# 2015-2017 Transformation Plan Timeline - *June 10, 2015 Benchmark Submission Elements and* 2014 Part 1 and Part 2 Ongoing Items Carried Forward to 2015-2017

**Legend:**

*Red Text = 2015-2017 State*
***Orange Text = XXX Edits***
*Completed Items*
*New Items or Changed Wording*
*Date Change*
*Magenta Text = 2014 State Benchmarks*

## Benchmark 1 - 2015-2017 Transformation Plan Information

| | Completed | Lead | Action Step | Lead/Participants | Timing | Benchmark or Milestone | Misc. | | | Community Advisory Council (CAC) Reporting | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **BENCHMARK 1** | | | | | | | **Social Determinants of Health Yes/No** | **CHIP Healthy Behaviors/ Living** | **CAC Updated? Yes/No** | **Date CAC Updated** |
| **Benchmark 1** | **BENCHMARK 1**<br>**Developing and implementing a health care delivery model that integrates mental health and physical health care and addictions and dental health, when Dental Services are included. This plan must specifically address the needs of individuals with severe and persistent mental illness.** | | | | | | | | | | |
| | 2015-2017 Benchmark 1 | Bruce Abel | All Members will have access to Providers that have integrated primary care and behavioral health services through co-location, virtual integration, or programmatic alliances. Payment restructuring will be recommended, approved and implemented. | | 31-Jul-17 | How Benchmark will be measured (Baseline to July 31, 2017) | | | | | |
| | 2015-2017 Benchmark 1 Completed | Bruce Abel | A revised model of care will be adopted by the CAP committee that describes program criteria to be contrated with Trillium as an integrated primary care home by 12/31/15. | | January, 2016 | Milestone(s) to be achieved as of July 31, 2016 | | | | | |
| | 2015-2017 Benchmark 1 Completed | Bruce Abel | A revised model of care will be adopted by the CAP committee that describes program criteria to be contrated with Trillium as an behavioral health medical home by 6/30/15. | | January, 2016 | Milestone(s) to be achieved as of July 31, 2016 | | | | | |
| | 2015-2017 Benchmark 1 Completed | Bruce Abel | TCHP complex case care coordinationcommittee will meet weekly for 1 hour. By 1/1/16 TCHP will contract with selected providers for enhanced care coordination through the delivery system to assure appropriate and non-duplicated services with provider communication. | | Jan-16 | Milestone(s) to be achieved as of July 31, 2016 | | | | | |
| | 2015-2017 Benchmark 1 | Bruce Abel | Alternative payment strucutures will be approved by the finance committee. This might include fee-for service enhancements, per member/month payments, or other methodologies. Engage consultant by 7/31/15. Release RFP for programs to implerment altrernative payment approaches by 9/1/15. Incorporate alternative payment approaches in contracts by 1/1/16. | | June, 2016 | Milestone(s) to be achieved as of July 31, 2016 | | | | | |
| | 2015-2017 Benchmark 1 Completed | Bruce Abel | By 1/1/16 contracts will be completed with providers that result in 40% of members assigned to an integrated primary care clinic. | | Jan-17 | Milestone(s) to be achieved as of July 31, 2016 | | | | | |
| | 2015-2017 Benchmark 1 Completed | Bruce Abel | A required component of these contracts will be completion of the SBIRT and other screening tools. | | May-16 | Milestone(s) to be achieved as of July 31, 2016 | | | | | |
| | 2015-2017 Benchmark 1 | Bruce Abel | By 1/1/19 four behavioral health provider contracts will incorporate alternativer payment approaches. | | May-16 | Milestone(s) to be achieved as of July 31, 2016 | | | | | |
| | 2015-2017 Benchmark 1 Completed | Bruce Abel | TCHP will continue to contract with Public Health for prevention services including mental health promoition. By 1/1/16 TCHP will contract for additional primary prevention and wellness services. | | Jan-16 | Milestone(s) to be achieved as of July 31, 2016 | | | | | |
| | 2015-2017 Benchmark 1 Completed | Bruce Abel | Mid-course review and adjustment to models of care are completed. | | Jul-16 | Benchmark to be achieved as of July 31, 2017 | | | | | |
| | 2015-2017 Benchmark 1 | Bruce Abel | Alternative payment strucutures are refined and expanded. | | Jan-17 | Benchmark to be achieved as of July 31, 2017 | | | | | |
| | 2015-2017 Benchmark 1 | Bruce Abel | Contracts will be completed with providers that result in 60% of members assigned to an integrated clinic using alternative payment approaches. | | Jan-18 | Benchmark to be achieved as of July 31, 2017 | | | | | |

## Benchmark 2 - 2015-2017 Transformation Plan Information

| | Completed | Lead | Action Step | Lead/Participants | Timing | Benchmark or Milestone | Misc. | | | Community Advisory Council (CAC) Reporting | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **BENCHMARK 2** | | | | | | | Social Determinants of Health Yes/No | CHIP Healthy Behaviors/ Living | CAC Updated? Yes/No | Date CAC Updated |
| **Benchmark 2** | **Continuing implementation and development of Patient-Centered Primary Care Home (PCPCH).** | | | | | | | | | | |
| | 2015-2017 Benchmark 2 | TBD | Provider Panel will be assessed for the number of Primary Care Provider (PCP's) practicing in a recognized PCPCH. | | | How Benchmark will be measured (Baseline to July 31, 2017) | | | | | |
| | 2015-2017 Benchmark 2 | TBD | 65% of plan PCP's practicing in facilities eligibile to be a PCPCH will be practicing in a recognized PCPCH. | | | Milestone(s) to be achieved as of July 31, 2016 | | | | | |
| | 2015-2017 Benchmark 2 | TBD | >85% of plan PCP's practicing in facilities eligibile to be a PCPCH will be practicing in a recognized PCPCH | | | Benchmark to be achieved as of July 31, 2017 | | | | | |

## Benchmark 2 2014 Part 1 Ongoing Items Carried Forward to 2015-2017

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|---|---|---|---|---|---|---|---|---|---|---|---|
| **Part 1** | **TC1-2.A:** *Develop and implement a technical assistance program to assist the CCO's PCPs in becoming Tier 3 PCPCHs.* | | | | | | | | | | |
| | Benchmark 2 | TBD | 2. Determine the current percentage of PCPs that are recognized by OHA as Tier 1, Tier 2, and Tier 3 PCPCHs. Provider panel will be assessed for number of PCP's practicing in a recognized PCPCH. | Trillium Medical Mgmt and Analytics Staff | Q3 2013 | How Benchmark will be measured (Baseline to July 1, 2015) | | | | | |
| **TC1-2A** | Benchmark 2 | TBD | 3. 65% of plan PCPs practicing in facilities eligibile to be a PCPCH will be practicing in a recognized PCPCH. | Trillium Medical Management and Analytics Staff | Q2 2016 | | | | | | |
| | Benchmark 2 | TBD | 4. >85% of plan PCPs practicing in facilities eligibile to be a PCPCH will be practicing in a recognized PCPCH. | Trillium Medical Management and Analytics Staff | Q2 2017 | | | | | | |
| | Completed | TBD | 6. Identify a schedule for provider group achievement of Tier 3 PCPCH status for 100% of their providers. | PCPCH Subcommittee of the Clinical Advisory Panel with support from staff | Q4 2013 | | | | | | |
| | Completed | TBD | 8. Based on the survey results, offer targeted assistance to each provider group to achieve highest Tier possible for that group. | PCPCH Subcommittee of the Clinical Advisory Panel | Q4 2013 | | | | | | |

## Benchmark 3 - 2015-2017 Transformation Plan Information

| | Completed | Lead | Action Step | Lead/Participants | Timing | Benchmark or Milestone | Misc. | | | Community Advisory Council (CAC) Reporting | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **BENCHMARK 3** | | | | | | | Social Determinants of Health Yes/No | CHIP Healthy Behaviors/ Living | CAC Updated? Yes/No | Date CAC Updated |
| | **Implementing consistent Alternative Payment Methodologies that align payment with health outcomes.** | | | | | | | | | | |
| | **NOTE: Benchmark 3 ties into Trillium's 2015-2018 STRATEGIC PLAN - *Alternative Payment Methodologies:*** ***Trillium work work to broaden the use of alternate payment moeles, with the goal of increasing positive health outcomes for emmbers while reducing healthcare costs.*** | | | | | | | **2015-2018 Strategic Plan *Alternative Payment Methodolgies*** | | | |
| **Benchmark 3** | 2015-2017 Benchmark 3 | Todd Graneto | Reduction in the PMPM amount paid to ER physicians by at least 2% while also reducing visits to the ER when measured by visits/1,000 Members. Baseline and method of calculation to be determined and mutually agreed upon by OHA and Contractor. | | | How Benchmark will be measured (Baseline to July 31, 2017) | | | | | |
| | 2015-2017 Benchmark 3 | Todd Graneto | PCP groups that reduce the number of ER visits/1,000 Members by at least 2% will receive a bonus payment. Baseline and method of calculation to be determined and mutually agreed upon by OHA and Contractor. | | | How Benchmark will be measured (Baseline to July 31, 2017) | | | | | |
| | 2015-2017 Benchmark 3 | Todd Graneto | Determination that, out of the 100% paid to behavioral health Providers, 30% (by dollar amount) was paid using the case rate methodology. | | | How Benchmark will be measured (Baseline to July 31, 2017) | | | | | |
| | 2015-2017 Benchmark 3 | Todd Graneto | Capitation arrangement with ER physicians. | | | Milestone(s) to be achieved as of July 31, 2016 | | | | | |
| | 2015-2017 Benchmark 3 | Todd Graneto | Methodology established for providing Bonus payments to PCP groups that reduce ER visits. | | | Milestone(s) to be achieved as of July 31, 2016 | | | | | |
| | 2015-2017 Benchmark 3 | Todd Graneto | Case rates for behavioral health Providers. | | | Milestone(s) to be achieved as of July 31, 2016 | | | | | |
| | 2015-2017 Benchmark 3 | Todd Graneto | Trillium continues to work on Alternative Payment Methodologies in all parts of our Health Care Network. We have successfully completed two of our milestones for the July 31, 2016 timeline. We have capitation arrangements with both hospital systems ER physicians and they also continue to participate in our risk pools. We continue to work with the local PCP groups to determine an equitable bonus program for those groups that reduce ER visits, but have yet to find a method that works with all the groups. Currently one of large Behavioral Health providers works under a Case Rate, which has proven administratively effective for both the provider and the Health Plan, we hope to have enough utilization data soon so the appropriate analysis can occur. Along with this we are about to start our second year of our BH/Primary Care Integration, which includes an alternative payment component, again we hope to have enough utilization data soon so that appropriate analysis can occur. | | | Milestone(s) to be achieved as of July 31, 2016 | | | | | |
| | 2015-2017 Benchmark 3 | Todd Graneto | Transformation Area 3: Alternative Payment Methods:<br>It was noted in the Trillium specific section that more detail on the PMPM payments was needed. One of the groups is currently paid a capitation while the other is paid a using Case Rates. As mentioned above both groups continue to participate in the Risk program for Trillium. | | | Milestone(s) to be achieved as of July 31, 2016 | | | | | |
| | 2015-2017 Benchmark 3 | Todd Graneto | Reduction in the amount paid to and the services provided by ER physicians. | | | Benchmark to be achieved as of July 31, 2017 | | | | | |
| | 2015-2017 Benchmark 3 | Todd Graneto | Reduction in the number of ER visits/1,000 Members by at least 2%. Baseline to be determined and mutually agreed upon by OHA and Contractor. | | | Benchmark to be achieved as of July 31, 2017 | | | | | |
| | 2015-2017 Benchmark 3 | Todd Graneto | 30% (by dollar amount) of payments made to behavioral health Providers will be through case rates. | | | Benchmark to be achieved as of July 31, 2017 | | | | | |

Part 1

## Benchmark 3 — 2014 Part 1 Ongoing Items Carried Forward to 2015-2017

| | Completed | Lead | Action Step | Lead/Participants | Timing | Benchmark or Milestone | Misc. | Social Determinants of Health Yes/No | CHIP Healthy Behaviors/ Living | Community Advisory Council (CAC) Reporting: CAC Updated? Yes/No | Community Advisory Council (CAC) Reporting: Date CAC Updated |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Alternative Payment Methods (IS1)** | | | | | | | | | | | |
| **IS1** | | | | | | | | | | | |
| IS1 | | Todd Graneto | 1. Analysis of the OHA CCO Incentives Workgroup efforts as they unfold. | Trillium Finance Committee | Ongoing | | | | | | |
| IS1 | In Process | Todd Graneto | 4. Analysis of the effectiveness of the primary care and specialty care payment reforms. | Trillium Quality Management Staff and Committee | Q1– Q2 2013 | | | | | | |
| IS1 | In Process | Todd Graneto | 5. Research on best practice alternative payment models for mental health, chemical dependency and other sectors of the delivery system. | Trillium Finance Committee and Staff | Q1 – Q2 2013 | | | | | | |
| IS1 | In Process | Todd Graneto | 6. Development of a phased implementation plan for alternative payment models and shared savings model enhancements. | Trillium Finance Committee and Staff | Q3 2013 | | | | | | |
| IS1 | | Todd Graneto | 7. Begin phased implementation of additional new approaches. | Trillium Finance Staff and Provider Network | Q1 2014 | | | | | | |
| IS1 | Benchmark 3 | Todd Graneto | 8. Reduce the amount paid to ER physicians by at least 2% while also reducing visits to the ER when measured by visits/1,000 members. | | Q3 2015 | How Benchmark will be measured, Baseline to July 1, 2015 | | | | | |
| IS1 | Benchmark 3 | Todd Graneto | 9. PCP groups that reduce the number of ER visits/1,000 members by at least 2% will receive a bonus payment. | | Q3 2015 | How Benchmark will be measured, Baseline to July 1, 2015 | | | | | |
| IS1 | Benchmark 3 | Todd Graneto | 10. Determine out of the 100% paid to Behavioral Health Providers that 30% was paid using the Case Rate Methodology. | | Q3 2015 | How Benchmark will be measured, Baseline to July 1, 2015 | | | | | |
| IS1 | Benchmark 3 | Todd Graneto | 11. Capitation arrangement with Emergency Room Physicians | | Q1 2014 | Benchmark Milestone to be achieved by July 1, 2014 | | | | | |
| IS1 | Benchmark 3 | Todd Graneto | 12. Methodology established for providing Bonus payments to PCP groups that reduce ER visits. | | Q1 2014 | Benchmark Milestone to be achieved by July 1, 2014 | | | | | |
| IS1 | Benchmark 3 | Todd Graneto | 13. Case Rates for Behavioral Health Providers. | | Q1 2014 | Benchmark Milestone to be achieved by July 1, 2014 | | | | | |
| IS1 | Benchmark 3 | Todd Graneto | 14. Reduction in the amount paid to and the services provided by Emergency Room Physicians. | | Q3 2015 | Benchmark to be achieved by July 1, 2015. | | | | | |
| IS1 | Benchmark 3 | Todd Graneto | 15. Reduction in the amount of ER visits by at least 2%. | | Q3 2015 | Benchmark to be achieved by July 1, 2015. | | | | | |
| IS1 | Benchmark 3 | Todd Graneto | 16. 30% of payments made to Behavioral Health Providers will be through Case Rates. | | Q3 2015 | Benchmark to be achieved by July 1, 2015. | | | | | |

## Benchmark 4 - 2015-2017 Transformation Plan Information

| | Completed | Lead | Action Step | Lead/Participants | Timing | Benchmark or Milestone | Misc. | | | Community Advisory Council (CAC) Reporting | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **BENCHMARK 4** | | | | | | | **Social Determinants of Health Yes/No** | **CHIP Healthy Behaviors/ Living** | **CAC Updated? Yes/No** | **Date CAC Updated** |
| **Benchmark 4** | **Preparing a strategy for developing Contractor's Community Health Assessment and adopting an annual Community Health Improvement Plan consistent with ORS 414.627.** | | | | | | | | | | |
| | 2015 Benchmark 4 | Karen Gaffney | Adoption and distribution of collaborative Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) by Contractor Board, Lane County Public Health, and PeaceHealth/Sacred Heart Medical Centers. Contractor adoption as documented by Board of Directors minutes. | | | How Benchmark will be measured (Baseline to July 31, 2017) | | | | | |
| | 2015 Benchmark 4 | Karen Gaffney | Adoption of collaborative CHA/CHIP in 2016 by Contractor Board of Directors, Lane County Public Health, and PeaceHealth/Sacred Heart Medical Centers. Contractor adoption as documented by Board of Directors minutes. | | | Milestone(s) to be achieved as of July 31, 2016 | | | | | |
| | 2015 Benchmark 4 | Karen Gaffney | Adoption of collaborative CHA/CHIP by Contractor Board of Directors, Lane County Public Health, and PeaceHealth/Sacred Heart Medical Centers. Contractor adoption as documented by Board of Directors minutes. | | | Benchmark to be achieved as of July 31, 2017 | | | | | |

## Part 1

### Benchmark 4 2014 Part 1 Ongoing Items Carried Forward to 2015-2017

| | **Community Health Assessment (SP1)** | | | | | | | | | | |
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| | **SP1-A:** *Using the Mobilizing for Action through Planning and Partnership (MAPP) process, complete and publish a comprehensive Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) by June 2013 in collaboration with Lane County Public Health, PeaceHealth/Sacred Heart Medical Center and others.* | | | | | | | | | | |
| **SP1** | Completed | Karen Gaffney | 7. Engage partners and community about the findings of CHA and the elements in CHIP. | CAC | Q3 2013 Ongoing | | | | | | |
| | Completed | Karen Gaffney | 8. Monitor progress on CHIP and report to community. | CAC | Q2 2014; Q2 2015 | | | | | | |
| | Completed | Karen Gaffney | 9. Conduct new CHA/CHIP process. | CAC, Sacred Heart Lane County Public Health and others | Complete Q2 2016 | | | | | | |

## Benchmark 5 - 2015-2017 Transformation Plan Information

| | Completed | Lead | Action Step | Lead/Participants | Timing | Benchmark or Milestone | Misc. | Social Determinants of Health Yes/No | CHIP Healthy Behaviors/ Living | Community Advisory Council (CAC) Reporting: CAC Updated? Yes/No | Community Advisory Council (CAC) Reporting: Date CAC Updated |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Benchmark 5 | **BENCHMARK 5** | | | | | | | | | | |
| | **Developing a plan for encouraging Electronic Health Records; health information exchange; and meaningful use.** | | | | | | | | | | |
| | 2015-2017 Benchmark 5 | TBD | Baseline- In January 2013 there was no shared care plan system.<br><br>Measuring Benchmark- Measurement will be verifying a care plan system is operating and linking the different actors specified. | | | How Benchmark will be measured (Baseline to July 31, 2017) | | | | | |
| | 2015-2017 Benchmark 5 | TBD | Shared care plan system (Pre-Manage) links >80% Contractor, contracted PCPCHs and behavioral health Providers | | | Milestone(s) to be achieved as of August 1, 2016 | | | | | |
| | 2015-2017 Benchmark 5 | TBD | Shared care plan system links 100% Contractor, contracted PCPCHs, behavioral health Providers, specialists, community health workers, and selected social service agencies. | | | Benchmark to be achieved as of December 1, 2016 | | | | | |

## Benchmark 5 2014 Part 1 Ongoing Items Carried Forward to 2015-2017

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|---|---|---|---|---|---|---|---|---|---|---|---|
| Part 1 | **Smart HIE (IS2)** | | | | | | | | | | |
| | **IS2-1.C:** *Refine the shared care plan by customizing views and adding additional user types.* | | | | | | | | | | |
| | | TBD | 1. Trillium/Centene IT, Vendor | | Q2 2016 | | | | | | |
| | | TBD | 2. Develop case management workflows. | | Q2 2016 | | | | | | |
| | | TBD | 3. Begin providing eligibility and plan information to vendor. | Trillium/Centene Implementation Team<br>CMT Implementation Team | Q3 2016 | | | | | | |
| | | TBD | 4. Vendor interfaces data with clinical management platform (TruCare). | Trillium/Centene Implementation Team<br>CMT Implementation Team | Q3 2016 | | | | | | |
| | IS2-1C Benchmark 5 | TBD | 5. PreManage links Trillium, contracted PCPCHs and behavioral health providers. (This task was updated in 2016 and doesn't reflect original 2014 benchmark.) | Trillium/Centene Implementation Team<br>CMT Implementation Team | Q3 2016 | Trillium, Centene IT, Vendor, External staff | Benchmark Milestone to be achieved as of August 1, 2016 | | | | |
| | | TBD | 6. Train Medical Management staff on Smart HIE | Trillium/Centene Implementation Team<br>CMT Implementation Team | Q2 2016 | Trillium/Centene IT, Vendor | | | | | |
| | Benchmark 5 | TBD | 7. PreManage links Trillium,contracted PCPCHs, behavioral health providers, specialists, community health workers, and selected social service agencies. | Trillium/Centene Implementation Team<br>CMT Implementation Team | Q4 2016 | Trillium, Centene IT, Vendor, External staff | Benchmark to be achieved as of Dec. 1, 2016 | | | | |

## Benchmark 5 — 2014 Part 1 Ongoing Items Carried Forward to 2015-2017

Part 1

| | Completed | Lead | Action Step | Lead/Participants | Timing | Benchmark or Milestone | Misc. | Social Determinants of Health Yes/No | CHIP Healthy Behaviors/ Living | Community Advisory Council (CAC) Reporting: CAC Updated? Yes/No | Community Advisory Council (CAC) Reporting: Date CAC Updated |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **IS2-1D** | **IS2-1.D:** *Implement the Smart HIE, feeding the shared care plan from the HIE.* | | | | | | | | | | |
| | | TBD | 1. Identify needs /develop technical designs. | CTC Project Manager<br>CTC Implementation Team | Q1 2014<br>Ongoing | Trillium, Vendor, External staff | IT | | | | |
| | | TBD | 2. Financial implications. | CTC Project Manager<br>CTC Implementation Team | Q1 2014 | | | | | | |
| | | TBD | 3. Develop project implementation and oversight plan. | CTC Project Manager<br>CTC Implementation Team | Q2 2014<br>Ongoing | Trillium, Vendor, External staff | IT | | | | |
| | | TBD | 4. Implement | CTC Project Manager<br>CTC Implementation Team | Q3 2014<br>Ongoing | | IT | | | | |

Part 1

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|---|---|---|---|---|---|---|---|---|---|---|---|
| **IS2-2A** | **IS2-2.A:** *Engage members in the use of the shared care plan.* | | | | | | | | | | |
| | In Process | TBD | 1. Develop engagement stratgegy inlcuding promotional materials. | Trillium/Centene Implementation Team<br>Jim Connolly | Q2 2016 | Trillium staff, Vendor | IT | | | | |
| | In Process | TBD | 2. Develop web based and hard copy training materials and help desk. | Trillium/Centene Implementation Team<br>Jim Connolly | Q1 2016 | Trillium staff, Vendor | IT | | | | |
| | | TBD | 3. Identifify and train contracted PCPCHs, behavioral health providers, specialists, community health workers, and selected social service agencies. | Trillium/Centene Implementation Team<br>Jim Connolly | Q2-Q3 2016 | | IT | | | | |
| | | TBD | 4. Follow-up with providers and agencies to identify concerns with use. | Trillium/Centene Implementation Team<br>Jim Connolly | Q4 2016-Q1 2017 | | IT | | | | |

## 2014 Part 1 COMPLETED and Ongoing

Part 1

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|---|---|---|---|---|---|---|---|---|---|---|---|
| **IS3** | **Performance Measurement (IS3)** | | | | | | | | | | |
| | Completed | Patrice Korjenek | 8. Create and submit required reports. | Performance Officer | Q2 2013<br>Ongoing | | | | | | |
| | Completed | Patrice Korjenek | 9. Analyze performance reports (as appropriate, by provider association.) | Performance Officer | Q2 2013<br>Ongoing | | | | | | |
| | Completed | Patrice Korjenek | 10. Share analysis with the CCO Board, management, employees, CAC, CAP, Quality, PCPCH committees and others as appropriate. | Performance Officer | Q2 2013<br>Ongoing | | | | | | |
| | Completed | Patrice Korjenek | 11. Conduct further data inquiries related to performance as requested. | Performance Officer | Q2 2013<br>Ongoing | | | | | | |
| | Completed | Patrice Korjenek | 12. Incorporate performance findings into improvement activities. | Performance Officer | Q2 2013<br>Ongoing | | | | | | |

## Benchmark 6 — 2015-2017 Transformation Plan Information

| | Completed | Lead | Action Step | Lead/Participants | Timing | Benchmark or Milestone | Misc. | Social Determinants of Health Yes/No | CHIP Healthy Behaviors/ Living | Community Advisory Council (CAC) Reporting: CAC Updated? Yes/No | Community Advisory Council (CAC) Reporting: Date CAC Updated |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Benchmark 6 | **BENCHMARK 6** | | | | | | | | | | |
| | **Assuring communications, outreach, Member engagement, and services are tailored to cultural, health literacy, and linguisitic needs.** | | | | | | | | | | |
| | 2015-2017 Benchmark 6 | Lucy Zammarelli | Assuring member communications, outreach, engagement, and services are tailored to a culturally diverse membership and are appropriate for health literacy and linguistic needs. Percentage of Contractor Member materials and outreach efforts (telephone, print, web based) are available in formats for whom English is not their primary language, and with low literacy levels. | | | How Benchmark will be measured (Baseline to July 31, 2017) | | | | | |
| | 2015-2017 Benchmark 6 Completed | Lucy Zammarelli | Contractor Member materials and outreach efforts are continually assessed for language and literacy appropriateness, including concept of Plain Language review and any necessary improvement plans are implemented in order to achieve Benchmark. | | | Milestone(s) to be achieved as of July 31, 2016 | | | | | |
| | 2015-2017 Benchmark 6 | Lucy Zammarelli | 90% of Contractor communications and outreach materials are available in formats appropriate for a culturally diverse membership for whom English is not their primary language, and for those with low literacy levels. | | | Benchmark to be achieved as of July 31, 2017 | | | | | |

## Benchmark 6 — 2014 Part 1 Ongoing Items Carried Forward to 2015-2017

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| Part 1 | SP2-1 | **Cultural Competence and Disparities (SP2)** | | | | | | | | | |
| | | **SP2-1**: *Develop and implement professional development for CCO service providers on culturally competent care.* | | | | | | | | | |
| | | | Lucy Zammarelli | 3. Select evidence-based clinical practice guidelines to shape the delivery system to eliminate disparities relating to race, ethnicity, language, socio-economic status, and services to people with disabilities. | Clinical Advisory Panel | Q1 2015 | | | | | |
| | | | Lucy Zammarelli | 4. Work with the CAP, CAC ad CHIP Health Equity. | CAP, CAC<br>United Way's 100% | Ongoing | | | | | |
| | | | Lucy Zammarelli | 5. Integrate cultural competence improvement and issues of Health Equity into Trillium Operations. | Lucy Z. | Ongoing | | | | | |
| | | | Lucy Zammarelli | 6. Develop a recruitment plan for the CCO service delivery system to address disparities between the workforce and member population. | Equity Lead Staff<br>Clinical Advisory Panel<br>Community Advisory Council | Q4 2014 | | | | | |
| | | Benchmark 7 | Lucy Zammarelli | 7. Percentage of Trillium members who report that service providers respected their cultural values, language, and literacy needs. | | Q2 2015 | How Benchmark will be achieved by Q2 2015 | | | | |
| | | Benchmark 7 | Lucy Zammarelli | 8. Percentage of over/under representation of gender and cultural/language diversity of staff at the provider, mid-level, support, front office, and community health worker population in Lane County. | | Q2 2015 | How Benchmark will be achieved by Q2 2015 | | | | |
| | | Benchmark 7 | Lucy Zammarelli | 9. Reduce percentage of under representation of gender and cultural/ language diversity of staff at the provider and front office role by 25%. | | Q2 2015 | Benchmark to be achieved by July 1, 2015 | | | | |
| Part 1 | SP2-2 | **SP2-2:** *Assess needs and implement improvement plan for cultural competence, linguistic appropriateness, and health literacy of CCO communications and outreach strategies.* | | | | | | | | | |
| | | Benchmark 6 | Lucy Z.<br>Shannon<br>Debi | 1. Complete assessment of Trillium member materials and outreach efforts (web based, telephone, print materials, etc.) for cultural, linguistic, and literacy appropriateness. | Equity lead staff, Public Relations Director | Q1 2013 and Ongoing | | | | | |
| | | Benchmark 6 | Lucy Z.<br>Shannon<br>Debi | 2. Based on above assessment, implement any necessary improvement plans in order to achieve benchmark. Revise and replace materials and outreach strategies as necessary. | Health Equity Officer<br>Public Relations Director | Q2 2013 and ongoing | Benchmark Milestone to be achieved as of July 1, 2014 | | | | |
| | | | Lucy Z.<br>Shannon<br>Debi | 3. Work with providers to assess their communications and materials, and improve as necessary. | Clinical Advisory Panel<br>Health Equity Officer<br>Public Relations Director | Q4 2013 and ongoing | | | | | |
| | | | Lucy Z.<br>Shannon<br>Debi | 4. Utilize periodic member survey, Community Health Worker, and other community feedback for continuous quality improvement of materials. | Health Equity Officer | Q4 2013 and ongoing | | | | | |
| | | Benchmark 6 | Lucy Z.<br>Shannon<br>Debi | 5. Percentage of TCHP member materials and outreach efforts (web based, telephone, print) are available in formats appropriate for members for whom English is not their preferred language, and for those with low literacy levels. | Health Equity Officer<br>Public Relations Director | Q4 2013 and ongoing | How Benchmark will be measured (Baseline to July 1, 2015) | | | | |
| | | Benchmark 6 | Lucy Z.<br>Shannon<br>Debi | 6. 90% of Trillium communications and outreach materials are available in formats appropriate for members for whom English is not their preferred language, and for those with low literacy levels. | Health Equity Officer<br>Public Relations Director | Q4 2013 and ongoing | Benchmark to be achieved by July 1, 2015 | | | | |

## Benchmark 7 — 2015-2017 Transformation Plan Information

| | Completed | Lead | Action Step | Lead/Participants | Timing | Benchmark or Milestone | Misc. | | | Community Advisory Council (CAC) Reporting | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **BENCHMARK 7** | | | | | | | Social Determinants of Health Yes/No | CHIP Healthy Behaviors/ Living | CAC Updated? Yes/No | Date CAC Updated |
| **Benchmark 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 reflects Member diversity).** | | | | | | | | | | |
| | 2015-2017 Benchmark 7 | Lucy Zammarelli | Percentage of Members who report satisfaction with how their cultural values, language, and literacy needs were met.<br><br>Percentage of over/under representation of gender and cultural/language diversity of staff by the CCO and contracted providers. | | | How Benchmark will be measured (Baseline to July 31, 2017) | | | | | |
| | 2015-2017 Benchmark 7 Completed | Lucy Zammarelli | Complete re-assessment of contracted provider system to determine progress with increased provider staff diversity and cultural competency training standards. | | | Milestone(s) to be achieved as of July 31, 2016 | | | | | |
| | 2015-2017 Benchmark 7 | Lucy Zammarelli | Increase the percentage of members who report satisfaction with how their cultural values, language, and literacy needs were met.<br><br>Reduce percentage of under-representation of gender and cultural/language diversity of staff at the CCO, provider and front-office role by 25%. Method of calculation to be determined and mutually agreed upon by OHA and Contractor. | | | Benchmark to be achieved as of July 31, 2017 | | | | | |

## Benchmark 7 — 2014 Part 1 Ongoing Items Carried Forward to 2015-2017

**Part 1**

**SP2-3A**

**Cultural Competence and Disparities (SP2)**

**SP2-3A:** *Analyze outcome data from the Community Health Assessment to identify disparities in access, quality of care and health outcomes related to race, ethnicity, language, socio-economic status, and*

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Benchmark 8 | Karen Gaffney | 2. Develop recommendations regarding methods the CCO could use to address the disparities related to ACA conditions identified in the assessment. | Community Advisory Council | Q3 2013 | | | | | | |

## Benchmark 8 — 2015-2017 Transformation Plan Information

| | | | | | | | | | | CAC Updated? Yes/No | Date CAC Updated |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **BENCHMARK 8** | | | | | | | | | | |
| **Benchmark 8** | **Developing a quality improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes.** | | | | | | | | | | |
| | 2015-2017 Benchmark 8 | Lucy Zammarelli | Reduction of identified racial/ethnic disparities in Affordable Care Act (ACA) conditions. Method of calculation to be determined and mutually agreed upon by OHA and Contractor. | | | How Benchmark will be measured (Baseline to July 31, 2017 | | | | | |
| | 2015-2017 Benchmark 8 | Lucy Zammarelli | Complete re-analysis and identification of disparities related to ACA conditions and development of priority improvement plans. | | | Milestone(s) to be achieved as of July 31, 2016 | | | | | |
| | 2015-2017 Benchmark 8 | Lucy Zammarelli | Reduction by 30% of disparities identified as priority for improvement. Method of calculation to be determined and mutually agreed upon by OHA and Contractor. | | | Benchmark to be achieved as of July 31, 2017 | | | | | |

## Benchmark 8 — 2014 Part 1 Ongoing Items Carried Forward to 2015-2017

**Part 1**

**SP2-3B**

**SP2-3B**: *Identify and implement evidence-based practices that address the priority disparities identified by the Community Health Assessment and Community Health Improvement Plan.*

| | | | | | | | | Social Determinants of Health Yes/No | CHIP Health Behaviors/ Living | CAC Updated? Yes/No | Date CAC Updated |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Lucy Zammarelli<br>Debi Farr | 2. Design and deliver education presentations for sevice provider offices on Health Disparities and responsiveness. | Lucy Z, Trillium University | Q2 2015 and ongoing | | | | | | |
| | Benchmark 8 | Lucy Zammarelli | 3. Reduction of identified racial/ethnic disparities in ACA conditions. | How Benchmark will be measured (Baseline to July 1, 2015) | | | | | | | |
| | Benchmark 8 | Lucy Zammarelli | 4 Reduction by 30% of disparities identified as priority for improvement. | Benchmark to be achieved as of July 1, 2015. | | | | | | | |

## 2014 Part 2 Items Carried Forward to 2015-2017
## Updated with December 21, 2015 Revisions

### Benchmark 9-2

| | | Completed | Lead | Action Step | Lead/Participants | Timing | Benchmark or Milestone | Misc. | Social Determinants of Health Yes/No | CHIP Healthy Behaviors/ Living | Community Advisory Council (CAC) Reporting: CAC Updated? Yes/No | Community Advisory Council (CAC) Reporting: Date CAC Updated |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Benchmark 9-2 | | **Primary Prevention (TC3)** | | | | | | | | | | |
| | TC3-1A | **TC3-1.A** *Develop and implement an evidence-based strategy to address tobacco reduction among pregnant women.* | | | | | | | | | | |
| | | Completed | Karen Gaffney | 2. Implement with fidelity, including incentives for participation for all eligible beneficiaries. | Clinical Advisory Panel<br>Prevention Staff | Q3 2013<br>Ongoing | | | | | | |
| | | **TC3-1.B** *Develop and implement an evidence-based strategy to address tobacco reduction among members with behavioral health issues.* | | | | | | | | | | |
| | | Completed | Karen Gaffney | 2. Implement with fidelity, including incentives for participation for all eligible beneficiaries. | Clinical Advisory Panel | Q4 2014<br>Ongoing | | | | | | |
| | | **TC3-1.C:** *Create a tobacco-free campus initiative.* | | | | | | | | | | |
| | | | Karen Gaffney | 1. Assess current tobacco use policies for all Trillium facilities and contractors. | Prevention Staff | Q2 2014 | | | | | | |
| | | | Karen Gaffney | 3. Work with providers and other contractors on implementation of model policy. | Prevention Staff | Q4 2014<br>Ongoing | | | | | | |
| | TC3-2A | **TC3-2.A:** *Develop a comprehensive immunization strategy for OHP Members.* | | | | | | | | | | |
| | | Completed | Karen Gaffney | 3. Based on assessment, implement communication and other strategies to engage Trillium beneficiaries. | Prevention Staff | Q3-4 2013<br>Ongoing | | | | | | |
| | TC3-3A | **TC3-3.A:** *Develop a comprehensive obesity reduction strategy for OHP Members.* | | | | | | | | | | |
| | | | Karen Gaffney | 1. Assess current availability and use of BMI data and tracking across providers. | Prevention Staff<br>Clinical Advisory Panel<br>Community Advisory Council | Q2 2014 | | | | | | |
| | | Completed | Karen Gaffney | 2. Engage community partners in planning for implementation of EBP targeted at childhood obesity in specific communities with large percentage of Trillium beneficiaries. | Prevention Staff<br>Community Advisory Council | Q3 2013<br>Ongoing | | | | | | |
| | TC3-4A | **TC3-4.A:** *Complete a data-informed prevention plan for years 2-5.* | | | | | | | | | | |
| | | **NOTE: TC3-4A ties into Trillium's 2015-2018 STRATEGIC PLAN - *Primary Prevention & Wellness***<br>**Trillum will work to leverage Trillium Behavioral Health, legislative resources, technology, community partners, public health and marketing to drive changes in member and provider behavior (prevention).** | | | | | | | **2015-2018 Strategic Plan**<br>***Primary Prevention & Wellness*** | | | |
| | | Completed | Karen Gaffney | 3. Based on the data and a literature review, identify evidence-based strategies at the policy, system, and individual level to address CHIP. | Community Advisory Council | Q3-4 2013<br>Ongoing | | | | | | |
| | | | Karen Gaffney | 4. Develop targets and data collection methods for each of the identified strategies. | Community Advisory Council | Q3-4 2014<br>Ongoing | | | | | | |
| | TC3-5 | **TC3-5:** Identify and implement evidence-based programs to reduce incidence of specific priority conditions identified with speciality providers. | | | | | | | | | | |
| | | Completed | Karen Gaffney | 1. Work with Clinical Advisory Panel to review data and identify priority opportunities for prevention with specialty providers. | Prevention Staff<br>Clinical Advisory Panel | Q2 2013<br>Ongoing | | | | | | |
| | | Completed | Karen Gaffney | 2. Identify evidence-based program to target identified condition/issues. | Prevention Staff<br>Clinical Advisory Panel | Q3 2013<br>Ongoing | | | | | | |
| | | | Karen Gaffney | 3. Implement selected evidence-based program. | Prevention Staff<br>Providers | Begin Q4 2013<br>Ongoing | | | | | | |
| | | Completed | Karen Gaffney | 4. Gather data on effectiveness, revise as appropriate. | Prevention Staff<br>Providers, Performance Officer | Begin Q4 2013<br>Ongoing | | | | | | |

## Benchmark 10-2

| | | Completed | Lead | Action Step | Lead/Participants | Timing | Benchmark or Milestone | Misc. | Social Determinants of Health Yes/No | CHIP Healthy Behaviors/ Living | Community Advisory Council (CAC) Reporting: CAC Updated? Yes/No | Community Advisory Council (CAC) Reporting: Date CAC Updated |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Benchmark 10-2 | | **Comprehensive Care Coordination Plan (TC4)** | | | | | | | | | | |
| | | **TC4-1A:** *Design and implement an integrated care management design by December 2012, centered on coordinated intake, a unified assessment, and a shared care plan, supported by a combination of centralized care management staff and a community-based, multi-disciplinary workforce.* | | | | | | | | | | |
| | TC4-A | **NOTE: TC4-1A ties into Trillium's 2015-2018 STRATEGIC PLAN - *Comprehensive Care Coordination* :** ***Trillium will work to expand and refine comprehensive coordination of care to meet member's care needs. This plan will include prioritized aspects of health built on a robust IT infrastructure and will be developed in coordination with care providers and members.*** | | | | | | | **2015-2018 Strategic Plan** ***Comprehensive Care Coordination*** | | | |
| | | Completed | Lucy Zammarelli | 12. Roll-out of Phase 2 of the Care Coordination Plan. | Quality Management and CTC Implementation Team | Q1 2015 Completed | | | | | | |
| | | | Lucy Zammarelli | 13. Continued monitoring and adjusting of the design, staffing needs, goals and implementation. | Quality Management and CTC Implementation Team | Ongoing | | | | | | |

## Benchmark 11-2

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Benchmark 11-2 | | **Behavioral Health System Improvements (TC5)** | | | | | | | | | | |
| | | **TC5-1.A:** *Implement Mental Health/Substance Use (MH/SU) Integration Strategies.* | | | | | | | | | | |
| | TC5-1A | **Ongoing** | Bruce Abel | 3.Identify consulting resources, develop an integrated MH/SU Program Change Package and a Rapid Cycle Improvement curriculum package. | Steering Committee | **Ongoing** | | | | | | |
| | | | Bruce Abel | 6. Develop an integrated assessment, authorization, treatment, and documentation for MH/SA treatment. | | Q3 2016 | | | | | | |
| | | **TC5-3 A:** *Implement Treat to Target in Behavioral Health Provider Organizations.* | | | | | | | | | | |
| | TC5-3A | | Bruce Abel | 7. Review Treat to Target. | Treat to Target Steering Committee | Ongoing | | | | | | |
| | | **TC5-4.A:** *Implement Integrated Care Management in Behavioral Health Provider Organizations.* | | | | | | | | | | |
| | TC5-4A | **Completed** | Bruce Abel | 1. Develop a Certified Community Behavioral Health Clinic Learning Community. | Bruce Abel | Q1 2016 | | | | | | |
| | | | Bruce Abel | 2. Develop a Certified Community Behavioral Health Clinic Work Plan that will help clinics meet state criteria for certification. | Integrated Care Management Steering Committee | **Ongoing** | | | | | | |
| | | | Bruce Abel | 3. Identify consulting resources, develop a Certified Community Behavioral Health Clinic development plan. | Integrated Care Management Steering Committee | **Ongoing** | | | | | | |
| | | **Completed** | Bruce Abel | 4. Enlist participants for the Certified Community Behavioral Health Clinic Learning Community. | Integrated Care Management Steering Committee | Q1 2016 | | | | | | |
| | | | Bruce Abel | 5. State Certifies Community Behavioral Health Clinics. | Integrated Care Management Steering Committee and Teams | Q4 2016 | | | | | | |

## Benchmark 11-2 *(Continued)*

| | | Completed | Lead | Action Step | Lead/Participants | Timing | Benchmark or Milestone | Misc. | Social Determinants of Health Yes/No | CHIP Healthy Behaviors/ Living | Community Advisory Council (CAC) Reporting: CAC Updated? Yes/No | Community Advisory Council (CAC) Reporting: Date CAC Updated |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Benchmark 11-2 | **Social Determinants of Health (TC6)** | | | | | | | | | | | |
| | **TC6-1.A:** *Address social determinants of health in Lane County through community collaboration and educational opportunities.* | | | | | | | | | | | |
| | | | L. Zammarelli | 1. Collaborate with the CAC's Health Equity Work Group established in the Community Health Improvement Plan to address Health Disparities in Lane County | United Way, L.C. Public Health/Prevention; PeaceHealth | Ongoing | | | | | | |
| | | | L. Zammarelli | 2. Meet with Lane County Medical Society, Behavioral Health Consortium, CCO partners, service providers, Legal Aid, and community resources to discuss the social issues that are most prevalent for their populations and to develop equity improvement models of change | Lucy Zammarelli<br>Identified Organizations<br>CAC Health Equity Work Group<br>RAC | Ongoing | | | | | | |
| | **TC6-1A** | | L. Zammarelli | 3.Train and support service providers at LIPP, OMG, PeaceHealth, FQHC, Behavioral Health Consortium and others to address social determinants of health. | Lucy Zammarelli<br>Identified Organizations<br>Alex MacKenzie | Ongoing | | | | | | |
| | | | L. Zammarelli | 4. Train and support Trillium Care Coordination staff to address social determinants of health with members through effective Care Coordination and use of Community Health Workers. | Lucy Zammarelli<br>Trillium Care Coordination Team | Ongoing | | | | | | |
| | | | L. Zammarelli | 5. Refer members and providers to local resources such as http://www.preventionlane.org/?s=211 and www.211info.org for Resource Directories to assist in community referrals for social challenges. | Lucy Zammarelli<br>Member Services<br>Website Developer | | | | | | | |
| | | | L. Zammarelli | 6. Identify emerging populations at risk for Health Disparities (such as military families, veterans, those with mental illness and addiction) and proactively address population issues in the community. | Lucy Zammarelli | Ongoing | | | | | | |
| | **TC6-1B** | **TC6-1.B:** *Design and implement a Continuing Medical Education (CME) presentation that addresses the social determinants and how to address them in a healthcare setting.* | | | | | | | | | | |
| | | | Debi Farr<br>L. Zammarelli | 1. Utilize Trillium University conferences to present information on Health Disparities and Cultural Competence to physicians. | Debi Farr<br>Lucy Zammarelli | Ongoing | | | | | | |

## Benchmark 12-2

| | | Completed | Lead | Action Step | Lead/Participants | Timing | Benchmark or Milestone | Misc. | Social Determinants of Health Yes/No | CHIP Healthy Behaviors/ Living | Community Advisory Council (CAC) Reporting: CAC Updated? Yes/No | Community Advisory Council (CAC) Reporting: Date CAC Updated |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Benchmark 12-2 | **Wellness (TC7)** | | | | | | | | | | | |
| | **TC7-1.A:** *Integrate evidence-based wellness approaches into the work of the PCPCHs.* | | | | | | | | | | | |
| | | | Karen Gaffney | 1.Analyze the demographics of the Member population to identify key wellness issues to address. | Community Advisory Council | Q1 2014 | | | | | | |
| | **TC7-1A** | | Karen Gaffney | 2.Design an evidence-based program to integrate wellness activities in the PCPCHs (such as Acceptance Commitment Therapy); develop the program centrally and implement it at the different PCPCHs and with Community Health Workers. | Community Advisory Council/PCPCH Group | Q2 2014 | | | | | | |
| | | Completed | Karen Gaffney | 3. Promote use of Chronic Disease Self- Management programs as appropriate. | Community Advisory Council/PCPCH Group | Q1-2 2013<br>Ongoing | | | | | | |
| | **TC7-1B** | **TC7-1.B:** *Design and implement wellness programs that address the key health challenges facing Trillium members—both physical and behavioral health.* | | | | | | | | | | |
| | | | Karen Gaffney | 2. Using concepts from ACT and other evidence-based programs, design and implement a best practice program that engages members to exercise, eat healthy foods, manage stress, avoid tobacco and excess alcohol, etc. | Community Advisory Council | Q2 - Q3 2014 | Assigned to Public Health Prevention Team | | | | | |
| | **TC7-1C** | **TC7-1.C:** *Develop partnerships with other key organizations in the community that are focused on promoting health and wellness.* | | | | | | | | | | |
| | | Completed | Karen Gaffney | 2. Prioritize specific policy initiatives to support that would yield the most positive impact on the Triple Aim. | Community Advisory Council<br>Board of Directors | Q2 2013<br>Ongoing | Assigned to Public Health Prevention Team | | | | | |

## Benchmark 13-2

| | | Completed | Lead | Action Step | Lead/Participants | Timing | Benchmark or Milestone | Misc. | | | Community Advisory Council (CAC) Reporting | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | Social Determinants of Health Yes/No | CHIP Healthy Behaviors/ Living | CAC Updated? Yes/No | Date CAC Updated |
| Benchmark 13-2 | | **Public Reporting (IS4)** | | | | | | | | | | |
| | | **IS4-1.B.** *Conduct awareness campaigns to increase community understanding of the Community Health Improvement Plan and its role in the healthcare system and its performance relative to the Triple Aim.* | | | | | | | | | | |
| | **IS4-1B** | | Debi Farr | 1. CHNA-surveys, focus groups and key informant interviews; public meetings. | Debi Farr<br>Karen Gaffney | Q4 2015-<br>Q1 2016 | | | | | | |
| | | Ongoing | Debi Farr | 2. Strategic media releases, PSAs, opinion pieces, articles, social media. | Debi Farr<br>Karen Gaffney | Ongoing | | | | | | |
| | | **IS4-2.A.** *Conduct information campaigns to educate members about the CCO and how to participate more actively in it.* | | | | | | | | | | |
| | **IS4-2A** | | Debi Farr | 1. Quarterly Member Newsletter regarding prevention, health screenings and member engagement. | Debi Farr | Q1 2013<br>ongoing | | | | | | |
| | | | Debi Farr | 2. Bi-annual Public Meetings. | Debi Farr<br>Karen Gaffney | Ongoing | | | | | | |
| | | | Debi Farr | 3.Earned media stories; social media campaign. | Debi Farr | Ongoing | | | | | | |
| | | | Debi Farr | 4. CAC/RAC Engagement | Debi Farr | Ongoing | | | | | | |