCO, FamilyCare, Jackson Care Connect,

⁹⁸ <http://www.orhealthleadershipcouncil.org/edie/>

PacificSource Central Oregon, PacificSource Columbia Gorge, Trillium Community Health Plan and Umpqua Health Alliance). There were questions initially raised at the health equity consultations whether these programs included data fields for member demographic data, and how granular or specific any allowable responses to those demographic data fields might be. It was confirmed that the EDIE system indeed has the *capability* of documenting and sharing member race, ethnicity and language data, but that it was up to each user (especially hospital emergency departments) to enter the demographic data into the system. During the health equity consultation with FamilyCare, it was noted that EDIE/PreManage reports could also be sent by fax if the small, culturally unique and neighborhood-centered practices that serve many of its diverse members do not yet have EHRs to receive the reports electronically.

There has not been any specific technical assistance provided or offered to front-line users of health information technologies such as electronic health records and EDIE on how to collect and document such demographic data from CCO members. There was discussion that technical assistance to providers on how to document and use patient demographic data would be useful.

Some CCOs are using other software programs to electronically manage their member data but were not sure whether they had the capability to stratify and analyze their data by member race, ethnicity, and language (e.g., the data visualization program Tableau being used by FamilyCare, Health Share of Oregon, PacificSource Columbia Gorge and PacificSource Central Oregon). When CCOs are using common health information technologies, they should be leveraging those technologies to assist them in identifying and addressing health disparities.

Transformation area 4: Preparing a strategy for developing a community health assessment and adopting an annual community health improvement plan

There has been increasing recognition that health status and health disparities are significantly influenced by factors beyond the control of health care providers and health care systems — factors that are known as the social determinants of health. Another transformation area requires CCOs to assess and prioritize these broader health needs in their service area through community health assessments (CHAs) and then develop and support the implementation of community health improvement plans (CHPs) to address those identified community needs. CCOs are required to convene and support community advisory councils (CACs) as part of this process, to ensure that community stakeholders are engaged in both the CHAs and the CHPs. While there is a wide degree of variation in how each CCO conducted its CHA and how each CCO developed and is implementing its CHP, each of these processes includes opportunities to advance health equity.

Seven CAC coordinators or their equivalents and several members of CACs participated in the health equity consultations. For some of the CAC members, this was one of the first opportunities to learn more about the incentive measures in general, and their CCOs' performance on those measures. It also was one of the first times that CAC members reviewed demographic data about the members of their CCO and quality performance data stratified by race, ethnicity, household language and disability. At several of the health equity consultations, there were discussions about how the CACs might become more informed and engaged in health equity work. After one health

equity consultation, the CCO's CAC invited its first ever Latino member to participate and reported back to the OHA Transformation Center how valuable that additional community-specific perspective was to the CAC meeting. At several health equity consultations, OHA Transformation Center staff noted that public service announcements about recruiting CAC members were available in English and Spanish⁹⁹; these could be used by CCOs, e.g., uploaded and available for viewing on a CCO website. At another health equity consultation, there was a discussion about strategies to engage communities that had not yet been represented on a CAC through meetings and other engagement with community leaders and organizations, or less formal community needs assessments or listening and learning sessions.

Among the CHAs conducted, several CCOs collected input directly from diverse community members through focus groups and surveys. For example, Trillium Community Health Plan conducted more than 2,200 surveys, 50 focus groups and more than 50 key informant interviews. Columbia Pacific CCO worked with the Lower Columbia Hispanic Council to collect 300 narrative stories about the lives of Hispanic community members and conducted a community survey, with 7% of respondents being Hispanic/Latino. Eastern Oregon CCO conducted Spanish-language focus groups in Morrow and Malheur counties, one-on-one interviews with the Hispanic population in Morrow County, and a health assessment specific to the needs of the Hispanic population in Umatilla County. Yamhill Community Care Organization also conducted focus groups with its Latino population.

FamilyCare decided to focus on the needs of transition age youth (ages 15–25) that included youth of color, homeless youth and youth with mental health and substance use issues. However, so many needs were identified that it has stalled in how best to respond to those overwhelming needs.

The CHAs also identified and used external data sources, including data on rural populations. Participants at several CCOs noted that for CCOs serving members in more than one county, county-level data were more useful than CCO-level data. This is particularly true when the geographic, demographic, economic, and other characteristics among those counties are significantly distinct (e.g., more rural or greater migrant/Hispanic/Latino population or less populated, including fewer health care providers and other services).

At several of the health equity consultations, there was discussion about local and regional collaborative processes for conducting the CHAs with hospitals, health departments and regional health equity coalitions. While recognizing the timing of the CHA and CHP responsibilities was based on the three-year CCO contract cycle, there was some discussion about accommodating CHA and CHP processes that might not start and end with the CCO contract periods and would be better aligned with local and regional collaborations.

Many of the CHPs have elements that explicitly focus on advancing health equity. These will be summarized in the next section.

⁹⁹ <http://www.oregon.gov/oha/Transformation-Center/Pages/CAC-Learning-Community.aspx> Other recruitment materials and support for CACs are available as well.

Transformation area 3: Implement consistent alternative payment methodologies that align payment with health outcomes

At two of the health equity consultations (Jackson Care Connect and AllCare CCO), there were discussions about transformation area 3. These discussions raised the question whether Alternative payment methodology (APM) projects could explicitly address health equity by requiring providers to report and analyze certain quality improvement measures stratified by member race, ethnicity, language, disability and other demographic characteristics, identify disparities, and then be required to demonstrate how identified disparities had been reduced or eliminated.¹⁰⁰ A first step could be adding questions about race, ethnicity, language and disability to the quality performance measure reports required in the APMs. AllCare CCO noted that it has engaged more than 400 of its providers (75% of its total number of providers) in its APMs, and there could be an opportunity to integrate health equity in those projects. At Jackson Care Connect, all the providers participating in APMs participate in a Regional Learning Collaborative and are currently reporting on three to five quality measures. There was discussion whether there might some additional reporting on these measures to identify health equity opportunities.

Transformation area 1: Developing and implementing a health care delivery model that integrates mental and physical health care and addictions and dental health

Finally, although not discussed at the health equity consultations, one could make the case that the remaining transformation area 1 also could support health equity by ensuring culturally and linguistically appropriate access to integrated behavioral health and dental health services for a CCO's diverse members. Similar to the analysis that could be conducted for whether all of a CCO's diverse members are assigned to clinics that have been recognized as patient-centered primary care homes, CCOs could ensure that members from all racial, ethnic and linguistic groups, and members with disability, are accessing integrated behavioral health and dental health services.

In summary, each CCO's transformation plan presents many opportunities to advance health equity. While the CCOs are engaged in many activities to implement their transformation plans, there could be additional sharing of examples and best practices of transformation area activities that specifically support health equity.

¹⁰⁰ Such an approach would be consistent with the quality improvement elements for recognition of Patient Centered Medical Homes by the National Committee for Quality Assurance (2014), which include at least one disparity reduction quality improvement objective (standard 6, element D7), at <http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh>

Section 6: Health equity opportunities from CCO community health improvement plans

Several of the CCO community health improvement plans (CHPs) have explicit discussions about and prioritization of health equity. For example, Trillium Community Health Plan's CHP states:

Achieving health equity requires structural, social and political changes to equalize the conditions that promote health for all people, especially populations that have experienced historical injustices or face socioeconomic disadvantages....An equity lens process is a method for identifying and addressing health inequities. The equity lens is used to assess policies and programs for disproportionate effects on specific populations. Then, necessary modifications can be made that would improve health equity.

Similarly, Columbia Pacific CCO's CHP states:

A guiding principle of the regional health needs assessment process recognizes current perceptions of health equity within the Columbia Pacific CCO service area and works to create a culturally-specific definition of health and a community-specific definition of, and standards for, cultural competence...

PacificSource Central Oregon's CHP states:

...disparity is also inequitable as it is avoidable and unjust...[i]mproving public health will require work toward health equity - aiming for communities where all individuals have the opportunity to attain their full health potential, and where no one is disadvantaged from achieving this potential due to socially determined circumstance.

Willamette Valley Community Health's CHP states:

[Our CCO] maintains the unambiguous expectation that individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientation and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each...

FamilyCare's CHP states that one of the guiding principles for its CHP is "culturally-competent and equitable care." InterCommunity Health Network CCO's CHP states that one of its organizational values is "delivering service that is culturally sensitive" and that among the guiding principles for its CHP were "health equity" and "cultural and linguistic competence." Willamette Valley Community Health's CHP states that "health literacy and a "culturally sensitive approach is an important focus for all health care interactions and sets a foundation" for all of the recommendations in the CHP, and that "every strategy outlined in the CHP has been crafted with the explicit expectation that individuals and organizations executing the CHP will work to address existing and emerging health disparities within the community." Yamhill Community Care Organization worked through a health disparity and health equity worksheet to use the information from community

surveys and focus groups to create strategies to make sure CHP would improve health disparities and eliminate health inequities; one of 10 guiding principles/values for its CHP is equity.

Health equity also was prioritized as one of the goals or strategies in many CHPs. Jackson Care Connect Health, PrimaryHealth and AllCare CCO identified equity as one of three focus areas in their CHPs. PrimaryHealth is committed to examining all strategy areas as a whole for all members and with an additional lens for members of minority groups, including racial and ethnic groups, sexual orientation and persons with disabilities.

One of five priority areas in Trillium Community Health Plan's CHP is health equity; work in each of the four other priority areas also will be prioritized to focus community energy on efforts with the greatest potential to improve health equity. One of PacificSource Central Oregon's nine strategies is to "improve health equity and access to care and services" and one of its 10 focus areas is "health disparities and inequities." PacificSource Columbia Gorge asks those working on all its focus areas: "In what ways do you adapt services to meet the needs of those with limited English proficiency?" "Do any population groups experience an uneven access to... health services? if so, how might we reduce that inequity?" In Yamhill Community Care Organization's CHP, "woven within the strategies for each of the four prioritized goals are various methods of addressing health disparities such as bilingual and bicultural provider recruitment and retention in the areas of physical, mental, and oral health services; health literacy trainings for providers; developing and distributing culturally and linguistically appropriate member materials."

Community advisory councils have an important role in developing the community needs assessment and CHP, and some have roles in reviewing and/or making funding decisions about CHP projects and investments. FamilyCare's CAC has asked the CCO: "How does FamilyCare begin to disrupt and dismantle inequities both perceived and real within the organization, amongst its providers and access to quality equitable care of its members?" Jackson Care Connect's CAC reviews health disparities data identified by its regional health equity coalition. Participants at several of the health equity consultations discussed the challenges of recruiting CAC members from rural and outlying areas. Eastern Oregon CCO's Umatilla County Local CAC held an Equity and Inclusion Summit in January 2017.

Several of the CHPs had priorities that were explicitly aligned with incentive measures. For example, Eastern Oregon CCO's CHP prioritized improvements on adolescent well-care visits and developmental screenings. The Regional Health Improvement Plan used by PacificSource Central Oregon prioritized diabetes, cardiovascular disease, and reproductive and maternal child health. The CCO's CHP supports diabetes programs in Crook and Jefferson counties. These CHP priorities present additional opportunities to advance health equity through improvements on the incentive measures that also reduce apparent disparities.

CHPs also provide an opportunity for CCOs to address the social determinants of health that are outside the health care system. For example, Cascade Health Alliance is participating in the Klamath Regional Health Equity Coalition, which has started a summer lunch program for children. The program includes health education on nutrition and physical activity, and materials are available in English and Spanish. Trillium

Community Health Plan is working with local elementary schools to collect body mass index data on its students and with its local Head Start programs to conduct focus groups in English and Spanish to better understand childhood obesity. One of InterCommunity Health Network CCO's current pilot projects focuses on the impact of housing planning on community health, and another supports emergency shelter and wraparound services for at-risk youth. Past pilot projects have focused on food insecurity and transportation. FamilyCare has supported projects improving nutrition and food security, housing with supportive services, and job training. PacificSource Columbia Gorge is participating in a Regional Achievement Collaborative to develop strategies to promote and support science, technology, engineering and mathematics (STEM) education.

Many of the CCOs also participate in regional health equity coalitions, including Mid-Columbia Health Equity Advocates, Oregon Health Equity Alliance, Linn Benton Health Equity Alliance, Let's Talk Diversity Coalition, Southern Oregon Health Equity Coalition and Klamath Regional Health Equity Coalition. There has been discussion about starting regional health equity coalitions in Josephine County and Lane County.

At the health equity consultations, each CCO's CHP was reviewed and these references to and prioritization of health equity were highlighted and discussed. While some of these statements and principles were aspirational and more difficult to operationalize and implement, they provide a solid foundation for integrating health equity within the CHPs.

Section 7: Follow-up health equity technical assistance

As these voluntary health equity consultations were being conducted, the OHA Transformation Center made up to an additional 10 hours of follow-up technical assistance on health equity issues available to each of the CCOs after they completed their health equity consultations. The availability of this additional technical assistance allowed many of the CCOs to follow up on the needs and recommendations identified during the health equity consultations. Nine of the 16 CCOs (56%) have used this follow-up technical assistance. Below is a table summarizing the additional technical assistance provided:

CCO	Follow-up technical assistance
Willamette Valley Community Health	Supported engagement with two county health departments; engagement with Latino community leaders; engagement/site visits with four provider clinics serving most of CCO's Latino members; provided input on best practices regarding Latino health; explored strategies to improve nutrition in local school districts; explored roles of regional health equity coalitions
Yamhill Community Care Organization	Supported development of CCO strategic plan on health equity, including reviewing human resource policies; providing staff training; updating language access policies; addressing health literacy; increasing awareness about lesbian, gay, bisexual and transgender health issues; reviewing data about members with disabilities; addressing disparities among Spanish-speaking members
Cascade Health Alliance	Reviewed updated website through equity lens; provided input on outreach to increase adolescent well-care visits and colorectal cancer screening among Latino members
Columbia Pacific CCO	Developed and provided staff training on health equity, including improving clinical care, community partnerships and internal organizational work
Trillium Community Health Plan	Supported revision of goals and measures for transformation areas 7 on provider education on language assistance services and for transformation area 8 on quality improvement on SBIRT and developmental screening for Hispanic/Latino and Spanish-speaking members
InterCommunity Health Network CCO	Supported Health Disparities Work Group in finalization of CCO strategic plan on health equity with goals, strategies and evaluation measures on data, training, diversity of workforce, traditional health workers and communications
PacificSource Central Oregon	Supported development of company-wide strategic plan on health equity that includes a staff education plan; increasing health workforce diversity; developing a business case for health equity; and integrating and measuring health equity through improving member experience of care and increasing member engagement
FamilyCare	Supported development of a strategic plan focused on health literacy and effective health communication to promote health equity
Eastern Oregon CCO	Facilitated training for local CAC to develop goals and strategies to engage in community conversations about health equity

The type of follow-up technical assistance requested and provided varied among the CCOs. The most frequent type of technical assistance provided was assistance with the development of a health equity strategic plan for the CCO. This is consistent with the need identified at many of the health equity consultations to improve the coordination and formalize often unconnected CCO activities to support health equity. Two of these follow-up projects were a direct response to instructions from CCO executive leadership participating at the health equity consultations to develop follow-up plans.

It would be useful for the CCOs that now have developed health equity strategic plans to share them with other CCOs as examples. The OHA Transformation Center and Office of Health Equity & Inclusion also could continue to provide technical assistance to the CCOs on developing and implementing such health equity strategic plans.

Several of the CCOs now have implemented or will be developing staff trainings on health equity (Yamhill Community Care Organization, Columbia Pacific CCO, PacificSource Central Oregon). Again, it would be useful for these CCOs to share the agendas and materials for these staff trainings with other CCOs. In fact, peer-to-peer training approaches among the CCOs might be effective and would build increased organizational capacity for health equity training across the CCOs.

Section 8: Recommendations for advancing health equity through Oregon’s CCOs

These health equity consultations provided the unique opportunity to meet with the staff and community stakeholders at each of the 16 CCOs and facilitate a tailored discussion of health equity specifically for that CCO. The consultations combined a common template for sharing and discussing the incentive performance measure data stratified by race, ethnicity, household language and disability, transformation plan and CHP for each CCO, with flexibility for tailored discussions. This proved to be an effective approach. The documentation of ideas, best practices, references and resources in the summary reports prepared and provided to each CCO also ensured that each CCO had materials to take next steps. The fact that more than half of the CCOs used the follow-up technical assistance made available reflects how ideas and momentum for specific next steps had been created.

A few lessons also were learned through this process of offering and conducting these health equity consultations. First, it was essential for the innovator agents to be involved in tailoring each consultation. The background knowledge about the CCO and the expected participants and the more recent updates on relevant CCO activities were vital in making each consultation more credible, relevant and up-to-date.

Similarly, the participation of several different parts of OHA — the Transformation Center, Office of Equity & Inclusion, and Office of Health Analytics — demonstrated the best in teamwork and collaboration. Each of these parts of OHA brought their own expertise and experiences that added to the relevance and usefulness of the health equity consultations. It also demonstrated how OHA could support an integrated interaction with each CCO, rather than having each part of OHA reach out and work with the CCO on siloed projects or activities.

The experience of preparing for and facilitating tailored health equity consultations with each of the 16 CCOs provided a unique perspective on the wide range of organizational structures, external and internal accountabilities, and organizational cultures among the CCOs. While appreciative of the level of interest and participation in these health equity consultations from all the CCOs, there sometimes was a feeling that key decision makers were missing from the conversations. For example, during several of the health equity consultations for CCOs that are part of larger organizations, it was sometimes challenging to understand where there might be accountabilities for certain parts of the transformation plan (e.g., who is responsible for member communications, provider training or human resources functions such as staff hiring). On the other hand, CCOs that were created specifically as part of this health system transformation initiative often are still working through some “start-up” organization dynamics, without long-standing partnerships and working relationships with other community stakeholders.

Here are some of the lessons learned from all the health equity consultations and follow-up technical assistance on health equity:

- Create a CCO-wide plan to advance health equity.
- Use each CCO’s own data to identify and prioritize disparities.
- Partner with diverse members and communities served.
- Engage clinics and providers.
- Build and sustain a diverse workforce.

- Integrate equity into health system transformation.
- Be accountable for advancing health equity.

Create a CCO-wide plan to advance health equity.

Many CCOs realized that there already were many activities related to health equity being conducted by the CCO, without much coordination. For example, many CCOs have separate equity-related training plans for their own staff and for their providers that are not aligned (offering some content to staff that might also benefit providers, or vice-versa). Similarly, many CCOs were struggling to conduct data analysis to develop new or additional work in transformation area 8 on reducing disparities while not looking at potential disparities in performance on the incentive quality measures, which already has the focus of attention of the CCO and its providers. One of the short-term results from the health equity consultations was the leadership of several CCOs asking for CCO-wide plans to advance health equity. Several CCOs used the follow-up technical assistance to help develop these plans.

Use each CCO's own data to identify and prioritize disparities.

Another recurring insight from the health equity consultations was that there were readily available sources of both quantitative and qualitative data to inform each CCO about the specific disparities that its members and communities might be experiencing. The review of incentive quality measures stratified by member race, ethnicity, household language and disability revealed many areas of potential disparities and opportunities to advance health equity. Other sources of data, including data already collected through community needs assessments, or that could be easily collected through ongoing forums such as monthly member engagement meetings, were highlighted. Some CCOs were taking the initiative to explore other important data sources such as member complaints and grievances, and reports of member experience of care. Finally, providing training and support to front-line users of health information technologies such as electronic health records and EDIE to document patient demographic data would enable another level of data analytics to identify and monitor disparities.

Partner with diverse members and communities served.

There were rich discussions at the health equity consultations about how to deepen and broaden CCO partnerships with diverse members and communities served. All CCOs can build on existing structures such as community advisory councils and member meetings to deepen and broaden their member and community engagement. Members and community partners are particularly essential partners to ensuring that member communications are appropriate (checking health literacy, accuracy of translations and accessibility for individuals with communications-related disabilities).

Engage clinics and providers.

Another important theme that emerged from the health equity consultations was the critical role that each CCO's clinics and providers have in advancing health equity. Supporting each CCO's patient-centered primary care homes in building ongoing care relationships with diverse members is a first step in advancing health equity. Engaging hospital and emergency department partners, especially through health information exchanges and health information technologies, can put a spotlight on potential disparities in access, use, coordination and transitions of care. Provider trainings related to equity can be more focused on clinical issues and communications skills that will equip providers to provide more patient-centered, culturally and linguistically appropriate services.

Build and sustain a diverse workforce.

There were many ideas for building and sustaining a diverse workforce discussed at the health equity consultations, including strategies for increasing the diversity of CCO staff, clinics and providers, and increasing the use of traditional health workers, community health workers and health care interpreters. While community partners can assist in recruiting and training traditional health workers, community health workers and health care interpreters in the short-term, longer-term partnerships and investments in educational and training pathways will be needed, especially in rural and other areas where there are chronic shortages of all health professionals. Cultivating and supporting local students and trainees for needed positions is the best long-term strategy for a diverse workforce.

Integrate equity into health system transformation.

These health equity consultations emphasized that advancing equity is not a separate or “extra” obligation for the CCOs but an integral element of the design and goals for health system transformation. There are CCO obligations and opportunities to advance health equity embedded throughout the transformation plan and in each transformation area. There are many opportunities to advance health equity through improvements on the incentive quality measures, which also will create short-term financial benefits for the CCO. Finally, the structure and processes for community needs assessments, community health improvement plans and community advisory councils allow CCOs to better understand and address the population-level and community-level opportunities to advance health equity, including addressing the social determinants of health.

Be accountable for advancing health equity.

Finally, these health equity consultations provided an example of how CCOs could be more publicly accountable for advancing health equity by sharing updated information about their activities and progress. The review of the incentive measure data was revealing for many community stakeholders; such data could be shared on a regular and ongoing basis with existing stakeholders such as CCO clinics and providers, clinical advisory panels and community advisory councils. There could be more explicit discussions of health equity at the CCO governance level, at their governing boards.

Here are specific recommendations for OHA, CCOs and other stakeholders:

Recommendations for OHA

- The OHA Transformation Center and Office of Equity & Inclusion could offer and provide technical assistance on the developing and implementing health equity plans by each CCO, including realistic and achievable evaluation measures, benchmarks and milestones.
- The OHA Transformation Center could continue to highlight opportunities and best practices, and provide technical assistance and other support to advance health equity in all eight of the transformation areas.
- The OHA Transformation Center could offer technical assistance on the health equity-related standards for patient-centered primary care home certification.
- OHA could facilitate training and community education on the importance of responding to the optional questions about demographic characteristics.
- OHA could address the challenges related to updating demographic and contact information about CCO members in monthly eligibility files.

- OHA can continue to support CCOs in obtaining clinical information from their providers for updated data about quality performance measures.
- The OHA Office of Equity & Inclusion could offer technical assistance to CCOs, providers, and community stakeholders as its standards for race, ethnicity, language and disability data are implemented.
- The OHA Office of Equity & Inclusion could develop standards for the collection of sexual orientation and gender identity data consistent with emerging federal data standards.
- The OHA Office of Equity & Inclusion could continue to work with CCOs and other community stakeholders to support regional health equity coalitions.
- The OHA Office of Health Analytics could offer technical assistance on the analysis of CCO quality measure data stratified by race, ethnicity, language and disability.
- The OHA Office of Health Analytics could continue to publicly report CCO incentive and other quality measure data stratified by race, ethnicity, language and disability.
- The OHA Office of Health Analytics and Metrics and Scoring Committee could continue to explore alternate or additional measures of member experiences of care that would more effectively measure the experiences of diverse CCO members.¹⁰¹

Recommendations for CCOs

- CCOs could develop health equity plans that would coordinate all activities related to health equity, and be integrated into the strategic and business planning for the CCO.
- CCOs could designate staff and staff teams/committees/work groups to focus on advancing health equity.
- CCOs could continue to share data, information and updates, and facilitate conversations about health equity among their executive/senior leadership with their governing boards, community advisory panels, community advisory councils and other stakeholder bodies.
- CCOs could continue monitoring, analyzing and publicly reporting their own quality measure data stratified by member demographic characteristics, to continue to identify opportunities to advance health equity.
- CCOs could support the comprehensive collection and use of member demographic data, including race, ethnicity, language, disability, sexual orientation, gender identity and rural status.
- CCOs could continue to review and monitor the assignment of members to patient-centered primary care homes, ensuring equal access to PCPCHs among diverse member populations.
- CCOs could provide technical assistance and other support to their clinics and providers to collect, analyze and use patient/member demographic data to identify and reduce disparities.

¹⁰¹ For example, the Metrics and Scoring Committee recently discussed National Quality Forum Measure 1821 L2, patients receiving language services supported by qualified language services providers, at: <http://www.oregon.gov/oha/analytics/MetricsDocs/January-2017-presentation.pdf>.

- CCOs could provide trainings for their clinics and providers on communications skills and interventions that will equip providers to provide more patient-centered, culturally and linguistically appropriate services.
- CCOs could explore the development and implementation of alternative payment methodologies that would incentivize the identification and reduction of disparities.
- CCOs could share the agendas and materials for staff trainings on health equity with other CCOs as best practices and for peer learning.
- CCOs could develop specific evaluation measures and milestones for developing translated materials (which materials, how many languages, by when, etc.).
- CCOs could prioritize translations of materials into Spanish and other languages related to the incentive measures where there are apparent disparities.
- CCOs could collaborate on strategies to expand training opportunities for health care interpreters, community health workers and traditional health workers.
- CCOs could collaborate on developing sustainable funding for traditional health workers and community health workers.
- CCOs could improve the diversity of community advisory council members to reflect the diverse demographic characteristics of members served.
- CCOs could continue to collect additional qualitative and quantitative data about their diverse members and communities served through member meetings, community needs assessments, and other strategies for ongoing member and community engagement.
- CCOs could continue to support regional health equity coalitions.

Recommendations for health information technology stakeholders

- Electronic health record vendors should be required to offer products and systems compliant with the 2015 Office of National Coordinator for Health IT certification requirements, including the documentation of patient race, ethnicity, language, sexual orientation, gender identity and social risk factors.
- Electronic health record vendors could offer training and technical assistance (and user group activities) to support the collection and documentation of comprehensive patient demographic data.
- Health information exchange providers and systems could support the collection, documentation, exchange and use of patient demographic data (using the 2015 ONC certification criteria), and offer training and technical assistance (and user group activities) to support the collection and documentation of comprehensive patient demographic data.
- Electronic population health management software and systems could support the collection, documentation, exchange and utilization of patient demographic data (using the 2015 ONC certification criteria) and offer training and technical assistance (and user group activities) to support the collection and documentation of comprehensive patient demographic data.
- CCOs could work with electronic health record vendors, health information exchange providers and systems, and electronic population health management software and systems to collect and analyze quality data by member demographic characteristics to identify and reduce disparities.
- CCO clinics and providers could work with electronic health record vendors, health information exchange providers and systems, and electronic population health management software and systems to collect and analyze quality data by CCO member demographic characteristics to identify and reduce disparities.

Recommendations for community stakeholders

- Community stakeholders could continue to ask CCOs for regular reporting of quality measure data stratified by member demographic characteristics.
- Community stakeholders could continue to ask CCOs for regular updates on progress on transformation areas 6, 7 and 8.
- Community stakeholder could continue to support efforts to increase the diversity of CCO staff and providers.
- Community stakeholders could continue to support efforts to recruit, train and place traditional health workers, community health workers and health care interpreters.
- Community stakeholders could continue to ask CCOs for opportunities to participate in trainings on culturally and linguistically appropriate services, health literacy and health equity.
- Community stakeholders could continue to raise health equity issues in upcoming community needs assessments and community health improvement plans.
- Community stakeholders could continue to support and participate in regional health equity coalitions.

Oregon's 16 CCOs have made important progress toward the goal of health system transformation and improved health care and health outcomes for CCO members. The health equity consultations and follow-up technical assistance described in this report highlight the many activities that CCOs already have conducted to advance health equity, as well as additional opportunities to deepen and broaden that work. The participation of all 16 CCOs in these health equity consultations allowed a unique overview of these opportunities across all the CCOs, but also revealed how additional sharing of resources and best practices would benefit all the CCOs and their diverse members. As Oregon's CCOs continue their work toward their goals of health system transformation that will result in better care, healthier people and smarter spending, they also have opportunities to make progress toward reducing disparities and achieving health equity for the diverse Oregon community members they serve.

Appendix: Participant evaluations of health equity consultations

At the conclusion of each health equity consultation, all participants were asked to complete a written evaluation. There was a combination of ranking and open-ended questions. A compilation of the evaluations was included in the draft written summary of the health equity consultation and reviewed during the debriefing call with the Technical Assistance Bank consultant, Transformation Center staff, Office of Equity & Inclusion staff, and innovator agent. Some of the suggestions resulted in changes to the process for conducting future health equity consultations and the format of the materials, as noted in Section 2 above. Below is a summary of the responses to the evaluation questions from the participants at the health equity consultations:

CCO Participant Evaluations of health equity consultations

Scale: 1=Not valuable, 2=Limited value, 3=Neutral, 4=Valuable, 5=Very valuable
 Scale: 1=Strongly disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly agree

CCO responses/ participants	Overall value of this consultation in supporting your work	Would recommend this consultation to another CCO	Consultation was effective for meeting the needs of my CCO
AllCare CCO 20/22	4.22	4.20	4.05
Cascade Health Alliance 3/3	4.67	4.33	4.67
Columbia Pacific CCO 4/4	4.50	4.25	4.50
Eastern Oregon CCO 4/6	4.33	4.75	4.00
FamilyCare 8/8	4.13	4.13	3.75
Health Share of Oregon 5/5	4.80	5.00	4.80
InterCommunity Health Network CCO 13/15	4.31	4.38	3.54
Jackson Care Connect 7/7	4.33	4.57	4.67
PacificSource Central Oregon 7/9	4.71	4.57	4.43
PacificSource Columbia Gorge 12/16	3.92	4.18	4.27
PrimaryHealth 4/5	4.25	4.25	4.25
Trillium Community Health Plan 11/13	4.10	4.45	4.27
Umpqua Health Alliance 4/7	4.33	4.67	4.67
Western Oregon Advanced Health 8/8	4.38	4.50	4.38

CCO responses/ participants	Overall value of this consultation in supporting your work	Would recommend this consultation to another CCO	Consultation was effective for meeting the needs of my CCO
Willamette Valley Community Health 2/8	3.50	3.50	3.50
Yamhill Community Care Organization 7/9	4.43	4.57	4.29

Overall, 119 of 144 participants completed the evaluations (82.6% response rate). While there was some range in the evaluation of the overall value of the health equity consultation, the lowest ranking from any CCO was 3.50, with the majority of rankings at 4.33 or higher (9 out of 16 CCOs)(ranking of 5=very valuable, 4=valuable). As for whether the health equity consultation was effective for meeting the needs of the CCO, the lowest ranking from any CCO was 3.50, with the majority of rankings at 4.25 or higher (11 of 16 CCOs)(ranking of 5=strongly agree, 4=agree). Finally, when asked whether the participants would recommend the health equity consultation to another CCO, the lowest ranking from any CCO was 3.50, with the majority of rankings at 4.33 or higher (10 of 16 CCOs)(ranking of 5=strongly agree, 4=agree).

Participants were also asked what actions they planned as a result of their participation in the health equity consultation (participants were asked to mark all that apply):

Actions Planned as a Result of Participation in Health Equity Consultation

CCO	Reach out to colleagues, community partners, experts or OHA for more information or ideas	Reach out to colleagues or community partners to make new relationships	Take action to improve processes within my organization, my CAC or committees in which I participate	Make changes to the way I conduct my daily work
AllCare CCO 20/22	10	6	15	9
Cascade Health Alliance 3/3	3	1	3	1
Columbia Pacific CCO 4/4	2	0	2	0
Eastern Oregon CCO 4/6	2	2	3	2
FamilyCare 8/8	7	4	7	1
Health Share of Oregon 5/5	3	3	4	5
InterCommunity Health Network CCO 13/15	9	6	12	4
Jackson Care Connect 7/7	2	1	7	1

CCO	Reach out to colleagues, community partners, experts or OHA for more information or ideas	Reach out to colleagues or community partners to make new relationships	Take action to improve processes within my organization, my CAC or committees in which I participate	Make changes to the way I conduct my daily work
PacificSource Central Oregon 7/9	5	4	7	2
PacificSource Columbia Gorge 12/16	6	3	8	1
PrimaryHealth 4/5	2	1	2	1
Trillium Community Health Plan 11/13	6	4	5	2
Umpqua Health Alliance 4/7	3	2	3	0
Western Oregon Advanced Health 8/8	5	1	6	1
Willamette Valley Community Health 2/8	1	2	1	0
Yamhill Community Care Organization 7/9	5	2	5	0

While there was a wide range of responses to these suggestions for potential follow-up actions that participants might take after the health equity consultation, participants were most likely to “take action to improve processes within my organization, my CAC or committees in which I participate” (at least a majority of participants from every CCO, except one) while very few participants reported that they would “make changes to the way I conduct my daily work.”

Write-in responses of other follow-up actions planned included:

- Would like to capture existing work in a plan and identify gaps.
- Be sure we incorporate this information into annual work plan.
- Do more research on disparities.
- Use to help me write the Community Health Assessment.
- Be aware of demographic areas highlighted in the report to use to concentrate improvement area recommendations.
- Be mindful of training opportunities or conversations to initiate with providers.
- Reach out to my team (CHWs).

Participants were asked to complete the following sentence: “As a result of this consultation, my CCO plans to...” Responses included:

Organizational commitment to health equity

- Continue to pursue health equity efforts
- Continue implementation of our equity plan
- Use input and resources to move forward with equity movement
- Continue our work to address health equity issues

- Continuing to move forward in this work
- Develop a more comprehensive health equity strategy
- Develop “equity lens” conversation
- Continue working on health care equity and improvement in the many areas identified today
- Continue work to reduce health disparities
- Seek new options and new ideas to provide equality when it comes to health care access
- Continuing integrating this work as a priority
- Collaborate on health equity opportunities in both CCO regions and keep this work alive in daily workflows
- Work better to have a better equity lens that we look through in all our work and as an organization
- Continue to improve on disparities issues
- Look at the health equity opportunities identified and implement strategies
- Coordinate/collaborate on health disparity issues/improvement goals
- Move forward creating a dialogue both within and outside our organization
- Assure that when gaps in access and care are identified, that our processes look for disparities in race, cultural, ethnic concerns
- Continue conversations on how to put best health equity practices in place
- Consider focus on structure and process that supports equity with less focus on specific numbers/outcomes as our group sizes are small
- Provide internal staff training
- Implement staff trainings
- Include ethnicity in discussions in future staff trainings
- Provide training related to disability/racial disparities in health care
- Examine and enhance health access through education to staff and members
- Continue to participate and collaborate with other CCOs and state representatives in the pursuit of health equity

Improvements in data collection, analysis and use

- Deliver quality performance data with racial and ethnic comparisons to identify disparities
- Utilize more data
- Collect more data
- Analyze deeper the data
- Identify opportunity to target disparities
- Ramp up Disparities Analytics Team
- Expand formal analysis of metrics and outcomes by racial/ethnic group, household language, disabilities
- Use statewide aggregate data as references, especially when comparing small numbers with large numbers
- Use BRFSS for benchmarking diagnosis rates
- Provide more thoughtfulness about how to present the data
- Develop policy, and change data processes around equity
- Review quality data development work plan
- Add REAL [race, ethnicity, and language] screen to quality improvement data
- Review the way we use data (we may have more of an equity lens than we think)
- Approach the CAP with new data

Communications with, and engagement of, diverse members

- Continue to learn how to reach out to diverse members
- Work with internal staff to ensure they are able to access and use the language line and TTY
- Use members services staff to capture language spoken and preferred materials
- Look at our printed information
- Work with other CCOs to help obtain medically certified interpreters
- To implement some of the suggestions related to CHIP work and community/member engagement
- Increase language assistance
- Implement cultural competency/humility training; improve Spanish language accessibility; improve patient engagement throughout health system

Supporting providers

- Work to include health equity in our relationship with community providers and members
- Continue to work with provider offices to improve awareness
- Bring information to provider meetings
- Improve our provider education action plan
- Share ideas looking at priority areas that came from the data to discuss strategies for improvement and who we should engage, e.g., specific clinics, community partners
- Build relationships with culturally specific providers and community partners
- Work through our incentive programs to increase quality for disparate populations
- Revise existing APMs to raise awareness
- Looking at changing APMs, learning collaboratives, CAP, and strategic planning
- Integrate disparity focus on PIPs, transformation plan and outreach education
- Include more health equity analysis in our work around the quality measures and the QAPI
- Utilize CAP and CAC

Follow-up and technical assistance

- Will consult with senior leadership to identify opportunities
- Consult with internal and external partners
- I plan to bring health equity more into the conversations at Regional Health Improvement Plan workgroups as well as infuse it more into the CAC's discussions
- Gain more information and insight about equity initiatives and disparities
- Look into adolescent CAC participation
- Discuss further to develop next steps
- Discuss further needs for TA
- Find out best practices from other organizations

Participants were asked to identify the most helpful aspect of the health equity consultation; their responses included:

Format for health equity consultation

- Sharing ideas
- Hearing some ways we can improve
- Increased awareness of issues that impact equity balance
- Brainstorming
- Thinking about how to incorporate equity into daily work
- Your presence in person and knowledge
- The insight was great
- Technical assistance from knowledgeable people/professionals
- The prepped materials were very useful
- Information packet very well done
- I found all information was very helpful
- Learning from OHA
- Avenue to give feedback to OHA
- The summary I hope to receive; feedback
- Helped me think more broadly about equity
- New approaches, focuses
- Clarification of health equity for a community that is not diversified by race or ethnicity, i.e. substance abuse, disabilities
- The whole discussion was enlightening and helpful
- Ignatius was great; it was helpful to hear about some concrete recommendations
- Learning re: equity opportunities in CCO and sharing
- How committed our community is and knowing what the Gorge area is doing regarding health equity

Participation of diverse stakeholders at the health equity consultations

- Broader engagement of CCO leadership
- Having good staff representation at the meeting to learn about opportunities in equity work
- Discussing the quality improvement measures and Transformation Plan in same meeting; having multiple perspectives in the room
- Raise awareness of this topic among other departments

Review and discussion about incentive data stratified by member demographic characteristics

- Review and recommendations related to CCO metrics
- Review of our equity outcomes and discussion about ways to improve
- Understanding the data and how to use it
- Seeing what population was potentially underserved and, how in a rural area, we compare to other CCOs in the state
- Shed light on how we compare to other CCOs
- An outside perspective of our measurement results
- Raising my awareness of these measures and ethnicity/language barriers
- To again point out that if a population is small, we need to address needs
- Disparity data by metric
- Data!
- Data review
- Looking at the data
- The pre-work was great

- The way the data was presented
- The framing of the data
- Discussion of the meaning of variation in the performance measures
- Learning about data improvement that the state is making and that allow sharing this info with the CCO
- Data review, but also chance to talk about barriers
- Quality measure breakdown by race/ethnicity and language
- Education around the alignment with CCO measures and equity
- Data breakouts and explanations from Ignatius
- Guided conversations re: how to interpret data and how to address disparities
- Being about to compare measures across all CCOs and find areas of improvement
- State quality improvement measures and demographic data
- Seeing data on areas that PacificSource and CCOs are doing well and areas for improvement
- Summary and analysis of CCO data
- Looking at the data to see how it compares to the data from the Community Health Assessment
- Discussion around metrics, ideas for improvement
- The discussion of CCO metrics and where to drill down, i.e. most Hispanic members
- The analysis of the data
- Visualized data
- Actual discussion of health inequities
- Breakdown of metrics by categories
- Having the conversation with data for our region
- Data and observations by the state
- Comparisons with other CCOs
- Learning more about the incentive measures, where data are coming from, how it's measured, etc.
- Ignatius took time to review our data and had well-thought out suggestions
- Examples of stratification
- I appreciated the discussions around the data stratification
- Comparison data from across the state is useful
- Rate specific demographic information
- Discussion about state data collection
- Understanding measures of health equity/areas for improvement
- Overview of CCO metrics and the understanding of the disparities in each specific metric; this will help identify areas to focus on for our PIP and outreach
- Looking at data, but not seeing significant disparities

Review and discussion of transformation areas

- Connecting equity with Transformation Plan and measures
- Outlining all our CCO incentives and strategies
- Best practices and hearing about other projects
- Resources, thoughts, suggestions, on other data from a variety of CCOs
- Identified opportunities for metrics, Transformation Plan
- Clear link to measures and plans

- Reviewed Transformation Plan
- Highlighting areas of improvement
- Great ideas of where we can analyze and/or provide outreach to improve equity in the region
- Helpful suggestions on how to make improvements
- Hearing about what other CCOs are doing
- Seeing where we need to improve
- How we can implement specific items
- Concrete opportunities outlined

Discussion of technical assistance resources

- The TA discussion
- Awareness about resources available to the CCOs
- Understanding resources available
- Hearing about the technical assistance opportunities
- Learning what TA is available
- Learning more about the TA offerings
- List of OHA technical assistance available
- The knowledge about other programs in the country

When asked how the content or format of the health equity consultation could be improved, participants had the following responses:

Additional participants

- Have more CCO decision makers participate
- More CAC involvement? May not be appropriate for this meeting

Improvements about the data presented

- The data presented were very high level and not something the CCO could compile independently; more detailed analysis would be beneficial, perhaps including geomapping or specific strategies for a particular measure/ demographic
- More examples during metric review
- I would have liked more focus on gender, age, regional rather than so much on race
- I was hoping to have data based on the CHP Addendum; we have 16 outcomes and 56 indicators and we don't know how to get stratified data
- I was thrilled to receive the data before the meeting to review, though I only got it 4 days before and realized, after seeing the agenda, that other key staff needed to attend on short notice
- Can we include the denominator by race/ethnicity on each chart to keep it front and center
- More current, easier to read data
- Not as metrics intensive
- Ensuring that information on the CHP/Transformation Plan is updated

More specifics for quality improvement

- More structure for formal action planning
- More structured strategy development

- More discussion about creative options other CCOs are considering and putting into practice
- Specific tips for a sample improvement opportunity
- I would like to have real tools to be able to glean potential complaints that have origins in potential disparity issues
- Having some more practical examples would be very helpful
- More specific ideas
- It would help to hear more about successes and innovations of other CCOs and opportunities to implement them
- More conversation about what other CCOs are doing around health equity
- Want to have time to discuss how we might use/develop our plans for the 10 hours available from the TA Bank

Duration of the consultation

- With so many people, an extra 30 minutes would be better
- Need more time for discussion
- I think it would be great for an email to ask us 1-2 questions before the meeting; extending time to 3 hours
- Short, introductory meeting; not really designed for digging into the meat of the problems we could be addressing
- I think we could have used more time; 3-4 hours would have been even better
- A bit more time, maybe split into two meetings

Other comments and suggestions for improvement

- I found it interesting; I think there is a lot of pressure placed on CCOs for areas that they have limited capabilities for change; AllCare does a lot for their shareholders and members; I think more education publicly would benefit everyone; we need to change society opinion, not just providers/CCOs
- Do it more often!! Follow-ups
- It was all well organized and delivered; thank you!
- I thought it was good, especially the conversation between clinical and community work
- I felt it was fine
- It was great; no improvement suggestions
- It is great as is
- No comments – it was great!

Finally, participants at the health equity consultations provided the following additional comments:

- I would like more information on workplace diversity hiring practices; we have a very limited diverse applicant pool in southern Oregon
- Train hiring managers on how to broaden their interview process
- We need providers to help with this process
- Disability comments were very helpful!
- It probably could have been a 3 hour meeting; we really didn't get to talk a whole lot about equity, improving equity, how partners can work toward it
- The time spent reviewing data was excessive; perhaps future sessions could focus on a couple priority areas and use time to discuss/brainstorm
- Thank you so much for sharing the information and your patience as we learn
- Much appreciated expertise

- Very friendly team!
- Also, thanks for not doing a PPT presentation
- Thank you for the rich discussion!
- Thank you for the time and insights!
- Thank you for reminding us about other ways of thinking about disparities; also the information on expected system changes, improvements, etc. was very helpful
- Thank you; this is helpful; let's do more of this
- Thank you for your continued passion on equity and inclusion

About Technical Assistance Bank Consultant Ignatius Bau

Ignatius Bau is an independent health care policy consultant for patient-consumer organizations, community-based health and social service organizations, community health centers, minority physician associations, public hospitals, health systems, and state health departments. He works on issues of health care reform, health equity, health disparities, demographic data, language access, cultural competency, health workforce diversity, health IT and the social determinants of health. Mr. Bau also has worked on lesbian, gay, bisexual and transgender health issues, and on immigration law and policy.

Mr. Bau has provided training and facilitated discussions about demographic data collection, culturally and linguistically appropriate services, health workforce diversity, community health improvement, health equity, and health care reform with Oregon's coordinated care organizations, community advisory councils and other stakeholders through the Oregon Health Authority (OHA) Office of Health Equity & Inclusion and the OHA Transformation Center.

Mr. Bau has worked as interim executive director at the California Pan-Ethnic Health Network, program director at The California Endowment, policy director at the Asian & Pacific Islander American Health Forum, and staff attorney at the Lawyers' Committee for Civil Rights. He has served on expert advisory panels focused on health equity for the Institute of Medicine, National Quality Forum, Joint Commission, Institute for Healthcare Improvement, federal Office of Minority Health, Office of National Coordinator for Health IT, and Centers for Disease Control and Prevention.



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