Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed)

A. **Project short title**: Project 1: Maternal Child High Risk Identification and Collaboration

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

If continued, insert unique project ID from OHA: 47

B. **Components addressed**

i. Component 1: Access: Quality and adequacy of services
ii. Component 2 (if applicable): Social determinants of health & equity
iii. Component 3 (if applicable): Special health care needs
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☒ Economic stability ☒ Education
☐ Neighborhood and build environment ☒ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. **Component prior year assessment:**

AllCare Health created a collaboration with the Women's Health Center of Southern Oregon (WHC) with the intention of improving identification of, and Care Coordination efforts for, the most vulnerable, at-risk, pregnant members. During phase one, a formal process to share information between the Maternal Child Health team (MCH) and the WHC were developed. Scheduled meetings provided a forum to establish and expand communication and accessibility while reducing barriers of information deficiency and inaccessibility. MCH met with the WHC five times during the year (08-05-2020, 08-12-2020, 10-27-2020, 11-11-2020 and 12-03-2020). Baseline date was derived from the assessments received from the WHC.

Phase two of the collaboration developed the reporting process for information sharing which yielded a report of AllCare members (OHP primary and secondary insurance) categorized by risk. This report was distributed on December 1 for November 2020 and January 1 for December 2020.

Risk category one (1) means the member is pregnant and has no social determinants of health known which may affect her pregnancy.

Risk category two (2) means the member is pregnant and using tobacco or marijuana in any form.

Risk category three (3) means the member is pregnant with one or more of the following: late to begin pre-natal care, homelessness, less than 20 years old, any mental health diagnosis in which the member is prescribed medications for treatment (depression, anxiety, PTSD, etc.), domestic violence situation, and/or illicit drug use (excluding marijuana; including alcohol abuse).

Data reports summarized the following affected members:

The November 2020 report contained a total of 258 members stratified as follows:
Risk one (1) – 154
Risk two (2) – 67
Risk three (3) – 37

The December 2020 report contained a total of 307 members stratified as follows:
Risk one (1) – 186
Risk two (2) – 67
Risk three (3) – 54

At phase three, this data will be operationalized into the MCH hub for prioritized Care Coordination efforts.

At phase four, this project will be analyzed for effectiveness at reducing costs of care associated with high-risk pregnancies as well as children born of high-risk pregnancy.

D. **Project context:**

Pregnant women are a priority population of the Oregon Health Plan contract. Often high risk, this population can have special needs and challenges that require close monitoring. Identifying at-risk expectant mothers is a difficult task as some of the population can be missed due to inadequate data reporting.

AllCare Health traditionally has used data reporting to assist in identifying expectant mothers who may be at risk. This method has shown to provide only a partial view of this population, missing the high-risk expectant mothers who face challenges with Social Determinates of Health (SDoHE).

Partnering with WHC, AllCare Maternal Child Health Team (MCH) received two Master Lists of At Risk Expectant Mothers, one from November 2020 and one from December 2020. From November to December, a 16% increase of at-risk expectant mothers were identified in this process providing MCH opportunity for increased contact with this population.

November 2020 to December 2020:

Risk One: Starting with 154 members; 127 continued, 27 delisted, 60 new members totaling 186 members
Risk Two: Starting with 67 members; 49 continued, 16 delisted, 18 new members totaling 67 members
Risk Three: Starting with 37 members; 30 continued, 7 delisted, 24 new members totaling 54 members

E. **Brief narrative description**: 2021

The MCH and the WHC will continue to reassess and hone the received data from WHC such as what trimester the member is in and clarification of why an expectant mother is delisted, for example was the pregnancy to term or was the pregnancy aborted. This will help to further determine the needs of the member. Social Determinants of Health & Equity would then provide a basis for flex funds to attend to the non-covered needs of the expectant mother.

The MCH will make telephonic contact with all expectant mothers at the Risk Levels Two and Three subsequently mailing the Maternity Packet to the members. For expectant mothers at Risk Level One, a mailing of the Maternity Packet would initiate the contact, followed by appropriate communication, for example telephone calls, educational materials mailed.

Incentives presently in the discussion are doubling the funds from SNAP and doubling the funds for the Babe Store.

F. **Activities and monitoring for performance improvement**: Continue formal process to share clean information monthly

Activity 1 description (continue repeating until all activities included): The MCH and the WHC will continue to hone formal information sharing process

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Establish functional data sharing

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
AllCare Health (ACH) and the Women's Health Center of Southern Oregon (WHC) will enter a collaboration contract to directly funnel member information to the appropriate care hub. Within this contract WCH will provide monthly risk data on ACH members who are receiving care at WHC.	WHC will provide monthly maternal risk stratification reports to the ACH MCH Supervisor. Maternal risk stratification will be differentiated into three categories: one, two, & three. **Risk 1** - Pregnant with no other social determinants. **Risk 2** - Pregnant and using tobacco or marijuana in any form. **Risk 3** - Pregnant with one or more of the following: late to care, homelessness, < 20 years old, any mental health diagnosis for which the mother is taking medication, domestic violence, and/or illicit drug use (including alcohol, excluding marijuana)	01/2021	WHC reports will be regularly received, in an Excel format, stratified into risk categories (one, two, & three) to monitor risk progression through pregnancy. These reports will be sent securely to the MCH hub Supervisor who will assign Care Management.	06/2021

Activity 2 description: Using product of enhanced communications to facilitate and organize workflows

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Establish formal workflow between ACH & MCH

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Currently there are inconsistent meetings between AllCare Health and Women's Health Clinic of Southern Oregon (WHC) due to Covid and other influencing factors.	ACH and MCH will begin regular, monthly meetings to discuss report sharing and work flows which contribute to the Risk report, as well as any unique or special needs members.	02/2021	Seamless, regularly scheduled monthly meetings between the agencies.	06/2021

Monitoring activity 2 for improvement: Establish formal workflow within MCH hub

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Currently there is not a "lead" position within the MCH hub and assignments are voluntarily picked up at CM discretion. There is no identified process for prioritizing contact with at-risk pregnant members.	The MCH hub will be expanded to include a Registered Nurse "lead" who will be the recipient of these reports and primary point of contact for WHC. These reports will be assigned based on risk factor stratification and priority contact will be made with those members in Risk 3 category.	05/2021	50% of Risk 3 members will be referred to the Social Determinants of Health (SDoHE) hub for services & support	06/2022

Monitoring activity 2 for improvement: Reduce the costs associated with high-risk pregnancy

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
AllCare Health has previously not had the tracking information to identify costs of care associated with a maternal risk category.	ACH will capture costs associated with children born of high-risk (risk category three) pregnancies in their first year of life.	01/2022	Costs of care associated with children born in high-risk pregnancies (risk category three) will be identified, analyzed for themes, and reduced by 5%.	01/2023

Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed)

A. Project short title: Project 2: Intervening on Social Determinants of Health of the Special Needs Population
Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

If continued, insert unique project ID from OHA: 48

B. Components addressed

a. Component 1: Special health care needs
b. Component 2 (if applicable): Social determinants of health & equity
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☐ Yes ☒ No
e. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☒ Neighborhood and build environment ☐ Social and community health
f. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. Component prior year assessment:

Between January 2020 and April 2020, AllCare Health re-administered the new Health-Related Survey (HRS) to the Special Needs population of its membership. This population includes approximately 1300 members who are receiving Supplemental Security Income (SSI) & Long-Term Support Services (LTSS). The purpose of the HRS is to clarify the health-related needs of the AllCare Special Needs population and provide Care Coordination support and services to address the Institute of Healthcare Improvement's (IHI) triple aim of improving the experience of care, improving the health of populations, and reducing per capita costs of health care (IHI, 2021). AllCare Health is monitoring the entire plan's population through the year for any re-assessment triggering events, such as recent homelessness, or newly acquired special health needs status, to re-administer the HRS in order to gain an up to date and accurate understanding of this population's complex needs.

AllCare is collaborating with Oregon Health and Sciences University (OHSU) in a Social Determinants of Health Equity (SDoHE) study. Preliminary results indicate shelter and issues associated with safe housing are the second and third most frequently reported SDoHE challenge with food insecurity ranked first (OHSU, 2020). These findings indicate that safe housing is difficult to find and underscore the importance of keeping people at home as long as possible, even if small safety changes are needed.

In 2020, AllCare developed a partnership with Rebuilding Together Rogue Valley (RTRV) to administer a Fall Prevention program. This program is intended to enable members to remain safely in their homes, for as long as possible by making small modifications to the home. Through this collaboration, members received an in-home safety assessment to identify necessary safety modifications. Toilet risers, tub/shower grab bars, and other small changes can increase the ability for a member to avoid falls and remain independent in their own home. This program has a safe housing assessment component as well as providing assistance to fix or upgrade homes to make them safer. The aim of fall prevention is to reduce the risk and rate of falls for those at risk of falling - both individuals who have and those who have not experienced a fall.

D. Project context:

The programs results for 2020 were encouraging. 22 referrals were generated and 17 of these members had fall prevention work done to their homes. 12 of these members responded to follow up interviews. All reported satisfaction with the process and the work done. Additional outcome data includes;

1. All members contacted reported greater independence in activities of daily living
2. All reported no visits to the Emergency Room due to falls

No re-hospitalizations after discharge due to falling.

E. Brief narrative description:

To address safe housing and members with declining health despite Care Coordination intervention, AllCare Health is continuing its partnership with Rebuilding Together Rogue Valley to continue and refine our Fall Prevention program. The program has shown promise in reducing preventable injuries for members and increase member safety and independence levels.

Members are identified via these mechanisms:

1. Health Risk Survey (HRS) data
2. Hospital event notifications (HEN) are reviewed daily by Care Coordination leadership. Members who were treated/admitted for a fall, or an injury secondary to a fall, are contacted in attempt to engage them in the Fall Prevention program
3. Provider offices received information packets about the Fall Risk program to refer their at-risk members to Care Coordination for assistance with enrolling in the Fall Prevention program
4. Provider offices received a copy of AllCare's Fall Risk assessment form to use as a resource
5. All members involved in Care Coordination have the Fall Risk assessment completed. Their provider's office is notified when the member is enrolled into the Fall Prevention program

6. A member, family, or community partner can make a referral to Care Coordination for Fall Risk concern through calling "Customer Care", the receptionists at the front desk, Member Portal, Provider Portal, or directly to their Care Coordinator.

Acknowledging the significant role SDoHE play in AllCare's membership, it is addressed in a multidisciplinary venue throughout the organization.

1. AllCare supports health literacy by utilizing Health Wise education material to deliver material to members at the 6th grade reading level. Health Wise also provides AllCare with videos to support the learning of those illiterate or who prefer to learn through that medium. Member's health literacy is further supported by enabling them to request a Traditional Health Worker (THW) to attend their medical appointment(s) to assist them in understanding better what their provider has told them about their health as well as facilitate dialog between provider and member. AllCare supports members who have limited English language skills with live interpreters or iPads to navigate language barriers.
2. Identify gaps in services and resources – these may be identified by members through Care Coordination or our Community Advisory Councils (CACs), data publications, community services agencies, a provider's office, OHSU research project (SDoHE and frequent Emergency Department usage studies), family members, or any combination.
3. Expand capacity in existing programs to meet identified needs in our community; this may be through technical assistance, in-kind contributions of staff time, or financial resources. AllCare identified how a lack of communication hinders member's abilities to communicate with their healthcare team. To offset this barrier in our community, AllCare created a Loaner Phone program. Members who are in need work with their Care Manager to request a phone and are provided a pre-paid TracFone with 120 minutes loaded. Members are also provided an application to Assurance Wireless to help them establish a phone contract.
4. The SDoHE Manager at AllCare facilitates the exchange of best practices throughout the service area; which includes the following: Grants Pass Housing Committee, Collaborative Economic Development Committee, Southwest Oregon Collaborative, CCO Oregon SDoHE workgroup, the Housing and Transportation Committee (Jackson County), CACs, and regional networks.
5. Rogue Retreat data report (September 2019) provides data to guide project expansion to the most needed areas and which plan for expansion to support.
6. Partnership with United Community Action Network (UCAN) to develop expanded Rent Well program. A course for members aimed at building a plan and skills to maximize their ability to rent. The program goals are member involvement in developing an individual plan and action steps working towards their goal of obtaining housing.

F. Activities and monitoring for performance improvement:

Activity 1 description: Fall Prevention program assessment

Fall Prevention program participants will be assessed before in-home modifications and at three and six months post-modification. This assessment will be completed by Rebuilding Together Rogue Valley via telephone. The following is the standard survey tool utilized to measure impact:

1. How many times have you, the member, fallen since Rebuilding Together Rogue Valley did their Fall Risk assessment and provided the in-home modification(s)?
    a. If they fell, did they require emergency assistance (Fire Department, EMS, or ED visit)?
        i. If yes, was the member hospitalized, or re-hospitalized, because of the fall?
2. Do you feel more independent in your activities of daily living since the initial assessment and installation of in-home modification(s)? Yes No
3. Did the repairs and modifications improve your sense of safety and well-being? Yes No

4. Do you now feel you are more able to live in your home independently? Yes No
5. Do you expect to be able to remain in your home longer? Yes No
6. Are you satisfied with the quality of repairs and modifications to your home? Yes No

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Fall Prevention program evaluation and monitoring

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Fall Prevention Program initiated in January of 2019	Analyze results of 3 and 6 month follow up calls to determine measurable success. For members with no improvement, determine if additional factors correlate with falls. Survey tool responses clarified to standardize data.	12/2021	Analysis of results for year of 2020 were encouraging and indicated the program may be having desired results. Increase member satisfaction by 10% compared to 2021 data.	12/2022

Activity 2 description: Wheelchair ramp installation

For frail or disabled seniors, wheelchair ramps are essential to maintaining their independence and ability to live at home. Seniors who use a wheelchair or electric scooter benefit from the ability to get more of their activities of daily living accomplished with less assistance. Wheelchair bound seniors with easy access to a handicap ramp will likely interact more socially, access social services more, and generally age in place more easily. Ramps also serve an important function in emergencies should medical staff need to enter and exit the senior's home.

Having a ramp installation program is new for AllCare and members in Josephine and Jackson counties. The plan is to collect data on the number of ramps being installed for all members, regardless of county of residence. This data will:

a) Provide an initial number of members utilizing this service
b) Provide a starting point from which ACH will work to expand those services through 2021-2022 for qualified members
c) Provide quantitative data for the quality of work and member satisfaction of such services
d) Quantitative data for how the program is affecting falls related to the lack of a ramp in members' homes.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: To improve self-sufficiency within our service communities.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Collate data on number of ramps installed for ACH members & cost associated with each ramp.	Evaluate the number of members served by Rebuilding Together Rogue Valley program with ramp installation.	06/2021	Evaluate program data and results to guide development of model & increase member participants by 5%.	07/2022

Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed)

A. Project short title: Project 3: Aging in Place

Continued or slightly modified from prior TQS? ☐Yes ☒No, this is a new project or program

If continued, insert unique project ID from OHA: **N/A**

B. Components addressed

a. Component 1: Special health care needs
b. Component 2 (if applicable): Choose an item.
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☒ Yes ☐ No
e. If this project addresses social determinants of health & equity, which domain(s) does it address?
   ☒ Economic stability ☒ Education
   ☒ Neighborhood and build environment ☒ Social and community health
f. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. Component prior year assessment: Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

AllCare Health (ACH) partnered with Rebuilding Together Rogue Valley (RTRV) to offer members a home assessment for risk factors which may contribute to falls or other injuries. This assessment will then be utilized for home modifications to reduce those risk factors and increase in-home safety. The intention of this collaboration is to decrease the risk of admissions due to falls/injuries and allow members to remain in their homes as long as possible. The member's Case Manager will document completed follow-ups.

The following services were provided to members by RTRV in 2020:

- 69 Members served
- 4 home ramps installed and 1 pending for 2021
- 2 air purification modifications completed to the home
- 10 members declined services, were unreachable and/or passed away
- 12 home risk assessments scheduled for 2021
- 32 homes had safety modifications installed such as various grab bars, toilet risers, etc.

These outcomes were lower than expected due to the pandemic and local wildfires. The goal is to continue our outreach efforts and coordination of in-home risk assessments.

D. Project context:

Rebuilding Together Rogue Valley is affiliated with the national Rebuilding Together organization. Their mission is repairing homes, revitalizing communities, and rebuilding lives. Rebuilding Together Rogue Valley's Safe-at-Home program has been developed to help low-income seniors and persons with disabilities safely "age-in-place" as long as possible in their current homes. Preventing falls and improving accessibility will save lives, save dollars, and also address the housing crisis in Southern Oregon by helping keep this vulnerable demographic from needing public housing or becoming homeless. In Southern Oregon many low-income seniors are living independently but lack resources to make needed safety improvements. Their homes may be a single-family structure, a manufactured home, apartment, duplex, or even an aging recreational vehicle.

RTRV shares a similar goal as AllCare's Triple Aim (better health, better care, and better cost) and a collaborative partnership was natural. The aim of fall prevention is to reduce the risk and rate of falls for those at risk of falling - both individuals who have, and those who have not, experienced a fall. According to the National Council on Aging, falls are the leading cause of fatal and non-fatal injuries for older Americans. Falls threaten seniors' safety and independence and generate enormous economic and personal costs.
According to the Centers for Disease Control and Prevention (CDC):

- One in four Americans 65+ falls each year
- Every 11 seconds, an older adult is treated in the emergency room for a fall; every 19 minutes, an older adult dies from a fall.
- Falls are the leading cause of fatal injury and the most common cause of nonfatal trauma-related hospital admissions among older adults.
- 7,141 older adults were hospitalized in 2019 for a fall
- Hospitalizations from falls cost approximately $291 million in 2019.

E. Brief narrative description:

AllCare contracted with a community-based organization (CBO) called Rebuilding Together Rogue Valley (RTRV). RTRV's mission is to help people age safely in place, whether the concern is smoke, COVID-19, household accidents, or improving the quality of the air within the home. AllCare has been proud to partner with RTRV to help adults be safe in their homes, prolong lives, improve quality of life, and reduce hospitalizations.

RTRV is a non-profit organization which helps low-income, older adults, remain in their homes and communities safely. ACH collaborated with RTRV to develop an assessment process, based on CDC fall-risk criteria, designed to provide an evaluation of the home for fall risk(s) focusing on four critical areas: accessibility, trip hazards, bathroom safety, and home environment safety. The assessment at no cost by National Association of Home Builders (NAHB) Certified Aging-in-Place Specialists or trained volunteers under their supervision. Once the assessment is complete, the member is offered, at no cost, the identified equipment to improve home safety. If the member is renting their home, the property owner is contacted to provide written consent to have more permanent safety equipment installed.

RTRV installs:

- Grab bars
- Shower chairs
- Railings
- Air purifiers
- Toilet raisers
- Weatherization
- Smoke/CO alarms
- Nightlights

In 2018 and 2020, Southern Oregon experienced extended periods of wildfire-created smoky conditions that have ranged from "unhealthy" to "hazardous," particularly for those with chronic lung conditions such as asthma, bronchitis, or COPD. During smoky days, people are encouraged to wear facemasks or stay indoors. However, in homes with less than adequate air filtration remaining indoors may represent a health threat comparable to going outside. ACH members are able to access the Smoke Busters program through RTRV. A respiratory and pulmonary specialist can refer members to the Smoke Busters program.

Candidates would need to meet the following criteria:

- At-risk senior (≥ 60 years old)
- Be affected by a chronic lung condition requiring medication(s)
- Non-smoker
- Low income
- At-risk from wildfire smoke

F. Activities and monitoring for performance improvement:

Activity 1 description: Fall Prevention program assessments and monitoring

Fall Prevention program participants will be assessed before in-home modifications are completed and at three- and six-month post-installation follow-up calls. The following questions will be administered to capture measurable impact of the program:

1. How many times has a member fallen since Rebuilding Together Rogue Valley did their fall risk assessment and provided in-the-home modifications?

    a. If they fell, did the fall require a call for emergency assistance since the initial assessment?

2. If "Yes" has member been hospitalized or re-hospitalized because of a fall since the fall-risk assessment and the in-home modifications?

3. Does the member feel more independent in activities of daily living since the initial assessment e.g. toileting, bathing etc.?

    a. If no, why?

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Establishing a script and routine process for post-installation follow-up phone calls to members. This process will also gather data from the survey tool used at prescribed intervals.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No follow-up monitoring	A follow-up script and process will be developed. The script will contain the survey tool used to collect member feedback for pre-installation post-installation phone calls. The process of standardized, routine follow-up phone calls will be developed and regular reporting of process, barriers, and obstacles will be shared with joint RTRV/ACH workgroup meetings.	03/2021	A regular, predictive process of pre-installation and post-installation survey calls will be developed. Data will be regularly collected and reported to ACH. ACH will analyze data to develop expansion or modifications to the Falls Prevention collaboration with RTRV.	12/2021

Activity 2 description: Aging in place is the overwhelming preference of Americans over 50, but doing so requires assistance for low income seniors. This collaborative practice will provide in-home assessment services, low-cost safety devices to enable seniors to remain at home safely and reduce hospitalizations. The goal is to validate ACH's member experiences over the course of 2021 and analyze the data to ensure these services are a) utilized appropriately, b) meeting the expectations of improved cost efficiency, and c) members are indeed feeling more self-sufficient.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: **Monitoring activity 2 for improvement**: Monitor and evaluate program data for "self-sufficiency" for future program modifications

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No assessment monitoring in place	The results of survey question #3 ("Does the member feel more independent in activities of daily living….") will be analyzed regularly and organized by theme(s) and reviewed monthly.	05/2021	Claims data will be analyzed for members with installed in-home safety measure(s) compared with those members who do not have safety measures in place for reduced cost of care of 5%.	12/2021

Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed)

A. Project short title: Project 4: Under and Over Utilization of Services

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

If continued, insert unique project ID from OHA: 50

B. Components addressed

i. Component 1: Utilization review
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. Component prior year assessment: Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

AllCare has implemented a committee to ensure benefit utilization alignment with clinical practice guidelines (CPG) and treatment protocols, policies and procedures. The AllCare CCO Utilization Management Clinical Practice Guideline and Utilization Review Committee (UMCPGURC) is an internal committee made up of AllCare clinical and operations staff and subcontractor partners. UMCPGURC reviews utilization data with a focus on over and underutilization of services and the appropriateness of such utilization. This committee will continue the work discussed above with a goal to make proactive changes.

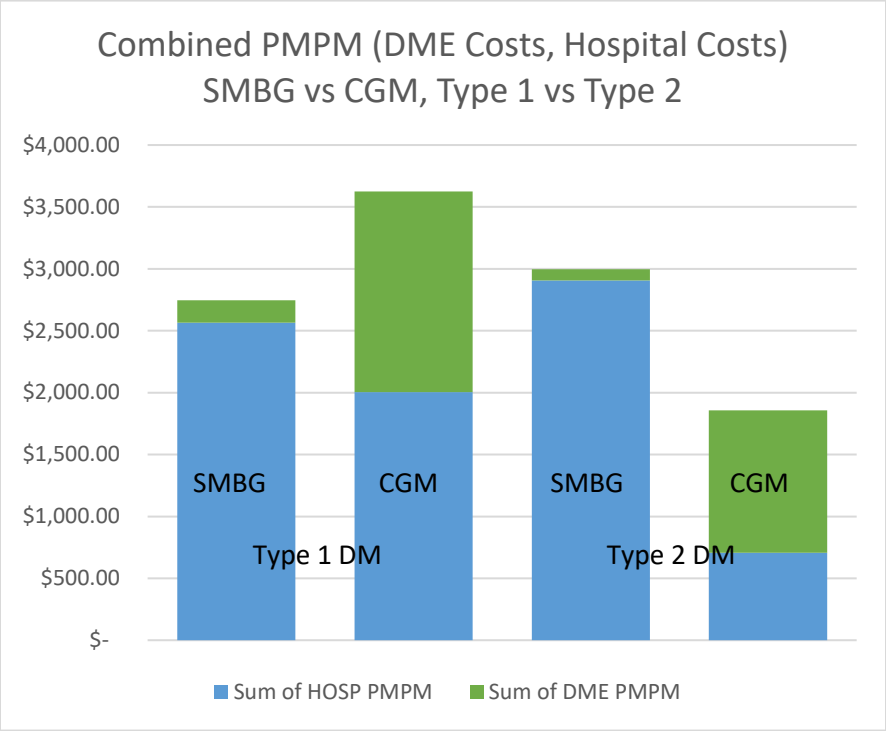
D. Project context:

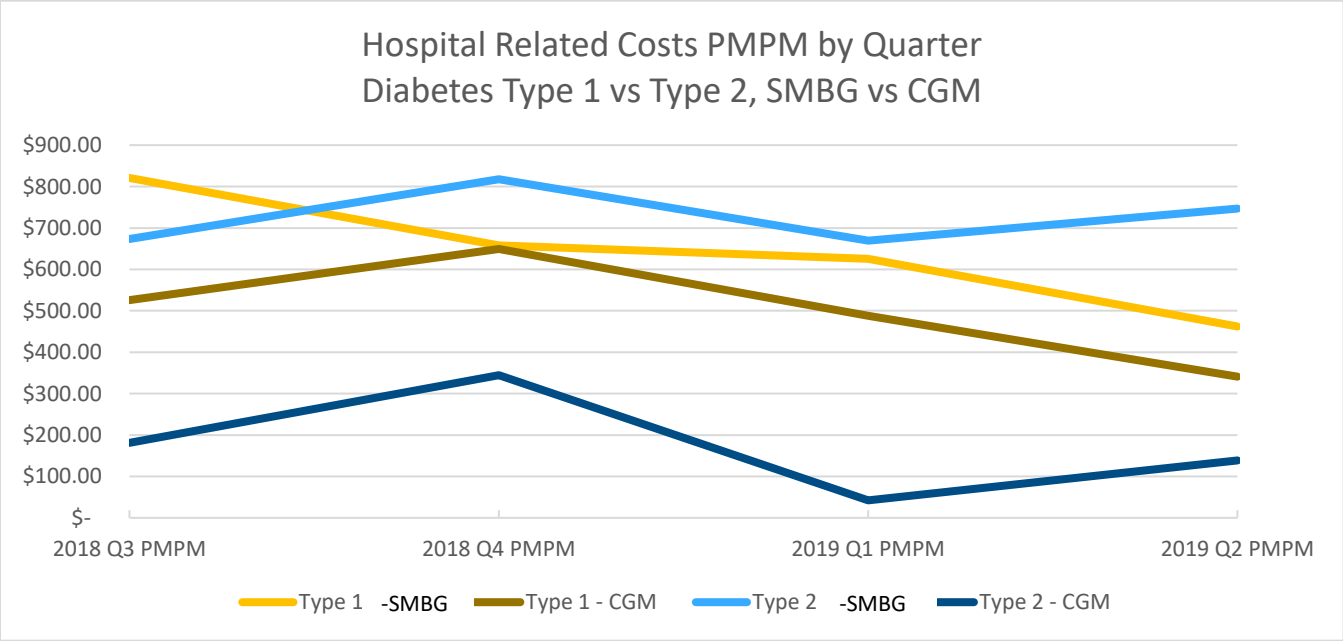
Through the UMCPGURC group, AllCare has identified new opportunities to discover and address over and underutilization. Prior projects included in the TQS reports included addressing underutilization of PrEP and HCV medications, overutilization of ED services, and increasing access to second opinions. Currently, we are focusing on improving care for our type 2 diabetic (T2D) population through increasing access to continuous glucose monitors (CGM) and referrals to endocrinology through changing utilization management policies and encouraging engagement in case management.

The 2020 American Association of Clinical Endocrinology and American College of Endocrinology (AACE/ACE) guidelines recommend using CGM in T2D with multiple daily insulin injections as well as those with recurrent hypoglycemia episodes (Diabetes Management Algorithm, Endocr Pract. 2020;26(No. 1)). Given the prioritized list guideline note 8 limits CGM use to patients with type 1 diabetes, AllCare CCO was aware that CGM was underutilized by our T2D population but wanted to explore increasing utilization in an attempt to improve patient outcomes.

There was some concern with increasing costs as CGM is more expensive than self-monitoring blood glucose (SMBG). We found when looking at PMPM costs for patients using SMBG compared with those using CGM that using CGM was associated with greatly decreased hospitalization costs in the CGM population. DME costs were higher for SMBG compared with CGM although this is likely affected by the uneven volume of members using SMBG versus CGM.

When looking at T2D members that used CGM in 2018 and 2019 we found 81% were followed by endocrinology. In 2020, we had nearly 4,300 adult members with a diagnosis of T2D. Of those adult members, our data shows for 2020 only 8% were using CGM and 15% had seen an endocrinologist. Nine percent of T2D members had engaged with AllCare CCO case management in 2020. Our goal is to increase utilization of CGM in appropriate T2D members to meet clinical practice guideline recommendation. In tandem, we would like to increase access and participation with endocrinology specialists.





E. Brief narrative description:

Poorly controlled T2D leads to significant morbidity as well as increased medical costs. Based upon OHA calculations, there is potentially $800,000 in associated avoidable medical costs affiliated with this population in Josephine County alone. Per our 2020 data, just over 13% of our CCO adult population has a diagnosis of T2D. Patients using insulin make

up >33% of all of our T2D medication claims and of those filling insulin, 44% are using bolus insulin indicating multiple injections per day. Based upon this, AllCare believes there is underutilization of CGM in our T2D members.

Our primary goal is to increase CGM utilization in adult T2D patients using insulin multiple times per day to better align with current clinical practice guideline recommendations. Given our past experience as to where CGM is prescribed, we would like to increase patient access to endocrinology in this population, while at the same time increase PCP prescribing for CGM through provider education.
Our secondary goals will be evaluated as the project moves forward but are likely to include measuring A1c trends, PMPM costs, as well as inpatient utilization and costs. Ideally, AllCare would like to set some goals around cost and utilization past 2021. Once we have established baselines for initial targets, we will set improvement targets (e.g. annual inpatient cost reduction of 3%) as interim steps toward benchmark achievement.
AllCare will evaluate if other interventions should be implemented: concurrent medication management (e.g. ACE inhibitors), frequency of eye evaluations, foot care education.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Review current CGM policy and evaluate if it aligns with current clinical practice guideline. Revise as needed to meet target population.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: The policy for CGM expansion will need revision to target patient population. The UMCPGURC work group will need to identify criteria for the population: multiple daily insulin injections, A1c minimum level, prior history of hypoglycemia. The policy will need to be approved by the Chief Medical Office (CMO).

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Policy exists	Policy revision/update	3/1/2021	Policy revision published and in use	4/1/2021

Activity 2 description: Collect data to identify T2D population and develop care coordination and UM workflow.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Pharmacy will need to pull reports to identify patients based upon UMCPGURC recommendations. Multiple data sources will need to be combined including medical claims, pharmacy claims and care coordination EHR. Evaluate if members meet criteria per internal policy. For example, potential criteria may include: insulin use, followed by endocrinology, compliant with checking blood glucose, HGB A1c target, etc. Implement workflows for UM, Medical Directors, care coordination and plan pharmacists. Clarify provider and member education and develop plans for contact and outreach.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Develop patient list criteria and data sources	Review and evaluate final patient list	3/15/21	Start member outreach	6/1/21
Implement workflows for UM, and care coordination.	Review and evaluate workflows	5/1/21	Start member and provider outreach	6/1/21

Activity 3 description: Implement care coordination and UM workflow. Begin provider education.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Measure distribution of continuous glucose monitors. Measure rate of prescribing by specialist versus PCP. Recruit subject matter expert to provide continuing education on CGM prescribing for PCP with high number of T2D patients. Evaluate need for other standard of care measures- ACE inhibitors, eye evaluations, foot care etc.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Record current baseline use of CGM, PMPM costs in population	Measure CGM utilization for increases	6/1/21	Increase CGM utilization by 5% from baseline. Measure CGM utilization, DME, total PMPM and hospitalization costs.	12/1/21

Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed)

A. Project short title: Project #5: Provider and Staff Health Literacy Education

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

If continued, insert unique project ID from OHA: 51

B. Components addressed

a. Component 1: Grievance and appeal system
b. Component 2 (if applicable): Choose an item.
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☐ Yes ☒ No
e. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
f. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. Component prior year assessment:

The number of complaints submitted by members for inadequate or incomplete explanations or instructions increased from 2019 to 2020. AllCare CCO's goal was to decrease complaints by conducting internal and external staff training. However, in March of 2020 Governor Kate Brown issued a Stay at Home order which shifted the CCO's focus. Scheduled trainings were put on hold.

There was a significant decline in the number of complaints submitted to AllCare CCO in the second quarter of 2020. 1Q 2020 had 61% of the complaints submitted for inadequate or incomplete explanations or instructions. In 2Q 2020 there was only one complaint submitted with a slow increase in complaints submitted for 3Q and 4Q (14 complaints). It was during the 1Q there were a total of 13 complaints submitted. 5 of those complaints were against behavioral health for inadequate or incomplete explanations or instructions. In comparison to 2019, the overall number of complaints for inadequate or incomplete explanations or instructions increased from 17 complaints to 28 in 2020. The number of complaints against the Health Plan for inadequate or incomplete explanations or instructions increased to 8 complaints when compared to 2019's 4 complaints. The complaints against providers decreased by 1.

Some of the issues that may contribute to the increased number of complaints are in the fishbone diagram below.

There have been several identified causes for the increase in complaints. We noted that during the onset of the pandemic, several provider offices quickly closed their doors to in-person appointments. The swift changes in how routine medical and dental care were being offered and scheduled was not communicated to patients in a way that encompassed the root for the change. In addition, there was a reduction in the provider office staff which caused a delay in referral processes to specialists, higher than normal turnover in provider office staff, and slow communication between providers. This also includes the closing of AllCare CCO offices to the public; and not having traditional healthcare workers attend doctor visits or allow for home and nursing home visits. We will monitor the environment going forward to see what additional interventions are needed to keep the number of complaints registered to the targeted level.

D. Project context:

AllCare CCO had aspirations of conducting in person health literacy training for our provider offices, however, with the State of Emergency for the COVID-19 Pandemic, the in person trainings were delayed. AllCare CCO has been able to conduct targeted education and training to providers and subcontractors during 2020. AllCare continues to work with Options for Southern Oregon, ReadyRide and Advantage Dental on the readability and understandability of their written communication to members. The benchmarks that were listed in the 2020 TQS were not met. The number of complaints increased in 2020 compared to 2019 and previous years.

	2016	2017	2018	2019	2020
Provider explanation/instruction inadequate/incomplete	7	15	11	13	20
Plan explanation/instruction inadequate/incomplete	7	4	6	4	8
Total complaints for the year	260	280	301	309	292
Average Enrollment for the year	50,622	48,756	48,690	49,651	49,687

In 2021, AllCare CCO will first focus on internal training of staff on health literacy. With the onboarding of new staff, and with staff leaving, effective training in health literacy has not been consistent. After completing the internal training, AllCare CCO will focus on training for our subcontractors with a focus on the entities who have been identified with the most complaints.

E. Brief narrative description:

AllCare CCO will focus efforts with our internal staff, behavioral health subcontractors and dental care organizations. Their three areas had higher complaints than any other. With the utilization of Zoom and other training platforms, AllCare will be able to conduct trainings remotely and in person if desired. The Health Literacy 1.0 Training will be utilized to start building the foundation to effective communication with our members.

F. Activities and monitoring for performance improvement:

AllCare CCO first implemented Health Literacy 1.0 Training in 2017 to the staff and provider offices. Trainings were offered annually to the staff. In 2019, Health Literacy 2.0 Training was implemented to build off of the 1.0 trainings. However, there was poor attendance to the 2.0 Training.

In 2020, it was noticed that the training conducted in 2018 and 2019 was not retained by the internal staff. In addition, there was a lack of training offered to the provider offices and the subcontractors. Additional coaching and training has been done with ReadyRide, the Non-Emergent Medical Transportation (NEMT) vendor on readability of letters and the importance of clarity in written communication to the member. In addition, AllCare CCO has worked actively with a dental plan to improve the Notice of Adverse Benefit Determination (NOABD) that are issued on AllCare CCO behalf for denial of dental services. AllCare has one subcontractor for mental health that is sending all NOABD to AllCare CCO prior to mailing to the member. This allows for immediate one on one training on clarity and readability of the letter. AllCare CCO will continue to work with our mental health subcontractor on other forms of communication as well.

2020 Complaint data for inadequate or incomplete explanation or instruction with provider or plan
(Complaint codes IP.E and IP.D)

	Pharmacy	**Dental**	**Mental Health**	**PCP**	**Health Plan**	**NEMT**	**Specialty Care**
Total:	1	3	8	4	9	1	2

Activity 1 description (continue repeating until all activities included): Implement the Health Literacy 1.0 internal training with our internal staff who have direct member contact. This will include the **S**peak Slowly, **T**each back, **E**ncourage Questions, **P**lain Language, and **S**how examples (S.T.E.P.S) method. Since the majority of the complaints were against AllCare CCO, we will focus first internally. Once they has been completed the focus will shift to our subcontractors and begin training with them.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Plan verbal Communication development.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No current internal training on S.T.E.P. occurred in 2020	Training for Customer Care; Care Coordination and Appeals and Grievance	07/2021	100% of targeted staff trained	11/2021

Activity 2 description: Offer the Health Literacy 1.0 internal training to the providers who had the highest complaints regarding inadequate or incomplete explanation or instructions. This will include the **S**peak Slowly, **T**each back, **E**ncourage Questions, **P**lain Language, and **S**how examples (S.T.E.P.S) method. AllCare CCO will focus our efforts on training for one Community Mental Health partner. AllCare CCO is contracted with two Mental Health entities, however, one has a higher number of complaints regarding the inadequate explanation or instructions. This will be our first targeted subcontractor. The next will be a Dental Plan. AllCare is contracted with three Dental Care Organizations with one standing out with the most complaints regarding inadequate explanations or instructions.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Provider communication improvement with training of

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No formal training on S.T.E.P.S. occurred in 2020	Conduct targeted training with one DCO and one behavioral health contractor.	08/2021	Additional training of subcontractors and providers as the need arises upon the level of complaints.	11/2022

Activity 3 description: AllCare will monitor the number of complaints registered against the plan and providers for inadequate or incomplete instructions and implement corrective actions to keep the number at an acceptable level.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: Monitor complaints to intervene with appropriate actions if an uptick is observed and drive for a 50% reduction in complaints registered for inadequate or incomplete instructions

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
28 complaints in 2020	5% annual reduction in # of complaints registered against plan and providers	1/2022	50% overall reduction relative to baseline.	5% annual improvement targets with a benchmark target of 50% reduction to baseline.

Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed)

A. Project short title: Project 6: Warm Handoff from Acute Psychiatric Hospitalization

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

If continued, insert unique project ID from OHA: 52

B. Components addressed

a. Component 1: Behavioral health integration
b. Component 2 (if applicable): Serious and persistent mental illness
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☒ Yes ☐ No
e. If this project addresses social determinants of health & equity, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☐ Social and community health
f. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. Component prior year assessment: Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

AllCare CCO had about 50,000 members in 2020 throughout our 4 county region. Due to changes in CCOs and Primary Care contracts, our membership has shifted to having most of membership in Josephine County. Our Jackson County membership has historically had higher inpatient psychiatric hospital utilization but that has dropped with the changes in contracts, shifting membership and the pandemic.

Due to the many changes, it is difficult to estimate how many members will need a warm handoff in the upcoming year. We had approximately 60 members admitted to our local inpatient psych unit, Asante Rogue Regional Medical Center BHU in 2020. This is down from previous years. It is unknown at this point, how the pandemic has and will affect our members needing inpatient psychiatric services. Another impact to psychiatric hospitalizations in 2020 was the suspension of Oregon State Hospital (OSH) Civil Commitment admissions due to the pandemic. Oregon already struggles with a lack of inpatient psychiatric hospital beds, as well as minimal residential and other intensive community placements to meet our SPMI population's needs. The lack of placements leads to longer inpatient psych stays which results in less available beds. The halt of OSH admissions just compounded an already bottlenecked system.

Around 15% of our membership in 2020 were identified as having a Severe and Persistent Mental Illness (SPMI). One way we work to ensure our members with SPMI and high behavioral health needs get services is to utilize the Collective Medical Platform HIE. AllCare CCO BH Team monitors ED and Inpatient psychiatric presentations daily to trigger coordination of care after hospitalization. We work to ensure follow up contact is made with members by an appropriate behavioral health agency within 7 days of discharge, most of the time much sooner. Our team worked with around 260 members who presented to an ED and/or inpatient psychiatric admit last year to ensure they received timely follow up after discharge. AllCare CCO quickly identifying, making outreach and remaining involved in the members care throughout the hospitalization and discharge is crucial to getting appropriate after care and hopefully reducing readmissions and lengths of stay. Furthermore, we believe that adding warm handoffs will increase successful transitions for our members.

D. Project context:

AllCare CCO was not able to implement any of our planned activities in 2020 due to the COVID-19 pandemic and local wildfires. AllCare's Behavioral Health staff working on these activities had to devote their time and resources to the urgent and ongoing pandemic response and wildfire recovery efforts. This included support of our members struggling

with behavioral health challenges and other special needs, as well as support of our behavioral health providers and systems. Our region, like so many others, saw major shifts in our behavioral health delivery systems, capacity and utilization that required intensive and ongoing support by AllCare CCO's Behavioral Health team. Additionally, our local hospitals were stretched very thin and did not have the time or resources to devote to the development of an additional initiative. Lastly, our community behavioral health partners were struggling with major workforce, personnel and programmatic challenges and were not able to work with AllCare CCO on the planning and implementation of warm handoffs. Providing a warm handoff via telehealth prior to the pandemic was a barrier for AllCare, some of our behavioral health providers and many of the Psychiatric Units due to not being able to adhere to CMS's strict rules about what qualifies for telehealth. Since the rules about telehealth have been relaxed during the pandemic, AllCare will be able to utilize this modality for warm handoffs more easily, which is ideal since many hospitals and providers are still limiting face-to-face meetings.

E. Brief narrative description:

"Warm Handoff" means the process of transferring a patient from an acute care psychiatric hospital to a community provider at discharge, that involves face-to-face meetings with the patient, either in person or through the use of telehealth, and coordinates the transfer of responsibility for the patient's ongoing care and continuing treatment and services.

A warm handoff shall take place prior to discharge and include either:
(a) Face-to-face meeting with the community provider and the client, and if possible, the hospital staff, or
(b) Transitional team to support the client as a bridge between the hospital and the community provider, and ensure that the client connects with the community provider.

AllCare CCO is continuing our plan from 2020 to assess and address gaps in warm handoffs for members discharging from acute psychiatric hospitals. AllCare CCO will create a policy and procedure and assign internal staff/teams responsible for the coordination and monitoring, and also create workflows. AllCare CCO staff will coordinate with the psychiatric unit staff and our community behavioral health partners that best fit the member's needs prior to discharge. AllCare will continue to coordinate and work with these partners to build professional relationships and will continuously evaluate and adjust procedures as needed so we all remain efficiently working together for the member's benefit. AllCare CCO will collect data on warm handoffs on an ongoing basis to establish a baseline, develop benchmarks and improvement targets and to continue to monitor this Transformation and Quality program for outcomes.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): AllCare CCO will develop a policy and procedure for warm handoff from acute psychiatric hospital to community care.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Policy and Procedure is developed and approved.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Informal warm handoff prior to discharge for members in acute psychiatric hospitals.	Approved Policy and Procedure for Warm Handoff and Discharge Planning from acute psychiatric hospitals.	03/2021	Warm handoff policy and procedure in place that is updated regularly to reflect improvements to the program.	03/2021

Activity 2 description: AllCare CCO will develop internal and external workflows and assign appropriate staff/teams to complete the work.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Documented processes, workflows and assigned staff/teams.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No formal process, workflow or documentation exists for warm handoffs.	Internal processes and assignments are in place. Workflows are introduced.	06/2021	Workflows are in place. Staff are assigned for each task. Tracking of warm handoffs has been developed.	06/2021

Activity 3 description: AllCare CCO will work with internal and external partners to refine, disseminate and educate on our warm handoff program.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Community partners participate in the warm handoff program.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No formal process, workflow or documentation exists for warm handoffs and are not disseminated to treatment partners.	AllCare's processes, workflows and responsible staff shared with all our local acute psychiatric hospitals and community behavioral health treatment partners.	06/2021	A community warm handoff process is agreed upon and documented. There is an avenue in place for the group to provide ongoing assessment and evaluation of the warm handoff program and adjust when needed.	09/2021

Activity 4 description: AllCare CCO will create a monitoring and tracking process that our local acute psychiatric hospitals and community behavioral health treatment partners will utilize.

☐ Short term or ☒ Long term

Monitoring activity 4 for improvement: AllCare CCO has a way to track and report out on all warm handoffs offered, declined and completed.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No baseline data for percentage of members offered a warm handoff from acute psychiatric care. Only have data on hospital follow up services in our claims system.	Develop a pilot for tracking warm handoffs.	9/2021	AllCare has an established tracking system for warm handoffs. A baseline is established for members offered, declining and receiving warm handoffs.	03/2022

Activity 5 description: AllCare CCO will execute a reporting process.

☐ Short term or ☒ Long term

Monitoring activity 5 for improvement: **Increase the percentage of AllCare CCO members with SPMI that receive a warm handoff prior to discharging from an acute care psychiatric facility.**

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No baseline data for percentage of members that received a warm handoff from acute psychiatric care. Only have data on hospital follow up services in our claims system.	Implement our tracking system to collect a baseline of how many members are receiving the warm handoff.	12/2021	AllCare has an established baseline, benchmark and improvement targets.	03/2022

Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed)

A. Project short title: CLAS Standards Project 7: Provider Training Program to Increase the use of Medically Certified Interpreters.

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

If continued, insert unique project ID from OHA: 53

B. Components addressed

a. Component 1: Access: Timely
b. Component 2 (if applicable): CLAS standards
c. Component 3 (if applicable): Access: Cultural considerations
d. Does this include aspects of health information technology? ☒ Yes ☐ No
e. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☒ Social and community health
f. If this project addresses CLAS standards, which standard does it primarily address? 5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services

C. Component prior year assessment: Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

In 2015 So-Health-E completed several listening sessions with the Latinx community. The response overwhelmingly was that the community needed more Certified Medical Interpreters.

Through AllCare's other Community engagement projects (i.e. Deaf and Hard of Hearing Committee, Multi-Cultural Fair, etc.) Qualified Interpreters is consistently mentioned as a priority for Limited English Proficiency individuals.

AllCare is an advocate for the use of in-person interpretation services by trained interpreters. To see further justification please see "Locatis C, Williamson D, Gould-Kabler C, et al. Comparing in-person, video, and telephonic medical interpretation. J Gen Intern Med. 2010;25(4):345–350. doi:10.1007/s11606-009-1236-x"

D. Project context:

The Covid-19 pandemic significantly impacted this project. As with many of the societal inequities for people of color, language access was further exacerbated. Many of the employed Medical Interpreters AllCare trained over the last five (5) years, were laid off during early lockdowns. Remote encounters largely shifted to Video Remote or Phone Interpretation services that do not enforce provisions related to Certified and Qualified Interpreters.

E. Brief narrative description:

AllCare CCO will develop and implement a training program to increase the utilization of Medically Certified Interpreter services. This project meets the following CLAS standards 1,5,6,7,8,9,12.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Train ten (10) organizations on how to work with, and access Interpreter Services.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: AllCare attempted to complete these trainings throughout 2020. The Covid-19 pandemic was a large factor in these services. The AllCare Language Access Manager shifted to working with two Federally Qualified Health Centers directly Siskiyou Community Health and Rogue Community Health. A language access assessment was completed by the organization, the Language Access Manager then outlined goals and policy recommendations for each organization.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Two organizations trained. A total of Sixty (60) providers were trained on Language Access Requirements.	Review organizations encounters to understand the impact of Language Access Encounters	12/2021	Ongoing monitoring related to encounters for organizations.	12/2021

Activity 2 description: OHA Contractual Language Services Reporting Template

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Quarterly AllCare will submit a Language Services Report to OHA. AllCare participated in the pilot study for this program. AllCare was able to identify all individuals identified by OHA that needed Interpreter Services. During the Covid-19 pandemic AllCare went from 29% of individuals receiving services from OHA Certified or Qualified, to 11% of members receiving services. The shift to telemedicine has greatly impacted this metric. Many Video Remote Interpreting agencies and Phone Interpretation Services do not work with Certified and Qualified Interpreters. Please see attached Memo TQS Project # 7 - Interpreter COVID 19 Memo ID-5 demonstrating AllCare's efforts to inform contractors of updated requirements.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
11% of Limited English Proficient Individuals had an Interpreter that was OHA Certified or Qualified at the encounter.	Increase the individuals that had an Interpreter that was OHA Certified or Qualified at the encounter to the baseline of 29%	6/1/2021	Continue efforts to increase encounters by 10% per year and achieve 52% of encounters with a Certified or Qualified Interpreter.	4/1/2024

Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed)

A. Project short title: Project 8: Patient-Centered Primary Care Home (PCPCH)

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

If continued, insert unique project ID from OHA: 54

B. Components addressed

a. Component 1: PCPCH: Member enrollment
b. Component 2 (if applicable): PCPCH: Tier advancement
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☒ Yes ☐ No
e. If this project addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☒ Social and community health

f. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. Component prior year assessment: Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

The CCO landscape in southern Oregon changed significantly in 2020. As a result of the significant disruption in our primary care network, we saw a 3% drop in member assignment at PCPCH clinics. The items listed below greatly impacted AllCare CCOs ability to advance recognized clinics' tier levels and maintain or increase member assignment to PCPCH clinics.

- In August of 2019, AllCare was informed that our largest contract (at the time) to provide primary care in Jackson County would be changing. Beginning January 1, 2020 we would no longer be able to assign our members in Jackson County to any Primary Care Provider with this contractor. This impacted the majority of our Jackson County membership, most of whom were assigned to providers working in PCPCH recognized clinics. For example, as of September 30, 2019, 22474 AllCare members were assigned to PCP's working in PCPCH clinics. This represented 45% of our total CCO membership and 84% of our Jackson County membership. If no action was taken on the part of AllCare, only 2983 of the 22474 members assigned to a PCPCH clinic in Jackson County, would remain with a recognized clinic.

- In an effort to continue providing optimal care to our Jackson County members we established direct contracts with two new clinics. To ensure member choice, members were offered to switch CCOs and to remain with the non-assignable PCPs or establish care with a provider in Jackson County that was open to assignment (and remain with AllCare CCO). Because these clinics were new, there was a waiting period before they could become recognized PCPCH sites. As of 12/2020, one of those sites is recognized as a tier 3 clinic; the other will become PCPCH certified in 2021.

- With the public health restrictions in place as a result of the COVID-19 pandemic, our team at AllCare shifted from a primary focus on in-person support to hybrid model that included in-person, Zoom, telephone and email engagement.

D. Project context:

AllCare CCO recognizes and believes that by rewarding high quality, efficient care we can support our providers and most importantly, our members, in achieving better health outcomes. This is the basis for our comprehensive plan to increase member assignment to recognized PCPCH clinics and to encourage upward tier recognition.

E. Brief narrative description:

AllCare CCO assigns members to provider offices based on quality performance and PCPCH recognition through our Quality Based Member Assignment tool. Whenever possible, we assign members to those providers who have proven their ability to manage care, care for the whole person and improve the outcomes of those members they serve.

AllCare CCO incentivizes provider offices for PCPCH recognition based on tier level, panel size, and geographical location. PCPCH payments are made using a per-member-per-month (pmpm) model. Historically, payments were distributed quarterly, but with the financial impact of COVID 19 on clinics, AllCare has increased the frequency of PCPCH payments to monthly distributions.

Because clinics recognized at higher tier levels: 1) demonstrate an increased level of quality, patient engagement and care coordination; 2) have an increased focus on whole-person care and care for members with special

healthcare needs and; 3) align with a greater number of measures (as outlined in the PCPCH Core Attributes), pmpm rates are adjusted accordingly.

In an effort to increase access and acknowledge that larger panel sizes present a greater risk, clinics with a patient panel size greater than 500, will receive an increased pmpm amount. Beginning in 2020 and continuing through the CCO 2.0 contract period, the pmpm will be adjusted according to tier level.

F. Activities and monitoring for performance improvement:

Activity 1 description: Because PCPCH clinics have been shown to provide high quality, cost-effective care for their patients, AllCare Health CCO will work to increase the percentage of its members who are assigned to a provider at a PCPCH recognized clinic.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: AllCare CCO will monitor member assignment among both PCPCH, and non-PCPCH provider offices in an effort to increase member assignment and/or promote tier advancement.

- As with recognized clinics, member assignment will be prioritized by those performing at higher levels.
- We will explore setting thresholds for providers who fall below specific quality benchmarks. Those providers will not be permitted to receive member assignment until they have improved quality and/or engaged in the PCPCH program.
- In an effort to support whole-person care and special health care needs members, we will utilize our internal Provider Program Coordinator (PPC) to work in an ongoing, supportive role with offices during and after the PCPCH certification process. The PPC will work to advise offices to attest only to those processes that they are actually doing and encourage them to explore ways in which they might incorporate higher levels of performance and process improvement.
- The PPC reaches out to unrecognized offices and encourages participation by:
    - Sending letters/emails and making phone calls to explain the role of the PPC.
    - Explaining the impact of participation in PCPCH on patient and clinic outcomes.
    - Offering technical assistance in the following ways:
        - Providing education about the PCPCH program and providing an example of their potential incentive amount should they become recognized at the various tier levels.
        - AllCare CCO has created a document, referred to as a "Roadmap to Certification," that lists the 11 must-pass criteria for PCPCH recognition. This document is used to approach non-participating PCPCH offices with a simplified version of the PCPCH program by displaying a smaller list of measures (11 instead of 33) to attest to in achieving PCPCH recognition.
        - Utilizing the PCPCH Technical Assistance Guidebook to assess clinic needs, barriers, and areas of improvement needed to help practices successfully implement PCPCH standards.
        - Making work-flow recommendations to better align practices with PCPCH measure intent and purpose.
        - Providing on-site PCPCH support to offices.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
87.5% of AllCare members assigned to PCPCH recognized clinics as of 12/31/2020.	3% increase from baseline annually	12/31/2021	93%	12/2022

Activity 2 description: Increase number of clinics that are newly recognized and/or increase tier for clinics at a level 3 or 4.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: In an effort to promote PCPCH tier level advancement, AllCare CCO will monitor those clinics that are currently not recognized as well as those who have an opportunity to attain a higher level.

- AllCare CCO will continue to pursue non-PCPCH clinics for recognition while encouraging recognized clinics to increase tier levels by:
  - Sending letters/emails and making phone calls to explain the role of the PPC and the impact of participation in PCPCH on patient and clinic outcomes.
  - Offer technical assistance in the following ways:
    - Providing education on the PCPCH program and provide an example their potential incentive amount should they become recognized at the various tier levels.
    - Utilizing the PCPCH Technical Assistance Guidebook to assess clinic needs, barriers, and areas of improvement needed to help practices successfully implement PCPCH standards.
    - Make work-flow recommendations to better align practices with measure intent and purpose.
- AllCare CCO will:
  - Assess whether or not the clinic score/tier level accurately reflects quality performance.
  - Encourage clinics to adopt a team-based approach to care and embrace new processes such as care coordination, while also using EHR and claims data to drive actions, resulting in better health outcomes.
  - Focus on increased understanding of organizational conditions and workflow improvement activities of high performing clinics.
  - Provide on-site support and technical assistance to offices.
  - Stay informed of changes to PCPCH program (quality measures, standards for tier level recognition).

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
OHA Tier Weighted Formula: 71.94% Member assignment as of 12/31/20 Non-PCPCH: 6551 Tier 1: 0 Tier 2: 0 Tier 3: 1170 Tier 4: 38840 Tier 5: 6136	Maintain current weighted tier rating of 71.94%. ***With the changes to the PCPCH 2020 TA Guide, higher tier levels are more difficult to maintain/achieve.***	12/31/2021	Annual improvement targets of +3% apply until AllCare attains current statewide CCO average.	12/2022 (+3% from baseline)

Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed)

A. Project short title: Project 9: Support Increased Access to Oral Health Services within a Physical and/or Behavioral Health Setting and Oral Health Referrals to Community Services

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

If continued, insert unique project ID from OHA: 55

B. Components addressed

a. Component 1: Oral health integration
b. Component 2 (if applicable): Social determinants of health & equity
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☒ Yes ☐ No
e. If this project addresses social determinants of health & equity, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☒ Social and community health
f. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. Component prior year assessment: Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

In 2020, an Expanded Practice Dental Hygienist (EPDH) worked at Options for Southern Oregon one day per week and Grants Pass Clinic one day per week. 35 patients seen in 2020 at Options for Southern Oregon with approximately 50% of follow up appointments attended at dental home office. 35 patients were seen at Grants Pass Clinic with approximately 40% of follow up appointments attended at dental home office.

D. Project context: For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

Oral health access was challenging in 2020 due to the COVID-19 pandemic. All dental offices were forced to close except for emergency visits only for approximately 6 weeks and when they did open back up, the OSHA requirements were extremely strict and PPE was in very short supply. As a CCO, we tried to support our DCO partners, and they were providing us with weekly reports as to the status of access and the reopening of offices. Toward the end of 2020, work began to get back to somewhat normal and the hygienist that was at Grants Pass Clinic and Options for Southern Oregon was able to get back into the clinics to continue the work that was started. Due to COVID restrictions last year we were unable to place an EPDH at Options in Jackson County, she will be starting late March 2021. With this addition, the clinic will integrate oral health into the Behavior Health/Physical Health setting for this location.

E. Brief narrative description:

AllCare CCO plans to continue to assess, address and expand oral health integration into our physical health and behavioral health clinics. AllCare CCO's Director of Oral Health Services has worked with our oral health partners and internal staff/teams responsible for the care coordination between the oral health providers in the physical and behavioral health clinics and our staff. AllCare's Director of Oral Health Services will continue to work with the oral health providers to coordinate with these partners to build professional relationships and will continuously evaluate and adjust procedures as needed so we all remain efficiently working together for the member's benefit. AllCare CCO will continue to collect data on the number of members seen at the clinics and the referrals made to the dental homes on an ongoing basis to establish a baseline, develop benchmarks and improvement targets. AllCare will also continue to monitor this Transformation and Quality Strategy program for outcomes. We are close to opening up a clinic in Port Orford where we will have dental services for a town that has never had a dentist.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): AllCare will continue to increase oral health integration into behavior and physical health clinics in Jackson, Josephine and Curry Counties.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: AllCare's Director of Oral Health Services will continue to work with the oral health providers as well as the behavioral and physical health clinics to determine additional locations where we can add integrated oral and behavioral or physical health services.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Currently, AllCare supports integration of oral health into the behavioral health and physical health setting by working with Capitol Dental Care and embedding a hygienist at Options for Southern Oregon in Josephine County (provider of community mental health services). We next plan to add integrated services to the Options clinic in Jackson County.	Increase the number of locations with integrated services.	07/2021	Additional locations targeted for expanding the integrated clinic concept include On-Track and ARC in Jackson County and Coast Community Health Center in Curry County.	1/2022

Activity 2 description (continue repeating until all activities included): AllCare will continue to increase oral health integration and increase the percentage of patients getting full oral health services.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: AllCare's Director of Oral Health Services will continue to work with the oral health providers as well as the behavioral and physical health clinics to monitor how many patients are seen and followed up with an appointment with their assigned dental home. Data will be tracked by claims and reports from providers.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
During the period in 2020 when the integrated clinic in Josephine County was operating at normal capacity we monitored the percent of patients seen by the onsite EPDH and referred for additional services who subsequently got treated for needed dental services.	45% of follow up appointments attended by patients referred for services.	07/2021	60% attendance rate by 2024 with 5% improvement targets to apply each year.	12/2024

Activity 3 description: AllCare will work with the Unite Us and Connect Oregon team to ensure oral health providers can make the appropriate referrals to Social Determinants of Health (SDOH) services as needed (within the oral health setting)

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: AllCare's Director of Oral Health Services will monitor the amount and type of referrals to include the Social Determinants of Health related services being made by the oral health providers.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No availability for oral health providers to send referrals to community partners.	Identify and enroll the oral health providers that will use the Unite Us platform.	06/2021	Monitor the amount and utilization of the referrals made by the oral health providers to the Unite Us platform. Determine if additional goals can be set once data is available and analyzed.	12/2021

Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed)

A. Project short title: Project 10: Health Equity, African American PCP visits

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

If continued, insert unique project ID from OHA: 56

B. Components addressed

a. Component 1: Health equity: Data
b. Component 2 (if applicable): Health equity: Cultural responsiveness
c. Component 3 (if applicable): Access: Cultural considerations
d. Does this include aspects of health information technology? ☒ Yes ☐ No
e. If this project addresses social determinants of health & equity, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☒ Social and community health
f. If this project addresses CLAS standards, which standard does it primarily address? 11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery

C. Component prior year assessment:

AllCare has a Data Workgroup as part of the Internal "Health Equity and Inclusivity Action Team". That data workgroup has identified that African American AllCare CCO members have the lowest Primary Care encounter rates compared to the rest of the AllCare CCO membership.

D. Project context:

The Steering Committee of the Health Equity and Inclusivity Action Team has approved for the Data Work Group to establish a dashboard to monitor this inequity. After the dashboard has been established, this project will be moved to the Culturally Specific Materials (aka CLAS workgroup). That group will begin Community Engagement efforts to identify short and long term goals to increase PCP engagement for African American AllCare CCO members.

The Oregon Health Authority has identified institutional bias as one of the strategic priorities for 2020-2025.

https://www.oregon.gov/oha/PH/ABOUT/Pages/institutional-bias.aspx

This project is further justified by empirical research of African American segregation in communities, and distrust of the medical community.

Arnett MJ, Thorpe RJ Jr, Gaskin DJ, Bowie JV, LaVeist TA. Race, Medical Mistrust, and Segregation in Primary Care as Usual Source of Care: Findings from the Exploring Health Disparities in Integrated Communities Study. J Urban Health. 2016;93(3):456–467. doi:10.1007/s11524-016-0054-9

E. Brief narrative description:

The internal infrastructure of AllCare's Health Equity workgroups was significantly impacted by the COVID-19 pandemic. These workgroups prioritized Covid-19 education and testing information within the region. Though some work was completed, this delayed many of the expected implementation plans.

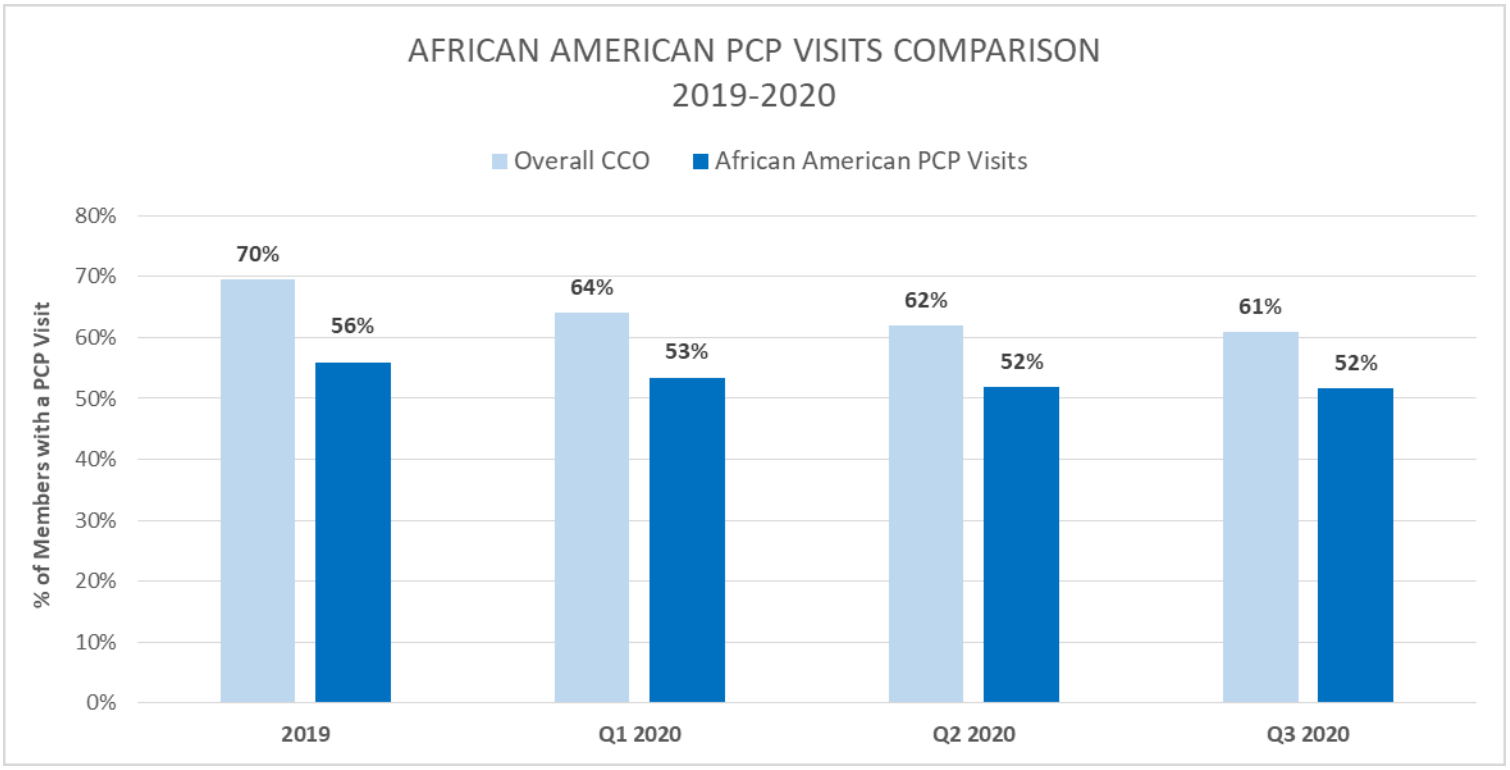
F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Establish a dashboard to monitor the inequity

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Report dashboard to local Regional Health Equity coalition and AllCare Board of Governors.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Inequity identified and approved as project.	Dashboard established and reported to AllCare and Stakeholders. Target was met and the dashboard is created as a rolling 12 month analysis.	12/1/2020	As interventions are further developed. Identifying further data points to expand the dashboard (i.e. Culturally Specific Providers)	6/1/2021



Activity 2 description: Community Engagement

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: AllCare's traditional approach of Multicultural Listening Sessions was not able to be utilized during the last year. AllCare is reassessing engagement strategies with the Regional Health Equity Coalition, Black Alliance for Social Empowerment, and Community Advisory Council Members. AllCare's engagement with LGBTQ and Latinx populations was significantly established prior to the pandemic, this allowed for agile Equity initiatives for these populations. This trust and partnership was not yet been established with Black community members.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Assessment of community engagement strategies	Three clear strategies developed with the community	06/01/2021	Increase African American PCP visits to within 5% of the overall CCO average.	4/1/2024

Activity 3 description: Provider Assessment

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Engagement with multicultural communities is a discipline for providers. As such, AllCare is developing several tools to assess a provider's ability to provide services outside of the standard established for the Dominant White Culture. Currently the CLAS workgroup is working with the Credentialing and Quality committee to develop questions that assess a provider's aptitude for working with Multicultural communities.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Development of assessment tool	Upon credentialing and recredentialing, a provider would be sent a questionnaire, developed in partnership with the regional health equity coalition, for the Quality committee to review and identify opportunities for additional cultural agility training and education.	06/01/2021	Policies, process and procedures fully implemented	6/1/2022

Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed)

A. Project short title: Project 11: Increased availability of Chiropractic Services in Jackson County

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

If continued, insert unique project ID from OHA: 211

B. Components addressed

a. Component 1: Access: Timely
b. Component 2 (if applicable): Choose an item.
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☐ Yes ☒ No
e. If this project addresses social determinants of health & equity, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☐ Social and community health
f. If this project addresses CLAS standards, which standard does it primarily address? Choose an item.

C. Component prior year assessment:

As policy, to ensure that AllCare CCO is providing an adequate network for the members we serve. To follow 42 CFR 438.206 “Availability of Services” and 42 CFR 438.207 “Assurances of adequate capacity and services.” Data is compiled monthly from the provider database to show network capacity by zip code for each specialty.

As part of this process, AllCare monitors the days until next appointment availability of all providers and specialties. This is done through self-attestation, secret shopper calls, and site visits by AllCare staff.

Within Josephine County, AllCare has eleven (11) contracted Chiropractors with an average appointment availability of 3.67 days until the next available appointment.

Within Jackson County, AllCare has thirty-seven (37) contracted Chiropractors with an average appointment availability of 37 days until the next available appointment.

D. Project context:

The Covid-19 pandemic significantly impacted this project. Shutdowns in 2020 radically changed provider availability and appointment availabilities. After the clinics reopened, many of the practices wanted to fill appointments and their schedules. This was an attempt to recoup funds lost during the shutdown.

E. Brief narrative description:

AllCare CCO will engage in dialogue with the Jackson County Chiropractors to gain a better understanding of what drives longer wait times in the county. We will begin Provider engagement within the county to educate Chiropractors on our expectation of timely access. AllCare will determine network adequacy in Jackson County without those providers deemed to have unacceptable wait times. Consideration will be given to reducing the size of the panel by eliminating those providers that are unwilling to take corrective action to bring wait times down. Monitoring of wait times will be done monthly to assess progress toward targeted improvement levels. See attached document TQS Project # 11 Timely Access ID-211 for access status by zip code within Jackson County as of end of Q3 2020.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Monthly Network Adequacy Analysis

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: With the Covid-19 pandemic Chiropractors were one of the specialties closed by the Governor's orders. As the restrictions were eased, access greatly increased within the County. Multiple providers were also added to the Medicaid Network. The current average wait time is 1.825 days for the entire county. There are still three providers outside of the 20 day goal.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Specialty has been identified as a problem area.	Identify Specific providers and what is driving wait times.	09/2020	Reduction of average appointment availability for Chiropractors in Jackson County to 20 days.	11/2020

Activity 2 description: Ongoing monitoring

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Ongoing monitoring please see attachment labeled TQS Project # 11 Timely Access ID-211 for an example of the type of report used to monitor provider access broken down by specialty, zip code, and wait time for appointment.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Access Monitoring	Maintain current access availability within county	06/2021	If availability increases to beyond 20 days. Begin interventions again to support providers	12/2021

Section 2: Discontinued Project(s) Closeout

(Complete Section 2 by repeating parts A through D until all discontinued projects have been addressed)

A. Project short title: Special Healthcare needs; transitions of care.

B. Project unique ID (as provided by OHA): #49

C. Criteria for project discontinuation: CCO's and/or organizations' resources must be reprioritized and shifted to other bodies of work

D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): The elements of this work required face-to-face contact with hospital staff and members within their homes. Due to the Covid pandemic, such face-to-face contact was deemed risky for exposure and contamination of the virus. Such contact was disallowed by local hospitals and AllCare Health. To comply with public health requirements, but continue with the mission of member-centric service, this goal was suspended and another selected which was more aligned with public health safety measures.

Section 3: Required Transformation and Quality Program Attachments

A. REQUIRED: Attach your CCO's Quality Improvement Committee documentation (for example, strategic plan, policies and procedures as outlined in TQS guidance).

B. OPTIONAL: Attach other documents relevant to the TQS components or your TQS projects, such as policies and procedures, driver diagrams, root-cause analysis diagrams, data to support problem statement, or organizational charts.

C. OPTIONAL: Describe any additional CCO characteristics (for example, geographic area, membership numbers, overall CCO strategy) that are relevant to explaining the context of your TQS: Add text here.

Submit your final TQS by March 15 to CCO.MCODeliverableReports@state.or.us.

allcare health®

Changing healthcare to work for you.

Date: March 23, 2020

To: All AllCare Health, Inc. contracted interpreters

From: Stick Crosby, Director, Network and Health Equity, AllCare CCO, Inc.

Subject: Video Remote Interpreting during the COVID-19 public health emergency

On March 17th, 2020 the Centers for Medicare & Medicaid Services (CMS) has broadened access to Medicare telehealth services so that beneficiaries can receive a wider range of services from their doctors without having to travel to a healthcare facility. These visits are considered the same as in-person visits, and are paid at the same rate as regular, in-person visits.

In order to mitigate the risk to the Certified and Qualified Interpreter workforce, and prevent further spread of the virus COVID-19, effective immediately, AllCare will exercise enforcement discretion related to Video Remote Interpreting (VRI).

AllCare classifies Interpreters, and direct service providers in the following categories:

- Contracted In-Person interpreters- Those interpreters contracted directly or subcontracted through an agency, or employed by a contracted Healthcare entity that provide in-person interpretation

- Video Remote Interpreters- A video telecommunication service that uses devices such as web cameras, or videophones, to provide sign language or spoken language interpreting services.

- Telephone interpreting- Is a service that connects interpreters via telephone to individuals who wish to speak to each other but do not share a common language.

- Direct Service- Those Providers, Medical Assistants, Receptionists, or healthcare staff that have completed a language proficiency test and are communicating directly with the LEP. Once the individual providing Direct Service begins communicating a message between the LEP and another individual, the communication becomes Interpretation.

All Contracted In-Person Certified or Qualified interpreters that serve Limited English Speaking Patients (LEP) in good faith will have the option to use everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency.

1701 NE 7th St.
Grants Pass, OR 97526
Phone (541) 471-4106
Fax (541) 471-3784
Toll free (888) 460-0185
TTY 711
AllCareHealth.com

- Directly Contracted or Subcontracted Interpreters AllCare will reimburse Interpreters at a **One-Hour Minimum**. Please document clearly on the invoice that the service was completed remotely.

- Those Interpreters employed by a contracted Healthcare entity please bill under **Place of Service 02.**

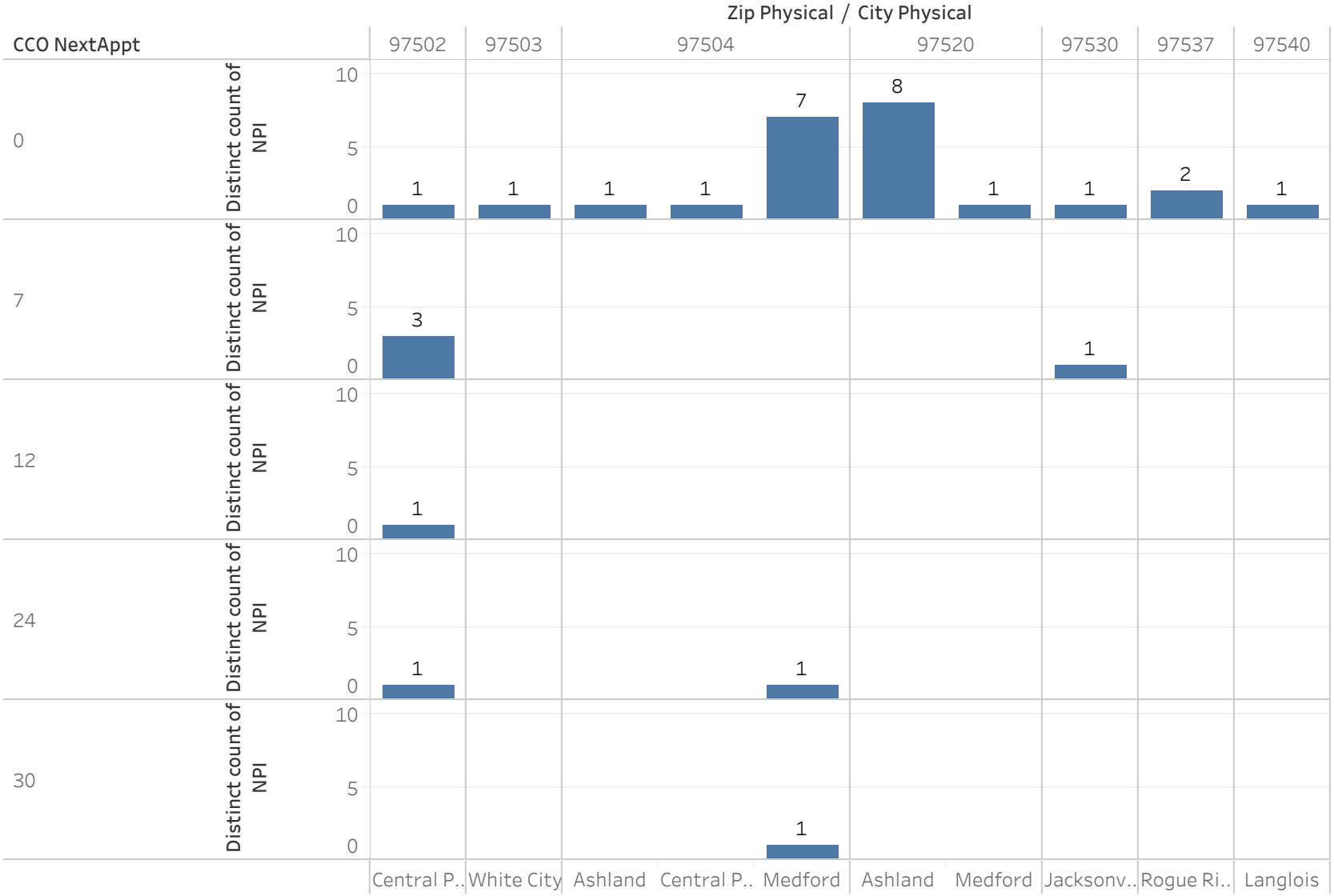
- There is no change at this time related to already established Video Remote Interpreters, Telephone Interpreters, and Direct Service providers.

This policy change will be in effect until Monday, June 15, 2020 AllCare will release another document at that time if this policy change will continue. Please send any clarification questions you may have to LanguageAccess@AllCareHealth.com

Thank you for your continued support of AllCare and the services that you provide our Members.

Stick Crosby
Director, Network and Health Equity
AllCare Health, Inc.
Pronouns: He/Him/His
Phone +1 (541) 471-4106
Email Stick.Crosby@allcarehealth.com

Quarter 3 2020,Jackson County,Chiropractor, Chiropractor/Orthopedic, Chiropractor/Sports Physician



Distinct count of NPI for each City Physical broken down by Zip Physical vs. CCO NextAppt. The data is filtered on County and F Spec. The County filter keeps Jackson. The F Spec filter keeps Chiropractor, Chiropractor/Orthopedic and Chiropractor/Sports Physician. The view is filtered on CCO NextAppt, which excludes Null.

CY 2020 Quality Assurance Program Improvement Assessment and
CY 2021 Quality Improvement Strategy Plan
Revised: 02/20/2021

Table of Contents

CY 2020 Quality Assurance Program Improvement Assessment and CY 2021 Quality Improvement Strategy Plan

Revised: 02/20/2021

Introduction

Program Mission:

AllCare Health is committed to excellence in the quality of care and services provided to members and to the competence of its providers, practitioners and ancillary networks. In embracing the Triple Aim and Health Care Transformation, the Quality Improvement Program is focused on the following: improving member satisfaction, improving the health status and quality of care for our members and communities served, improving member safety and ensuring member access to medical, oral health, mental health and social services in the most integrated and cost-effective manner as possible.

The Quality Improvement Program reflects adherence to state and federal laws, Oregon Administrative Rules, Oregon Statutes, CFRs and the OHA contract.

Mission Statement: *"Working together to provide quality, cost-effective healthcare for our communities."*

Brand Line: *"Changing healthcare to work for you"*

Belief Statements:

- "***We believe in compassionate care for all*.** Everyone deserves to know they're being cared for – that someone has their health and happiness in mind";
- ***"We believe in forward thinking***. Our unique programs for patients and progressive services for independent providers, are shaping the future of healthcare";
- "W**e believe in community. *We live here*.** We are part of the community and we care about its well-being"; and
- ***"We believe in helping.*** To us, better healthcare includes proactive customer service for patients and providers alike".

Program Scope

The Health Plan's Quality Assurance Performance Improvement Assessment and the Quality Improvement Performance Strategy establishes a formal QI Program that reflects the comprehensive processes for the development and implementation of an effective clinical quality improvement program, promotes objective and systematic monitoring and evaluation of clinically related activities, and continuously acts on opportunities for improvement (CQI). The Program focuses on activities related to health care provider access and availability, language access, member satisfaction, patient safety, continuity and coordination of care, quality measures, required quality projects, disease management, clinical pharmacy programs, preventative health, health equity, member rights and quality of care, focused behavioral health projects and over/under utilization of services. The Program's goal is to identify and adapt ineffective or inefficient systems to improve the health experiences and outcomes of our members. The Board of Governors annually approves and supports the continued dedicated efforts that have been part of the quality strategy by addressing and supporting the social determinants of health: sufficient food, housing, utilities, domestic violence and non-emergent transportation flex services.

As required, AllCare has included a review of the 2020 Quality Assurance Performance Improvement Assessment (QAPI) along with 2021 Quality Improvement Strategy Plan elements.

CY 2020 Quality Assurance Program Improvement Assessment and CY 2021 Quality Improvement Strategy Plan

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2020 Quality Assurance Performance Improvement Assessment includes quality projects that align with the CHP (Community Health Improvement Plan), Statewide Health Improvement Plan (SHP), Health Equity and Inclusion and the Triple and Quadruple Aim.

The pandemic had a direct impact on many of the preventive and quality performance measures; especially those dependent on preventative and direct non-urgent or emergent care. It was difficult to meet the improvement targets or benchmarks. The following are examples of the pandemic's direct impact on having the negative effect on maintaining the improvements made over the past several years: school closures and distance learning – no fluoride varnish, or dental assessments; non-essential medical care was delayed – colonoscopies, mammography, DEXA scans, and routine labs.

Additional information will provide insight into the extraordinary efforts made throughout the global pandemic and during the devastating wildfires to provide and ensure that Southern Oregon communities and AllCare members continued to receive the medical, oral health and behavioral health services, equipment, transportation and other critical support and care needed during these unprecedented times.

Respectfully Submitted,

Cynthia Ackerman, RN CHC
Chief Quality Officer

CY 2020 Quality Assurance Program Improvement Assessment and CY 2021 Quality Improvement Strategy Plan

Revised: 02/20/2021

Narrative

This 2020 Quality Assurance Program Improvement Assessment (QAPI) and 2021 Quality Improvement (QI) Strategy Plan provides a detailed description of quality improvement activities and significant accomplishments during the past year. The evaluation documents activities undertaken to achieve work plan goals and alignment with the collaborative CHP, SHP and establishes the groundwork for future quality improvement activities.

The development and execution of the Quality Improvement Program is a process that relies on input from committees, consumer advisory councils, focused work groups as well as dedicated organizational staff. The quantitative/qualitative work is directed at appropriate initiatives, activities, deliverables and policies and procedures that support the mission and direction established by the Board of Governors and overseen by the QIC.

The Chief Quality Officer takes the lead in compiling this report with support from the following departments: Appeals and Grievances, Integration Team, Compliance and FWA, Claims, Health Equity, Customer Engagement, Care Coordination, Population Health – Disease Management, Maternal and Child Health, Provider Services, Utilization Management, Pharmacy Services, Language Access, Health and Wellness, Behavioral Health, IT and Credentialing.

The Quality Improvement Strategy Plan Goals include but are not limited to the following:

1) Review the Quality Improvement Strategy Plan and Quality Assurance Performance Improvement Assessment (QAPI) and evaluate if the goals and objectives were met;
2) Prepare the QAPI and Strategy Plan with measurable goals and objectives;
3) Document discussion and encourage a thoughtful process in the development of interventions to address areas for improvement – aligning with the CHP, SHP and Quadruple Aim;
4) Demonstrate and document quantitative and qualitative analysis;
5) Make revisions, to meet current standards and requirements including changes approved through Committee action and analysis; include signature pages, Strategy Plan, QAPI Assessment, Policies and Procedures;
6) Utilize the annual evaluation, PIPs, TQS, Quality Incentive Measures, CHP goals and SHP goals in the development of the Annual Work Plan for the upcoming year;
7) Include a Strategy Plan that includes main quality project goals, due dates, responsible party with ongoing review and analysis;
8) Review all standing policies and procedures and make revisions as needed to meet all regulatory requirements and
9) Develop new policies and procedures for any areas not currently covered or to meet new/current regulatory requirements.

COVID-19 Global Pandemic

The contract year 2020 was challenging and stretched resources from the standpoint of conducting business during a global pandemic. Within 2 weeks of the initial shut-down (mid-March), 85% of AllCare's employees were mobilized to work securely from home. In contrast, prior to the pandemic AllCare had allowed very few employees the ability to work from home. This was primarily due to stringent security controls and honoring a culture of providing the highest level of customer service to our members, providers and community partners and more importantly 'meeting members where they are'.

CY 2020 Quality Assurance Program Improvement Assessment and
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Despite the pandemic and recognizing that risks were even greater for our vulnerable members, AllCare's Care Coordination, Customer Engagement, Quality Improvement staff, Integration Team and NEMT providers performed focused outreach and communications to ensure that our members still had access to needed health care, food, transportation and housing. The monetary support provided to Community Based Organizations focused on marginalized communities, language access, ensuring NEMT, food, housing, resources for the homeless, home-bound, families impacted by distance-learning and suddenly without resources, educational support and loss of employment.

Wildfires

Amidst the COVID global pandemic, in early September, devastating wildfires swept through several Southern Oregon communities in our service area with Jackson County suffering the most loss (4 people died) and damage to businesses and homes. In Jackson County, the Alameda fire destroyed: 2,364 homes with many being mobile homes or trailers that housed some of the area's poorest residents; 295 other structures were destroyed (this number included small businesses in Talent and Phoenix); and 81 provider officers were impacted by smoke damage with 2 offices burned to the ground.

AllCare's Equity staff, Care Coordination, Traditional Health workers. Quality Integration Team and Medical Directors mobilized the night of the fire, helping to stand up emergency shelters and care for evacuees and their families. Our Oral Health Director's husband delivered oxygen to the Emergency Shelter in Josephine County at midnight where evacuees from Jackson County had fled leaving behind oxygen, diabetic supplies, medications, wheelchairs and dentures. The Public Health Officer and a nurse practitioner oversaw the Emergency Shelter in Josephine County and were acutely aware that COVID was still a factor but that first night and ensuing days, the priority was getting people evacuated safely and providing critically needed supplies and care.

Because of a partnership between the State's Wildfire/Emergency Response Team and internal AllCare IT staff trained in the area of ArcGIS mapping, AllCare was able to identify the Level 3 burn areas and actual ash areas in Josephine and Jackson Counties. The information was then correlated with AllCare's member data (for both Medicare Advantage and CCO) and that data (address, phone number, age, county of residence, frailty) was given to the Care Coordination Team to make outreach calls. This happened within 48 hours of the fire event. More detail will be included in the body of the assessment detailing the work and support provided to members, providers and the communities in Southern Oregon during that time.

Service Area and Enrollment: In 2020, AllCare Health experienced significant changes in CCO enrollment and membership distribution. AllCare Health serves members residing in Josephine, Jackson, Curry and southern Douglas Counties in the Southern Oregon region.

Topic	2017	2018	2019	2020
AllCare CCO Enrollment	49,666	50,833	51,569	53,300

[redacted]

CY 2020 Quality Assurance Program Improvement Assessment and CY 2021 Quality Improvement Strategy Plan

Revised: 02/20/2021

[redacted]

Demographics (REAL-D)

Eligibility	African-Am /Black	American Ir Alaskan Nat	Asian/ American	Hawaiian/ Pacific Islan	Hispanic/ Latino	White	Other Race	Unknown	Grand Total
Adults	225	396	211	83	1023	19161	231	12022	33352
Children	123	203	81	35	784	7232	116	8828	17402
Grand Total	348	599	292	118	1807	26393	347	20850	50754

AllCare has dedicated staff for Language Access, Native American Liaison and continues to grow the Health Equity/Inclusion Program.

Policies and Procedures: AllCare Health recognized that the policies and procedures guiding our ability to adhere to contractual CMS and OHA requirements needed to be managed with a centralized software solution. Despite numerous setbacks, AllCare has a dedicated Director to train staff and oversee this project to completion. The NAVEX Global Policy Management software platform will be implemented by 05/31/2021 and will require training and support in all operational areas: Customer Engagement, Quality-(Appeals/Grievances and Quality Program), Population Health-Pharmacy Services and Utilization Management, Care Coordination/Intensive Care Coordination, Claims, Finance, Enrollment/Premium Payment, Provider Services (Credentialing, Contracting, Value Based Payment, PCPCH, Star Measures, Quality Incentive Metrics, TQS, MSO, eHealth), Administrative, Compliance (FWA, Ethics, HIPAA Privacy and Security), Human Resources, Brand Management, and Marketing (Medicare Advantage).

The implementation of this software platform will have many benefits: Version control with automatic archiving, stored employee signatures with each version at the time it was reviewed, provide reporting and support for audits, employees will be able to access documents anywhere, automatically route new and updated policies and procedures to employees, assign attestation completion, give comprehension quizzes and ad hoc reports.

2020 Regulatory Audits and Reviews - AllCare Health was audited in the following areas with minimal findings:

- Mental Health Parity Audit (10/30/2020): Three findings; Work Plan submitted 03/05/2021
- EQR Program Integrity Audit (11/10/20): Work Plan submitted 03/01/2021

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- Focused Review Encounter Data (10/15/20):
- NOABD Review: Results received 03/03/2021; Resubmission pending further guidance
- FWA Program Integrity Review: Resubmission 11/30/2020 with 3 findings; Annual Program Evaluation submitted 02/15/21.
- B-Corp Recertification: Documents submitted 01/2021;

1. Quality Improvement Committee and Governance Structure:

2020 QAPI Response: The ultimate responsibility for the Quality Improvement Program resides with the Board of Governors. Authority and responsibility are delegated to the board-appointed Quality Improvement Committee and other Board Subcommittees to direct and oversee the clinical Quality programs for AllCare Health. The Quality Assurance Performance Improvement Assessment is reviewed by the Quality Improvement Committee, CMO and Chief Quality Officer; the QI Committee and Executives provide feedback for potential strategies to address any less than desired outcomes or areas where improvement can be attained. The Quality Improvement Strategy Plan is distributed to the Board with the Board Liaison, CEO, CMO and Chief Quality Officer approving the Quality Improvement Strategy Plan. For 2020, the QI Strategy Plan was not completely implemented and with the onset of the COVID-19 Global Pandemic, internal resources were mobilized to provide outreach to members, provider offices and subcontractors. Through the 2020 QAPI review, it was determined that closer interdepartmental communication should occur between Credentialing>Compliance>Quality to better alert the Board Oversight Committees of providers with licenses under stipulated orders, under investigation for (FWA), and Quality of Care concerns. Given turnover of key positions (COO), it was also identified that several required elements needed to be integrated into the Quality Strategy Work Plan. Key departmental leads will develop processes to more closely align TQS, PCPCH, APMs/VBPs to have oversight by the QIC.

2021 QI Strategy Plan:
Quarterly or as needed, the Quality Improvement Committee will review the Strategy Plan and add new areas of concern (identified by emerging risks or noncompliance) or areas (because of the pandemic that performance benchmarks or improvement targets were not met) that may be identified during the contract year.

2021 Quality Improvement Goal	Action Steps	1Q	2Q	3Q	4Q	Responsible Party
Quality Improvement Committee (QIC) Training and Education	Perform trainings for the QIC members to provide a better understanding of their roles and Board oversight responsibilit	x	x	x	x	Chief Quality Officer and Chief Medical Officer
Quarterly and as needed, review the Quality Strategy Plan	The QIC will review the Strategy Plan and make needed revisions	x	x	x	x	Chief Quality Officer (CQO) and Chief Medical Officer (CMO)
QIC will meet monthly but no less than every other month.	Provide a calendar of schedule Zoom meetings	3x	3x	3x	3x	CMO and CQO

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Develop reporting Processes from each Operational areas responsible for Quality Requirements to the QIC on a quarterly basis.	The CQO and CMO will meet with Population Health-ICC, Disease Management, Maternal and Child Health UM Pharm Services VP for Medication Safety Pharmacy, NEMT, Customer Engagement, Timeliness, NOABD	xx x	xx x	xx x	xx x	CMO, CQO and Compliar Analyst
2021 Quality Improvement Goal (cont'd)	**Action Steps**	**1Q**	**2Q**	**3Q**	**4Q**	**Responsible Party**
By 2Q2021 Create a Quality Organizational Structure & Schematic	Work with Compliance Director develop a Quality Organizational and Governance Structure document	x	x			Director of Community Benefit Initiatives and CQO
Monthly ensure communication between Credentialing, Quality and Compliance occurs	During monthly Committee preparation meetings, create a Standing agenda item	xxx	xxx	xxx	xxx	Quality Director, CQO, CMO, Quality Board Chair, Credentialing Director
Develop reporting Processes from each Quality required projects: TQS, PIPs, PCPCH, Quality Incentive Measures, APM/VBPs to the QIC	Schedule as standing agenda On the QIC agenda high-light each of the required projects	xx	xx	xx	xx	TQS lead, APM/VBP Direct Health Equity Director, Quality Director, Care Coordination Director, Provider Network Director

1. Quality Improvement Program Policies and Procedures Management System

2020 QAPI Response: AllCare Health had a quality goal to transition from department specific policy repositories to a centralized electronic platform, Navex Global Policy Management software. Due to inadequate human resources to carry out the 2019 and 2020 quality goal, little advancement of the project occurred in 2020.

2021 QI Strategy Plan: By May 31, 2021 Navex Global Policy Management software will be implemented company-wide with a dedicated Director and trainer assigned to the project.

2021 Quality Improvement Goal	**Action Steps**	**1Q**	**2Q**	**3Q**	**4Q**	**Responsible Party**
By May 31, 2021, 100% of the Operational Areas will have transitioned policies to	1Q and 2Q assign a dedicated Director to manage the project. Train, create Listening Sessions, Transition policies to Policy Tech. 3Q and 4Q will be used	x	x	x	x	Chief Compliance Officer and Director of Community Benefit Initiatives

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the Navex Global Policy Management Platform	to circle back to determine if the System is being used appropriately.					

2. Quality Risk Assessment

2020 QAPI Response: The 2020 Risk Assessment Tool was originally designed to assess Compliance Risks from a legal, compliance, reputational and financial perspective. The Tool was equipped with formulas that allowed an objective assessment based on the Executive's 'level of confidence' that sufficient controls were in place to mitigate risks identified. In utilizing the Tool for 2021, it became evident that because of how the Tool was configured, that with every years' use, the formulas had broken down and were not consistently useable. The 2021 Quality Risk Assessment and other operational areas were manually calculated.

2021 Quality Improvement Strategy Plan: In 2021, an effective Risk Assessment Tool is essential to effectively manage enterprise wide-risks. The Risk Management Assessment Tool will be built in-house or purchased externally.

2021 Quality Improvement Goal:	Action Steps	1Q	2Q	3Q	4Q	Responsible Party
By 4Q create a Risk Assessment Tool for 2022 using SmartSheet or utilize a commercial product	Explore the feasibility of 'building' a risk assessment tool In house versus purchase of a Commercial product		x	x	x	CQO, Chief Compliance Officer and Compliance Analyst

3. Grievances-Appeals, ABA and Hepatitis C Denials and Internal Quality Concerns:

2020 QAPI Response:

Grievances - AllCare Health considers a grievance as 'any dissatisfaction with any aspect of a member's health care services, providers or health plan service'. All grievances whether oral or written are documented and logged by Member Services staff. Members are notified of their grievance and appeal rights through various communications including but not limited to the member handbook and AllCare's public facing website. Focused trainings occurred with 'member-facing' departments such as Member Services, Care Coordination, Reception and Utilization Management; these trainings are conducted to ensure that all employees understand the critical need to capture all complaints and grievances. Employees are encouraged to attain a satisfactory resolution as expeditiously as possible even though an ensuing investigation may occur. AllCare Health strives to ensure thorough, appropriate and timely resolution to members' grievances and to aggregate and trend reasons for grievances in order to take action to reduce future occurrence. Quarterly, summary results were reported to the Quality Improvement Committee, the Board of Governors and the Oregon Health Authority. The highest number of grievances were lodged against [redacted] .

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[redacted]**: 10 QIC and 1 complaint**
[redacted] is the only [redacted] who had internal concerns submitted. In 2019, AllCare CCO identified an issue with [redacted] billing members for services instead of billing AllCare CCO. An investigation began and monthly meetings with various compliance staff at [redacted] corporate office were initiated. During these calls it was identified that during a software upgrade the clearing house information for AllCare was not set up correctly which prevented claims from being submitted and received at AllCare electronically. [redacted] corrected the issue and the number of concerns dropped off. However, in 2020 AllCare CCO started receiving new concerns from members regarding bills they are receiving. During the root-cause analysis it was determined that only dual eligible members were being balanced billed based off the primary (Medicare/Medicare Advantage) remittance advice. AllCare CCO reached out to [redacted] to start conducting a deeper dive to uncover why this is occurring. The deeper dive revealed that [redacted] was billing AllCare CCO members based on an eligibility file supplied by the Medicare Advantage Plan. [redacted] was not reviewing the remittance advice for the cross over claim that included the Medicaid (AllCare CCO) adjudication information. AllCare is updating the remittance advice for dual eligible members to include an adjudication code indicating that the member is a dual eligible member. In addition, AllCare is in the process of surveying the dual eligible members who have a [redacted] primary claim to see if they have been billed for services and to assist the members with getting reimbursed for their out of pocket expense. Further follow up will be provided during 2021 reporting.
Because of repeated failed attempts to contact the Corporate Quality Officer and Corporate Compliance Officer to respond to the illegal balance billing of members [redacted]

[redacted]**:**
[redacted] is the corporate owners for [redacted]) ([redacted]) in Josephine and Jackson County. In 2020 there has been a notable increase in the number of quality of care concerns and complaints submitted against the [redacted] facilities. There were 7 incidents reported at [redacted]; 1 at [redacted] and 1 at [redacted].

With COVID 19 pandemic and the restrictions to access the [redacted] by the public, AllCare CCO relied up on member grievances, utilization review and our NEMT vendor to identifying quality of care concerns within the [redacted]. AllCare CCO has worked with the [redacted] Regional Nurse Consult to address the quality issues as they occurred. However with the significant quality of care concern in the complaints AllCare CCO has received, these concerns have been elevated up the Regional Vice President for additional review and to be addressed with each facility.

[redacted]**:**
In 2019 and the early part of 2020, AllCare CCO had [redacted] on a corrective action plan for the access issues in Jackson, Josephine and Curry County. Bi-Weekly progress reports were provided by [redacted] including updates to obtain additional coverage in the three county service area. Various solution to the access issues were the adoption of tele [redacted] in Curry County, bringing in [redacted] to all three counties, and developing a floating [redacted] position. The corrective action plan was completed at the end of February 2020.

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In 1Q2020- there were 9 complaints submitted regarding [redacted]. 6 of those complaints were about the Grants Pass [redacted] providers with 5 in regards to Access. The other three were regarding the Brookings office, but were related to access but with interactions with providers and the care they received.

In 2Q2020- the complaints increased to 12. However only 4 were regarding access, two had to do with Grants Pass providers and two with unknown locations, as they were taken and processed [redacted]. The remaining complaints were in areas such as Quality of Care and Quality of Service. All complaints were reviewed by the [redacted].

In 3Q and 4Q2020 the number of complaints decreased to 5 for 3Q and 4 for 4Q. None of the complaints were regarding access to [redacted] services.

DME Vendors:
In 2020 the number of complaints regarding DME vendors continued to be a concern. AllCare developed contractual professional relationships with each DME vendor to assist with timely resolution of complaints. In addition, AllCare CCO had periodic meetings with the individual DME vendors in order to maintain relationships, discuss complaints 'real time' and build a system for resolving issues quickly.

AllCare received complaints regarding the timing of receiving supplies. This was a known issue when the COVID pandemic began. The vendors were having issues with timely shipping of products when using FedEx and UPS. Once this was worked out with FedEx and UPS, the complaints in the delay of receiving shipped supplies decreased.

There were various billing complaints. In one incident, the vendor did not have the member's primary and secondary insurance information. AllCare provided the insurance coverage and the issue was resolved. There was an incident were the vendor wanted a prior approval for supplies. However, the items did not require prior authorization. Once this was explained to the vendor, there were no further issues. However, a member was not able to get supplies as the member had a previous outstanding balance on their account prior to being on the Oregon Health Plan. The member did switch to another DME vendor for their supplies.

It was noted that the member education on the oxygen and C-PAP benefits have not been ideal. There were 3 complaints submitted by members regarding not understanding how their oxygen or C-PAP equipment worked. Members were connected with our internal Respiratory Therapist who explained the equipment to the members. In addition, feedback was provided to the DME vendor.

AllCare monitors on a quarterly basis ABA and Hepatitis C denials:

Denials	1Q2020	2Q2020	3Q2020	4Q2020
ABA	0	0	0	0
Hepatitis C *	6	3	1	9

*Does not include the number of initial denials overturned and approved.

2021 QI Strategy Plan: 1) Continue to track, report ABA and Hepatitis C Denials to QIC and OHA as required; 2) Revise the reporting to reflect denied Hepatitis C prior authorizations that were overturned upon appeal; and 3) Perform a quality focused review on ABA Services; 4) Continue to monitor A & G and provide summaries to the

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QIC; 5) Monitor Internal Quality Concerns specifically [redacted] and AllCare IQCs; and 6) At the QICs recommendation, place [redacted] on CAPs and 6) Work with the Customer Care Department on internal trainings regarding benefit information and provide information on the Member Portal.

4. Member Rights and Responsibilities:

2020 QAPI Response: Through various OHA reviews, it was discovered that the Member Handbook still lacked the correct address to report FWA and Compliance concerns. The Handbook was revised to reflect the correct address and contact information.

2021 QI Strategy Plan: The following are Quality Strategy Goals for 2021: 1) Train internal staff who the designated Civil Rights designee; 2) Identify and bridge the gaps between Health Equity, Customer Care, Health Disparities, Internal Quality Concerns, Language Access; and 3) Ensure that all member materials, web site information are at appropriate grade levels, interpreted languages, 4) Launch a member portal and 4) Continue to build on existing language access (including ASL) resources available.

5. Health Equity-Inclusion and Language Access:

2020 QAPI Response: AllCare CCO had scheduled a 2020 Southern Oregon Interpreter Conference for mid-May. Due to the COVID pandemic, it was cancelled. AllCare distributed and trained subcontractors (Capital Dental) resources and information regarding Language Access. Materials included: an interpreter dictionary; 'I-Speak Pamphlet', 'I-Speak Cards', and FAQs on Language Access and a 'how to' on 'Accessing Interpreter Services'. Trainings also occurred with Primary Care Providers describing the importance of in-person interpretation and the interpreter services available to AllCare members. In addition, the same materials were provided and detailed instructions on how to access interpreter services. An Internal Employee 'Process Mapping' Survey was distributed in order to determine the most acute need for training and education. Questions included: 'How do you handle Language Access in your department?', 'If I was a person who spoke little to no English, how would you communicate what you do and what services you provide?', 'How would you get that information/translated?', 'How is a request made in your department when you need something interpreted?'. A Board presentation in early 2020 featured that AllCare had received the 2019 Language Access Champion Award from the NCIHC (National Council on Interpreting in Health Care. AllCare was recognized because of the following: Value Based Payment Model Measure; 2) Cross Cultural Healthcare Program (Bridging the Gap); 3) Created a written and oral testing site outside of Portland; 4) Only insurance plan in Oregon that allows providers to bill for Certified or Qualified Interpreters directly through the claims system and 5) Significant increases to the availability of interpreters.

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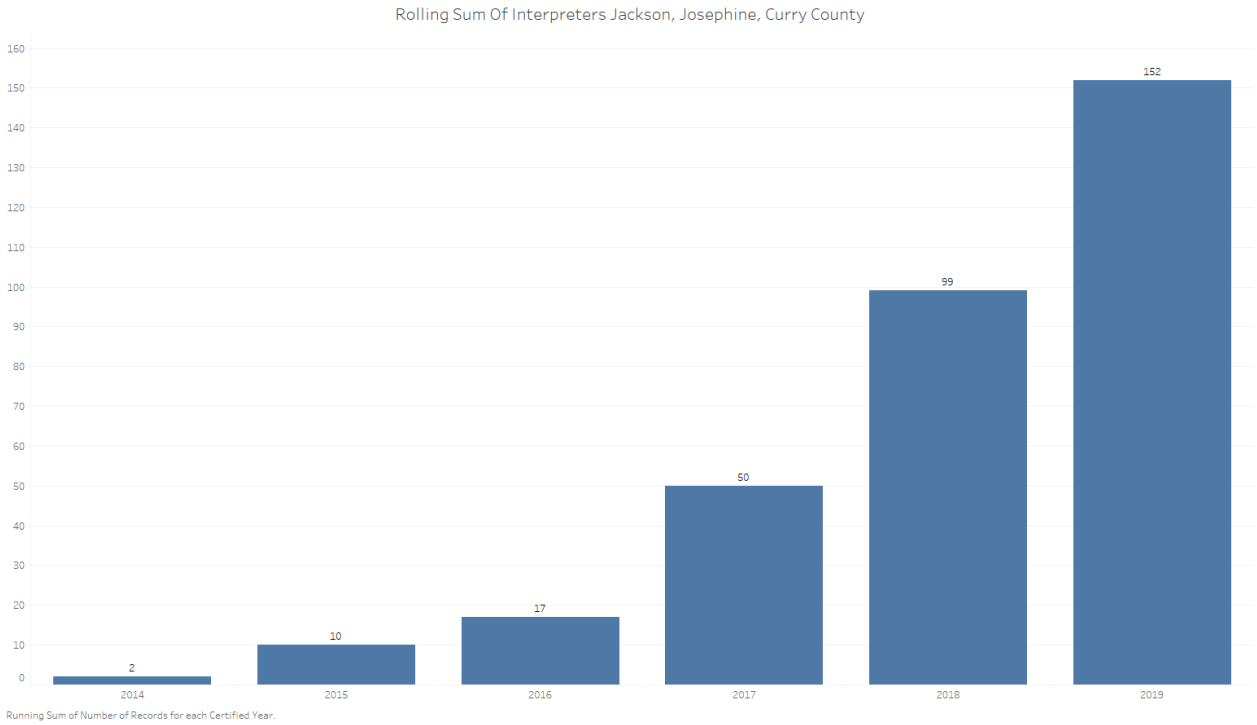

The number of Interpreters significantly increased between 2014 – 2019; from 2 (2014) interpreters to over 152 interpreters (2019).

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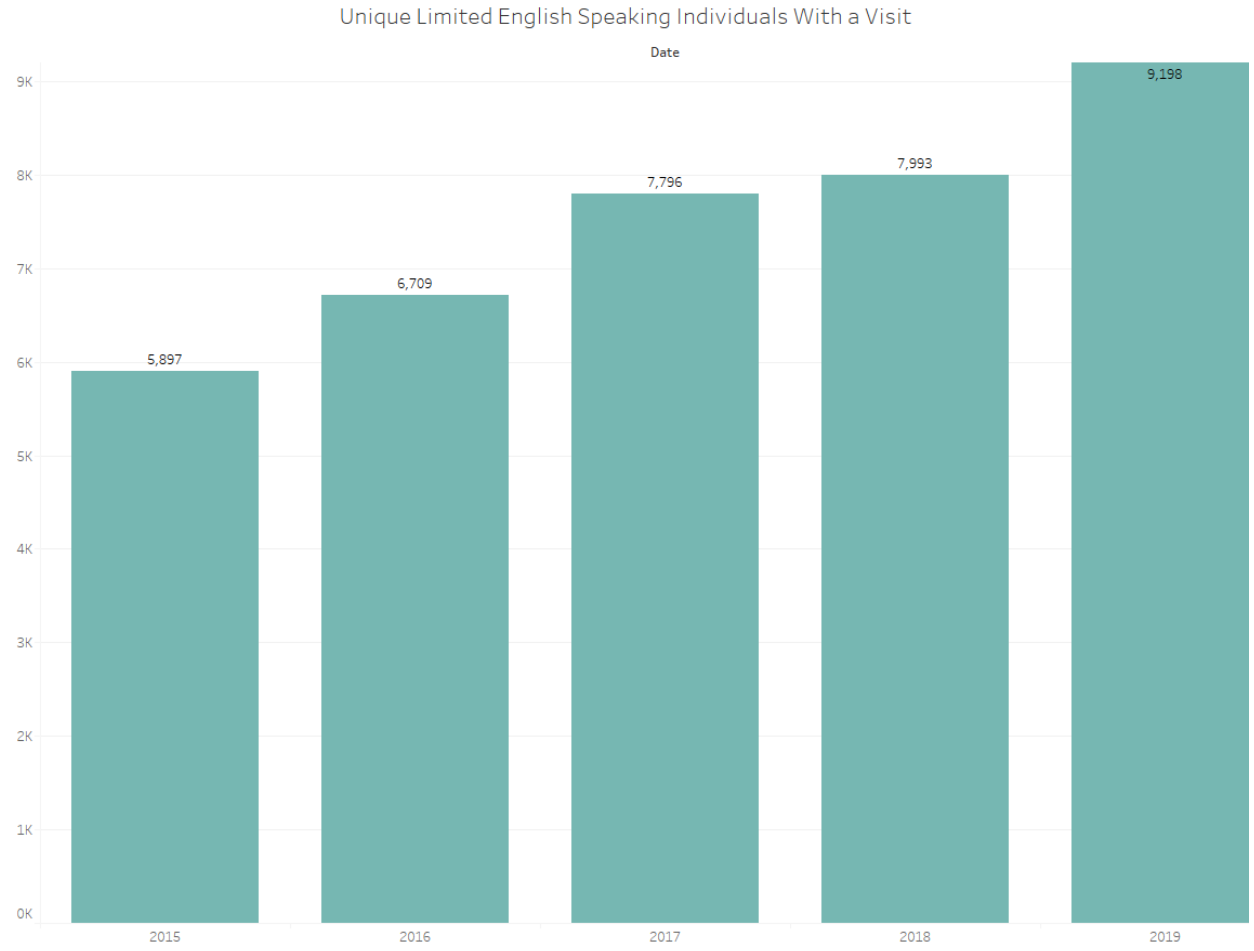

Between 2015 there were 5,897 unique Limited English Speaking Individuals with a PCP visit that increased to 9,198 unique Limited English Speaking Individuals with a visit.

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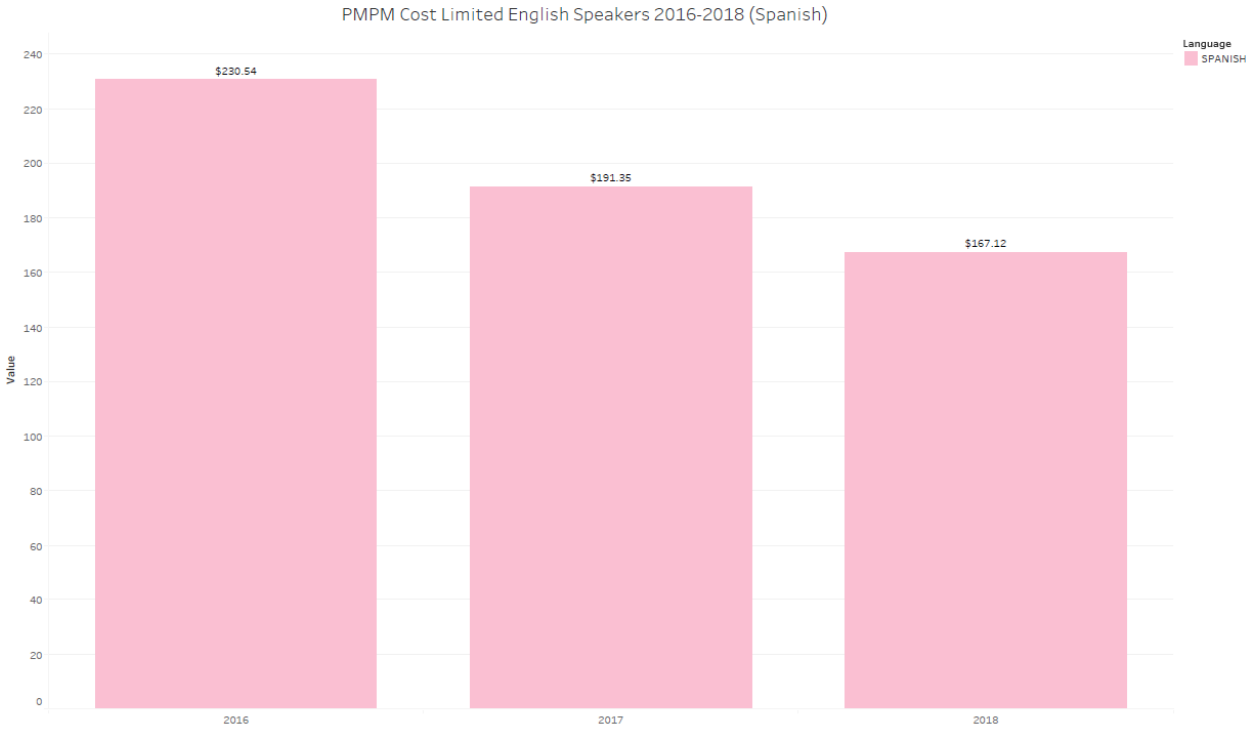

This graph depicts the average health care costs for unique Limited English Speakers from $230.54 in 2016 decreased to $167.12 cost per unique Limited English Speakers in 2018; demonstrating the correlation between having access to qualified interpreters and accessing appropriate health care in the right setting.

AllCare provided the following interpretive services for the following languages in 2020: Chinese Cantonese, Chinese Mandarin, French, Spanish, Tagalog, Vietnamese, Korean, Urdu, Punjabi, Rumen, Portuguese, Hindi, Farcie and ASL.

2021 QI Strategy Plan: [redacted]

6. Quality Project-Performance Improvement Projects (PIPs)

2020 QAPI Response: Three PIPs were retired in 2019, with three new PIPs being approved by the QIC: PIP#1, During the timeframe 2021 – 2023, AllCare CCO, Josephine County, pediatric population (ages 6 to 18 years of age), the aim is to increase adherence to asthma controller medications by 5% annually; PIP #2 In AllCare's service area (Josephine, Jackson, Curry and southern Douglas counties), all adults aged 18 and older, diagnosed with Type II diabetes will decrease their HgbA1C by 1 point annually or until it demonstrates good control, have fewer complications(ED and inpatient stays) and lower health care costs than

prior to being provided a CGM and PIP #3 Health Equity: Increase the number of Primary Care Visits for African/American AllCare members.

2021 QI Strategy Plan: The three PIPs align with TQS and MEPP projects, barrier analyses have been conducted and meetings will be scheduled with the different department leads to discuss quality strategies and identify internal and external stakeholders to assist in attaining the projects' aims.

7. Transformation Quality Strategies (TQS)

2020 QAPI Response: The Data Analytics Director, after the departure of the COO in October 2020, was designated as the TQS Lead and performed the required and necessary trainings, meetings, oversight and monitoring of the TQS projects adapting the changes outlined in the TQS Guidance Document distributed in late October 2020. The TQS Lead and the Chief Quality Officer performed one-on-one trainings on how to perform a barrier analysis, or a root-cause analysis, validating data, providing more in depth analysis of the projects, baseline data, and performance improvement targets. The TQS Lead presented to the QIC and described the changes and the timeline for the TQS deliverable.

2021 QI Strategy Plan: 1) Continue to keep the QIC updated and take recommendations if the improvement targets or benchmarks are not being attained; 2) Continue to schedule meetings with the department leads, Chief Quality Officer, Director of Quality Improvement, CMO, COO and other executives to ensure that the TQS projects are in alignment with the CHP, SHP and Triple Aim and that deliverable dates and updated reports to OHA are submitted timely.

8. Alternate Payment Methodologies (APMs) and Value Based Payments (VBP):

2020 QAPI Response: AllCare Provider Staff developed a power point presentation titled 'An Alternative Payment Model (APM), a Value-Based Payment Program for 2020' that included the Methodology and Measure Specifications for Primary Care and Pediatrics. (Please see the document 'Example ACH Alternate Payment Methodology- power point presentation'. The Program outlined the Measure (that reflects CHP, SHP, Quality Incentive, Performance Measures, Health Equity, Next Available Appointment and the measure type. The Provider Network staff provides quarterly report (gap reports) and data specifications.

2021 QI Strategy Plan: Because of the pandemic, the VBP/APM presentations may be modified but resurrected for 2021. The schedule and content have not been presented to the Board or QIC for endorsement or approval.

9. Quality Incentive Measures:

2020 QAPI Response: AllCare CCO met 80% of the 2019 Quality Incentive Metrics. The pandemic presented many challenges to meet the established quality benchmarks or improvement targets.

2021 QI Strategy Plan: The COO and Provider Network Director will present to the QIC the 2021 Quality Incentive Measures with any revisions from OHA. More is to be added to the 2021 Quality Strategy Plan as soon as the information has been submitted to the QIC.

10. PCPCH (Patient Centered Primary Care Homes):

2020 QAPI Response: In compiling the 2021 PCPCH report submitted to OHA, the Director of Provider Network Services requested to conduct a focused review of the 1) number of members assigned to PCPCH level 2, 3, 4, and 5. The Focused Review revealed

a minor discrepancy that was due to the 'movement' of AllCare members during the 1Q2020; members transitioning from AllCare to JCC and members transitioning from Primary Health to AllCare. However, the exercise did result in a validation methodology that would ensure that the membership at a specific monthly timeframe would be used, and a 'tighter' tracking of the movement of membership between PCP offices. The Provider Services Team works with the PCPCH offices to identify opportunities for support and attaining higher levels of PCPCH status.

2021 QI Strategy Plan: The plan is to continue to 'grow' PCPCH offices to higher levels of PCPCH status and maintain the contractually required number of membership to be in a PCPCH provider. Annually or as needed, the Provider Network Services Director will present the PCPCH data to the QIC and to the Board.

11. Collaborative CHA/CHP/SHP and Community Advisory Councils (CACs):

2020 QAPI Response: AllCare has 3 Councils: the Josephine/Douglas County CAC, Curry County CAC and the Jackson County CAC. Each Council has a Board approved funding budgets that are based on membership and baseline funding. The CACs utilize the CHP, SHP and Triple Aim as criteria to review each project funding request. During 2020 the Councils funded new projects based on needs emerging from the COVID-19 pandemic and the wildfires experienced in the region. Among those were the Greenway Project focused on providing food and other supplies, housing options if tested positive. Other projects included funds allocated to disadvantaged communities or language access challenges. AllCare's Innovator Agent attends each Council meeting, provides OHA updates and makes herself available for questions to the Councils. The Councils provide project reports funded (Community Benefit Initiatives) at every CCO Board of Governors meeting (the CAC chairs are members of the CCO Board.

2021 QI Strategy Plan: 1) Ensure that each project is viewed with a Health Equity lens and addresses the CHP, SHP and Triple Aim as it pertains to disadvantaged populations living in the AllCare Service Area; 2) Adjust priorities to include ongoing issues continuing to arise as a consequence to the pandemic and wildfires in Southern Oregon.

12. Behavioral Health:

2020 QAPI Response: In 2020, The Behavioral Health Director was active in the following workgroups and ad hoc meetings: 1) Participated in the OHA Work Group to review the Oregon State Hospital admission and discharge process in order to offer process improvement; 2) Participated and regularly attended the QHOC meetings; 3) Reviewed specific issues pertaining to the BH Benefits and the delivery of BH services and assisted with meaningful systemic recommendations and need for clarification; 3) CCO Oregon meeting weekly to review new proposed legislation, review as a group to see the benefits and risks to the efforts being made to deliver appropriate services to our members and focused on advocating for funding those receiving BH services, attempt to reduce system duplication and funding waste to free funding for additional services and assess state and federal barriers to true integration; 3) Participated in the Southern Oregon Region Mobile Crisis Community meetings to review a systemic gaps – listening sessions; and 4) Worked to look at the SHIP at the state wide goals for improving the health of Oregonians. The BH Liaison participated in the Beckett Center Collaborative Meeting, Cross-systems care coordination Steering Committee, Bi-weekly meetings requested by Community Partners (hospitals, schools, PCPs, parents, CCOs, DHS) to discuss specific cross-system cases that require extra attention (BH placement needs, ED over utilization, repeated Limited English contact) and targeted goal-setting by cross-system teams; CHP monthly meetings of a wide range of community providers to look at local population health goal-setting and metrics; LADPC (Local Alcohol and Drug Planning Committee meetings in Jackson County; Training-Breaking Through: Novel Treatments for Depression and KOBI-TV 'In This Together' Initiative (Quarterly meeting of community partners to

assist KOBI news station in their PSA initiative to raise awareness and destigmatize suicidality and Day-long conference with testimonials, MAT and SUD Tx Provider Trainings and review of multiple SUD service levels in Jackson County.

AllCare's Chief Quality Officer and Behavioral Health Director receive email notification on every member, seen through the ED and the use of physical or chemical restraints are utilized. Over 24 instances occurred in 2020; with an increase in the 3Q and 4Q2020. This was in alignment with increased psychosis due to multiple drug and alcohol use and overuse instances. The review allows the Executives to make sure that the appropriate documentation is in place and that the standards of care were followed to ensure that members' rights were not violated.

2021 QI Strategy Plan: 1) Continue to have representation on the State and local levels to implement 'changes' that will have a positive impact on AllCare membership and the communities we serve; 2) Continue to review and monitor the use of chemical and physical restraints.

13. Non-Emergent Transportation (NEMT):

2020 QAPI Response: ReadyRide is the exclusive Non-Emergent Medical Transportation vendor for AllCare Health. ReadyRide provides direct transport, subcontracts with independent transportation vendors, provides flexible service rides and reimburses family members for providing rides for family or friends. In 2020, ReadyRide provided the 1,000,000th ride demonstrating that transportation is a key driver in members maintaining optimum health status and having the capability of getting to needed services that have a direct impact on their health status.

2021 QI Strategy Plan: 1) Continue to meet bi-weekly with the ReadyRide staff, Quality Staff and the NEMT AllCare Liaison to review grievances, new requirements, monitoring and oversight of compiled data (flex rides, reimbursed rides, training).

14. Subcontractor Quality Monitoring and Oversight:

2020 QAPI Response: AllCare conducted quarterly oversight of the following subcontractors: Advantage Dental, Capitol Dental, Willamette Dental, ODS Dental (Contract termed 06/30/2020), NEMT (ReadyRide), Curry Community Health and Options for Southern Oregon. Note: Appeals are not 'delegated' to subcontractors. AllCare CCO is ultimately responsible for the delegated work and appeals processing.

The following elements are reviewed and feedback to the subcontractor occurs through email correspondence or by Zoom meeting: 1) number of grievances; 2) timely response; 3) trends identified; 4) analysis of grievances; 5) number of NOABD issues; 6) Analysis of NOABD issues; 7) Extension Letters; 8) Specific Feedback on NOABDs; 9) Timeliness Processing for Preservice Request; 10) Reading Level of NOABDs; and 11) documentation of any correspondence (email or Zoom meeting) between Quality Director, CQO, CMO and Medical or Dental Director.

2021 QI Strategy Plan: 1) Continue to provide the close 'monitoring' and auditing of the grievance, NOABD, timeliness, grade level, but to add language access and interpreter usage; 2) Provide training to the Provider offices regarding grievance, literacy levels; 3) with the Director of Oral Health Services create a quarterly meeting of all DCOs to discuss questions, concerns and resources; 4) Continue to meet with the NEMT Team and the AllCare Quality/Compliance staff to discuss real time grievances, utilization and flex services data.

15. Special Health Care Needs: Information not yet available. Will be added as soon as possible

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2021 QI Strategy Plan:

16. **Patient Safety: Information not yet available. Will be added as soon as possible.**
2020 QAPI Response:
2021 QI Strategy Plan:

17. **Learning Collaboratives:**
2020 QAPI Response:
AllCare Health continues to participate in the Learning Collaboratives hosted by the Transformation Center during the QHOC meetings. This is a forum where best practices are presented with time for questions and feedback from CCO participants. AllCare hosts 'Provider' Learning Collaboratives and hopes to resurrect these interactive learning sessions in 2021.
2021 QI Strategy Plan: AllCare will continue to have 4 – 5 Representatives at the QHOC meeting sponsored by OHA and will participate in the Learning Collaborative Sessions via Zoom or alternative settings. The COO, CMO, Chief Quality Officer, Provider Network Services Director, [redacted] will create an interactive Learning Collaboratives Schedule with Specialists being the guest speaker to the audience of PCPs to discuss laboratory, radiological testing prior to referral visits for example.

18. **Health Information Technology (HIT):**
2020 QAPI Response: AllCare Health continues to develop and utilize the following HIT systems/platforms/software: Navex Global Policy Management Software, EthicsPoint Platform (electronic platform for individuals to submit confidential anonymous FWA, Compliance or Ethics concerns), UniteUs (Community Information Exchange – CIE; a collaborative project between Jackson Care Connect and AllCare to stand up a CIE that will allow closed loop referrals, instant feedback, communication between stakeholders and provider offices); Essette (Case Management Platform that documents referrals to LTSS, to ED, Behavioral Health entities; Pre-Manage; IT Security Software.
2021 QI Strategy Plan: 1) Continue to expand adoption of HIT platforms taking precautions to risk and exposure to external ransomware attacks; 2) Transition to the Policy Management Systems to be completed by 05/31/2021.

19. **Clinical Practice Guidelines and Over-Under Utilization:**
2020 QAPI Response: AllCare has created an internal work group called the Utilization Management Clinical Practice Guideline and Utilization Review Committee (UMCPGURC). It is comprised of the UM, Pharmacy, Medical, Behavioral and Oral Health Directors. The Committee reviews utilization trends to ensure that services that AllCare provides are in alignment with appropriate durations, scope, amount and that under and over utilization trends are identified.
2021 QI Strategy Plan: During the QAPI review, it was found that the UMCPGURC did not bring the CPGs, Inter-Rater Reliability and Under/Over-Utilization data back to the QIC or other Board Oversight Committee. In 2021, the VP of UM and Pharmacy Services will present during scheduled presentations to the QIC. Over and Under-Utilization data is shared with the Cost Containment Task Force which is a forum to analyze benchmark data that assists the AllCare Management to identify areas where needed Care Coordination or other internal actions necessary.

CY 2020 Quality Assurance Program Improvement Assessment and
CY 2021 Quality Improvement Strategy Plan
Revised: 02/20/2021

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20. Health, Wellness and Prevention:

2020 QAPI Response: AllCare Health's Health/Wellness and Prevent staff are dedicated to assisting members in their weight loss, tobacco cessation efforts and dealing with chronic pain. Focused attention was made to members with special health care needs. Because of the mandatory closures of gyms, enrollment into weight loss and fitness programs dramatically decreased. However, efforts were made to engage members with tele-meetings with personal coaches, easy to follow program apps.

2021 QI Strategy Plan: 1) Continue to develop flexible strategies until gym memberships re-open; [redacted]

21. AllCare Health and Josephine/Curry County Public Health Partnership

2020 QAPI Response: AllCare Health pays for 3 positions at the Josephine County Health Department: A Registered Dietician (RD), a WHNP, and an Immunization RN. In addition, AllCare pays for a portion of the Public Health Officer for Josephine and Curry Counties.

[redacted]

CY 2020 Quality Assurance Program Improvement Assessment and
CY 2021 Quality Improvement Strategy Plan
Revised: 02/20/2021

[redacted]

CY 2020 Quality Assurance Program Improvement Assessment and
CY 2021 Quality Improvement Strategy Plan
Revised: 02/20/2021

CY 2020 Quality Assurance Program Improvement Assessment and
CY 2021 Quality Improvement Strategy Plan
Revised: 02/20/2021

[redacted]

2021 QI Strategy Plan: 1) Continue to pay for the critically needed positions in the JCHP and Curry County; 2) Cultivate and encourage partnerships with community stakeholders ([redacted]); 3) Partner with the health departments to mobilize vaccination efforts in our service area.

Quality Improvement Committee	January 22, 2020 Time 0700 – 0800am Location Downstairs Conference Room

Meeting Purpose:		
Monthly review and oversight of quality improvement activities, issues and quality management projects.		
Members Present:		
☐ Dr. Felicia Cohen, MD	☒ Dr. Mark Rondeau, MD	☒ Dr. Kristin Miller, MD
☒ Dr. Brian Mateja, DO	☒ Lisa Callahan, CPNP	☒ Dr. Mona McArdle, MD
Staff:		
☒ Dr. Kelley Burnett, DO	☒ Dr. Ray Gambrill, MD	☒ Cynthia Ackerman, RN, CHC
☒ Laura Matola, CHC	☐ Amy Burns, Phar.D., BCPS	☐ Laura McKeane, EFDA
☐ Gita Yitta, DMD	☐ Athena Goldberg, LCSW	☒ Will Brake, COO
☐ Shannon Meunier	☐	☐
Guests:		

	Discussion Topics	Discussion Type	Topic Leader	Open/ Close	Company
1.	Introductions/ Agenda Overview	Information Sharing	Ms. Matola	O	AllCare Health Plan Inc., AllCare Advantage, AllCare CCO
Discussion:	• The November 20, 2019 minutes were reviewed by the Committee. Dr. Rondeau made the motion to approve the minutes. Dr. Mateja seconded the motion to approve the minutes. The motion passed unanimously.				
2.	Member (Dual Eligible)	New Item	Dr. Ray Gambrill	O	AllCare Advantage, AllCare CCO
Discussion:	[redacted]				

Quality Improvement Committee	January 22, 2020 Time 0700 – 0800am Location Downstairs Conference Room

	[redacted] • **Action: Dr. Burnett will write a letter to send to the hospital on behalf of the Committee. Once a response is received, it will be brought back to the Committee for review.**				
3.	**Member (Dual Eligible)**	**Follow-Up**	**Ms. Matola**	**O**	**AllCare Advantage, AllCare CCO**
Discussion:	• Ms. Matola reminded the Committee the details of this case. Care Coordination expressed concerns surrounding the care member was receiving [redacted]. Concerns included member's water being out of reach, therefore member was not drinking much water, and member's oxygen tubing was caught under the wheel of his wheelchair. Ms. Matola stated the Committee has made several outreach attempts [redacted] in regards to the concerns. Several letters have been sent, meetings have been suggested, and phone messages have been left with the [redacted]. All attempts of correspondence by the Committee have gone unanswered. Ms. Matola asked the Committee how they would like to move forward. Dr. Miller suggested sending [redacted]. • **Action: The Committee requested AllCare contact the SNF's corporate office in order to receive a response to the Committee's correspondence.**				
4.	**Member**	**New Item**	**Dr. Burnett**	**O**	**AllCare CCO**
Discussion:	• Dr. Burnett presented this case to the Committee. The concern for this member was brought to Dr. Burnett's attention during a conversation with a local [redacted] provider. Member was seen at the hospital, and there was a delay in member's referral to [redacted] for follow-up care. [redacted] accepted the member's case, and the [redacted] performed surgery on member who then experienced complications post-surgery. Dr. Burnett stated the [redacted]. Dr. Gambrill questioned whether this would be a matter of provider education. Dr. Burnett stated that she advised the [redacted] provider to express his concerns with the hospital who made the referral [redacted], and suggested that this provider participate in one of AllCare Health's Provider Collaborative which would allow an opportunity to discuss complicated cases with other providers.				

Quality Improvement Committee	January 22, 2020 Time 0700 – 0800am Location Downstairs Conference Room

	• **Action: Dr. Burnett will write a letter to [redacted] on behalf of the Committee.**				
5.	**Member**	**New Item**	**Dr. Burnett**	**O**	**AllCare CCO**
Discussion:	• Dr. Burnett presented this case to the Committee. Member has history of [redacted] issues. Member was seen in the Emergency Room (ER) twice in one day, and was advised by ER staff upon discharge to follow –up with her Primary Care Provider (PCP). Member scheduled an appointment the same day with her PCP as member felt she was experiencing side effects from medication provided in the ER. ReadyRide took member to the appointment. [redacted] Dr. Burnett expressed her concerns for this member, and felt as though this was [redacted]. Dr. Miller stated that she does not feel that there are any signs of [redacted]. Dr. Burnett stated that member was given the option to change her PCP, however it is unknown at this time if the member was reassigned to a new PCP. • **Action: Dr. Burnett will write a letter to send to the PCP on behalf of the Committee. Once a response is received, it will be brought back to the Committee for review.**				
6.	**Member**	**New Item**	**Dr. Burnett**	**O**	**AllCare CCO**
Discussion:	[redacted] Dr. Burnett presented this case to the Committee. Member has a history of multiple medical complaints, and had [redacted] surgery scheduled for January 2020. [redacted] • **Action: Dr. Burnett will send a letter to the hospital on behalf of the Committee. Once a response is received, it will be brought back to the Committee for review.**				
7.	**NPI MD**	**Follow-Up**	**Dr. Burnett**	**O**	**AllCare Health Plan Inc., AllCare Advantage, AllCare CCO**
Discussion:	• Dr. Burnett stated that AllCare Health's Chief Medical Officer and Chief Operating Officer met with the provider in question. Dr. Burnett advised the Committee that AllCare had concerns surrounding inappropriate coding being used by the provider. The concerns were discussed during the meeting, and the provider office will be reaching out to AllCare in January in regards to a Corrective Action Plan. AllCare will be cosigning chart notes with this provider for the first 6 months of the year. In addition, AllCare recently hired a claims auditor who will be conducting a review of the provider.				

Quality Improvement Committee	January 22, 2020 Time 0700 – 0800am Location Downstairs Conference Room

	• **Action: AllCare will continue to monitor this provider and results will be brought to the Committee for review.**				
8.	**Incentive Measure Report**	**Follow-Up**	**Mr. Brake**	**O**	**AllCare CCO**
Discussion:	• Mr. Brake discussed the findings of the OHA Incentive Measure Report with the Committee. The report reflects the results of the measures from January 2019 – August 2019. The results from September 2019 – December 2019 are unknown at this time. Mr. Brake explained that there are numerous CCO's in the state that are not meeting the same measures as AllCare. • In addition, Ms. Matola stated that 3 of the Performance Improvement Projects (PIPs) AllCare that were adopted are being recommended to be retired. The Adolescent Well Care Visits, Effective Contraceptive Use and Colorectal Cancer Screening PIPs will be retired and with the recommendation to be replaced with A1c Improvement for Diabetic (performance measure), Oral Assessment for diabetic (CHP) and Focus on Initiation, Engagement and Treatment for Alcohol and Substance Use Disorder (CHP, SHP). • **Action: The Committee approved by consensus to retire the existing PIPs and replace with the PIPs: A1c Improvement for Diabetic (performance measure), Oral Assessment for diabetic (CHP) and Focus on Initiation, Engagement and Treatment for Alcohol and Substance Use Disorder (CHP, SHP).**				

Future Meetings		Location
February 26, 2020		AllCare Comm. Room A

Respectfully Submitted,

Cynthia Ackerman RN, CHC
Chief Quality Officer

Quality Improvement Committee	April 22, 2020 Time 0700 – 0800am Location Downstairs Conference Room

Meeting Purpose:		
Monthly review and oversight of quality improvement activities, issues and quality management projects.		
Members Present:		
☒ Dr. Felicia Cohen, MD	☐ Dr. Mark Rondeau, MD	☒ Dr. Kristin Miller, MD
☒ Dr. Brian Mateja, DO	☒ Lisa Callahan, CPNP	☒ Dr. Mona McArdle, MD
Staff:		
☒ Dr. Kelley Burnett, DO	☒ Dr. Ray Gambrill, MD	☒ Cynthia Ackerman, RN, CHC
☒ Laura Matola, CHC	☒ Amy Burns, Phar.D., BCPS	☒ Laura McKeane, EFDA
☒ Gita Yitta, DMD	☒ Athena Goldberg, LCSW	☒ Will Brake, COO
☐ Shannon Meunier	☐	☐
Guests:		
☐		

	Discussion Topics	Discussion Type	Topic Leader	Open/ Close	Company
1.	Introductions/ Agenda Overview	Information Sharing	Ms. Matola	O	AllCare Health Plan Inc., AllCare Advantage, AllCare CCO
Discussion:	• The February 26, 2020 minutes were reviewed by the Committee. Dr. Cohen made the motion to approve the minutes. Dr. Mateja seconded the motion to approve the minutes. The motion passed unanimously.				
2.		New Item	Ms. Matola	O	AllCare Advantage
Discussion:	•				
3.		New Item	Ms. Burns	O	AllCare Advantage
Discussion:	•				
4.	Member (Dual Eligible)	Follow-Up	Dr. Burnett	C	AllCare Advantage, AllCare CCO
Discussion:	• Dr. Burnett discussed the details of this case with the Committee. Member receives treatment [redacted] 3 days a week. This member expressed concerns and waged complaints with [redacted] regarding another patient who posed as intimidating and threatening to the member, and member felt as though his concerns				

	were brushed off by the [redacted]. AllCare outreached to [redacted], and was informed that the [redacted] had received several complaints and concerns about the same patient. The [redacted] also informed AllCare that they work with a separate entity who investigates all complaints. Unfortunately, the patient in question did not meet the required standards set by this entity that would allow [redacted] to take further action, aside from having a conversation with the patient. Dr. Burnett advised that a letter was sent to [redacted] on behalf of the QI Committee inquiring about concerns relating to this member's experience [redacted]. The [redacted] submitted copies of their policies and procedures in response to the QI letter, and advised that the issues have been resolved to the member's satisfaction by rescheduling [redacted] times. • **Action: The Committee agreed that no further action is required, and the case can be closed.**				
5.	**AllCare Enrollment**	**New Item**	**Mr. Brake**	**O**	**AllCare CCO**
Discussion:	• Mr. Brake informed the Committee that AllCare has approximately 13,000 members in Jackson County. In addition, AllCare is anticipating seeing an increase in OHP membership due to the high volume of unemployment due to COVID-19. Mr. Brake informed the Committee that AllCare does not have a huge capacity for this increase, but some providers have already agreed to increase their patient membership as a result. • **Action: The Committee will be updated of future enrollment numbers related to the COVID-19 pandemic.**				
6.	**Opioid PIP**	**New Item**	**Ms. Matola**	**O**	**AllCare CCO**
Discussion:	• Ms. Matola informed the Committee that AllCare's Opioid PIP (Performance Improvement Plan) has met all area's and is passing at 100%. Ms. Matola advised that the PIP is in regards to acute opioid prescribing for opioid naïve patients. Ms. Matola advised that there is an internal group at AllCare that is taking a deeper dive into this matter in effort to determine which providers are prescribing opioids. • **Action: The Committee will continue to be updated on the PIP findings.**				
7.	**Member**	**Follow-Up**	**Dr. Burnett**	**C**	**AllCare CCO**
Discussion:	• Dr. Burnett discussed the details of this case with the Committee. Member was seen at [redacted] and was advised to follow-up with her PCP as she was prescribed [redacted] Dr. Burnett advised that a letter was sent on behalf of the QI Committee in regards to concerns surrounding this member's complaint. PCP submitted a letter in response to				

	the QI letter, and the Committee reviewed it. It is not clear at this time if the member chose to change PCPs or if member chose to stay. • **Action: The Committee agreed that no further action is required, and the case can be closed.**				
8.	**Incentive Measure Report**	**Follow-Up**	**Mr. Brake**	**O**	**AllCare CCO**
Discussion:	• Mr. Brake informed the Committee that AllCare has not finalized the numbers for the incentive measure report. AllCare currently only has data through November 2019. Mr. Brake advised that the incentive measure report for 2020 is unknown as of now. The Metrics Scoring Committee will determine how to proceed with the CY2020 measures moving forward due to COVID-19. • **Action: The Committee will continue to be updated on the incentive measures.**				
9.	**Oral Health Update**	**Follow-Up**	**Dr. Yitta**	**O**	**AllCare CCO**
Discussion:	• Dr. Yitta reminded the Committee that due to the parameters set forth by Governor Brown, all dental offices are to remain closed until June 15th except for emergent services. Dr. Yitta advised that this order makes it difficult to investigate complaints and concerns, as we cannot get access to dental records due to dental office staff being furloughed. • [redacted] • **Action: No action required by the Committee at this time.**				
10.	**Behavioral Health Update**	**Follow-Up**	**Ms. Goldberg**	**O**	**AllCare CCO**
Discussion:	• Ms. Goldberg provided an update to the Committee regarding the Wraparound Policy. Ms. Goldberg advised that this policy has been a challenge in that OHA has provided recent changes, however AllCare is working to modify the policy to reflect those changes. Ms. Goldberg provided the Committee with a copy of the policy to review, and advised that any questions can be directed to her. • Ms. Goldberg also provided an update regarding [redacted]. Ms. Goldberg reminded the Committee that [redacted] audit took place in [redacted], and the [redacted] was placed on a Corrective Action Plan. Significant concerns surrounding [redacted] were discovered during the audit. The Substance Use Disorder Clinic also performed a retrospective audit on their own, [redacted]. Ms. Goldberg advised that				

Quality Improvement Committee	April 22, 2020 Time 0700 – 0800am Location Downstairs Conference Room

	overall the [redacted] has been very responsive and has addressed all areas of concern. • **Action: No action required by the Committee at this time.**

Future Meetings		Location
May 27, 2020		AllCare Comm. Room A

Respectfully Submitted,

Cynthia Ackerman RN, CHC
Chief Quality Officer

Quality Improvement Committee	June 24, 2020 Time 0700 – 0800am Location Downstairs Conference Room

Meeting Purpose:		
Monthly review and oversight of quality improvement activities, issues and quality management projects.		
Members Present:		
☒ Dr. Felicia Cohen, MD	☐ Dr. Mark Rondeau, MD	☒ Dr. Kristin Miller, MD
☒ Dr. Brian Mateja, DO	☒ Lisa Callahan, CPNP	☒ Dr. Mona McArdle, MD
Staff:		
☒ Dr. Kelley Burnett, DO	☒ Dr. Ray Gambrill, MD	☐ Cynthia Ackerman, RN, CHC
☒ Laura Matola, CHC	☒ Amy Burns, Phar.D., BCPS	☒ Laura McKeane, EFDA
☒ Gita Yitta, DMD	☒ Athena Goldberg, LCSW	☒ Will Brake, COO
☐ Shannon Meunier	☐	☐
Guests:		
☐		

	Discussion Topics	Discussion Type	Topic Leader	Open/ Close	Company
1.	Introductions/ Agenda Overview	Information Sharing	Ms. Matola	O	AllCare Health Plan Inc., AllCare Advantage, AllCare CCO
Discussion:	• The April 22, 2020 minutes were reviewed by the Committee. Dr. McArdle made the motion to approve the minutes. Dr. Miller seconded the motion to approve the minutes. The motion passed unanimously.				
2.		Follow Up	Ms. Matola	C	AllCare Advantage
Discussion:	•				
3.	Member (Dual Eligible)	Follow Up	Dr. Burnett	C	AllCare Advantage, AllCare CCO
Discussion:	• Dr. Burnett briefly reminded the Committee the details of this case. Member was [redacted]. It was determined by [redacted] that member [redacted]				

Quality Improvement Committee	June 24, 2020 Time 0700 – 0800am Location Downstairs Conference Room

	[redacted] • **Action: No further action required.**				
4.	**Member**	**New Item**	**Dr. Burnett**	**C**	**AllCare CCO**
Discussion:	• Dr. Burnett discussed the details of this case with the Committee. Member had [redacted]. Dr. Burnett advised that a letter was sent to this office on behalf of the QI Committee inquiring about their triage process for prioritizing appointments, including ER and hospital visits. A response letter was received and a copy was provided to the Committee to review, along with copies of the policies requested by the Committee. It was noted that their office policies were not dated. The Committee agreed that outreach should be made to the office manager at this office to encourage dating of their policies. • **Action: Ms. Matola will outreach to the office manager to encourage that they date their office policies.**				
5.	**Member**	**New Item**	**Dr. Burnett**	**C**	**AllCare CCO**
Discussion:	• Dr. Burnett briefly reminded the Committee the details of this case. [redacted] Dr. Burnett advised that a letter was sent to the Chief Quality Officer at [redacted] on behalf of the QI Committee. A response letter was received and a copy of the letter was provided for the Committee to review. The Committee again agreed that [redacted] appeared to have recognized the concerns. • **Action: No further action required.**				
6.	**ReadyRide Report**	**New Item**	**Ms. Matola**	**O**	**AllCare CCO**

Quality Improvement Committee	June 24, 2020 Time 0700 – 0800am Location Downstairs Conference Room

Discussion:	• Ms. Matola advised that in the coming months, the QI Committee will begin reviewing ReadyRide reporting and other documentation as part of NEMT and AllCare's Quality oversight. Ms. Matola stated that there were several new rule changes with CCO 2.0, and that AllCare is working to ensure there is proper oversight regarding NEMT. AllCare currently meets with ReadyRide once monthly, and sometimes weekly depending on the topic of discussion. ReadyRide meeting minutes and reporting are a few of the documents the Committee will begin seeing as part of their meeting material. ReadyRide video and audio recordings are also available to review when necessary. • **Action: The Committee will review ReadyRide documentation when it is presented for review.**				
7.	**External Quality Review (EQR)**	**New Item**	**Ms. Matola**	**O**	**AllCare CCO**
Discussion:	• Ms. Matola reminded the Committee that the EQR audit is quickly approaching. This is an audit by the state that will look at Care Coordination, Utilization Management, Appeals and Grievance, member information, and member rights and responsibilities. The QI Committee provides oversight to any findings or recommendations identified during the EQR audits. Supporting documents are due to the state on August 1st, and the onsite audit will be conducted on September 21st and 22nd. It will likely be sometime in November before AllCare will learn the results of the audit. • **Action: The EQR audit results will be brought to the QI Committee for review and ongoing oversight and monitoring.**				
8.	**1Q2020 Appeals and Grievance Report**	**Follow-Up**	**Ms. Matola**	**C**	**AllCare CCO**
Discussion:	• Ms. Matola displayed the 1Q2020 Appeals and Grievance report on the overhead projector for the Committee to review. Ms. Matola explained that the report breaks down the grievances received by provider and type of grievance. There were not many outliers this quarter, however the largest area of grievances were [redacted] for a total of 13. It was noted by Ms. Matola that these grievances were submitted during the period of time when AllCare CCO began [redacted] which resulted in an increase in grievances. • Ms. Matola reminded the Committee that AllCare delegates some of the grievance process to our subcontractors. Each delegate is responsible for documenting their grievances that are received, and at the end of each quarter they are to forward this information to AllCare so it can be compiled into the Exhibit I log. The Exhibit I log is due to OHA 45 days after the end of each quarter. Ms. Matola displayed the report on 1Q2020 oversight of grievance and NOABD of our subcontractors. AllCare delegates include: ○ Advantage Dental ○ Capitol Dental				

	○ Willamette Dental ○ ODS Dental ○ ReadyRide ○ Options for Southern Oregon ○ Curry Community Health Overall, there were a total of 91 grievances, 4,058 denial notices sent to members and 61 appeals submitted during 1Q2020. There was a low amount of hearings requested as members have to complete the appeal process prior to requesting a hearing. • **Action: The Committee will continue to be updated on the Appeal and Grievance report on a quarterly basis and be apprised of any grievances regarding access, quality of care, civil rights, language access.**				
9.	**Incentive Measure Report**	**Follow-Up**	**Mr. Brake**	**C**	**AllCare CCO**
Discussion:	• Mr. Brake discussed the incentive measure report with the Committee. Mr. Brake advised that this is the final report for CY2019. Overall, there were 5 measures that AllCare CCO did not meet: Adolescent Well Care Visits, Children who receive sealant on permanent molars, Childhood Immunization Status, Controlling High Blood Pressure and CAHPS Member Survey. Mr. Brake stated that AllCare received 80% of incentive dollars, and the total dollar amount was larger than expected. While AllCare will continue to maintain the quality program for CY2020, there will be no improvement targets set due to the pandemic. The goal for CY2020 will be to meet CY2019 results. • **Action: The Committee will continue to be updated on the quality measures as determined by OHA.**				
10.	**Oral Health Update**	**Follow-Up**	**Dr. Yitta**	**O**	**AllCare CCO**
Discussion:	• Dr. Yitta briefly discussed the details of a member complaint that was recently submitted. [redacted] Dr. Yitta stated she would like to send a letter to the dentist inquiring about the way the member was managed. • Ms. McKeane reminded the Committee that AllCare termed their contract with ODS Dental effective May 31st, 2020. AllCare is working closely with Capitol Dental to ensure that there are no breaks in the continuity of care for our members. Ms. McKeane also informed the Committee that one dental office will not contract with Capitol Dental to see OHP patients. • **Action: Dr. Yitta and Dr. Burnett will work together to determine if AllCare should write the QI letter or if it should to be written by the DCO.**				
11.	**Behavioral Health Update**	**Follow-Up**	**Ms. Goldberg**	**O**	**AllCare CCO**

Quality Improvement Committee	June 24, 2020 Time 0700 – 0800am Location Downstairs Conference Room

Discussion:	• Ms. Goldberg informed the Committee that were no new behavioral health updates. However she is tracking provider office staff who have been laid off, as there are certain administrative aspects in regards to auditing. Ms. Goldberg stated that member access to providers should not be effected by office staff being laid off. • Dr. Miller expressed some concern surrounding substance use facilities only offering Zoom calls with patients, even though not all patients and members have access to a phone or have limited data usage. Dr. Burnett advised that this information is very useful to know moving forward with the pandemic. Ms. Goldberg stated that many mental health providers are comfortable providing patients with a kiosk space to provide virtual appointments. • **Action: No further action required at this time; however the QIC will be keep updated on the use of tele-medicine and the impact of the pandemic on access to these needed services.**

Future Meetings		Location
July 22, 2020		AllCare Comm. Room A

Respectfully Submitted,

Cynthia Ackerman RN, CHC
Chief Quality Officer

Quality Improvement Committee	August 26, 2020 Time 0700 – 0800am AllCare Health Community Room A

Meeting Purpose:		
Monthly review and oversight of quality improvement activities, issues and quality management projects.		
Members Present:		
☒ Dr. Felicia Cohen, MD	☒ Dr. Mark Rondeau, MD	☒ Dr. Kristin Miller, MD
☐ Dr. Brian Mateja, DO	☒ Lisa Callahan, CPNP	☒ Dr. Mona McArdle, MD
Staff:		
☒ Dr. Kelley Burnett, DO	☒ Dr. Ray Gambrill, MD	☒ Cynthia Ackerman, RN, CHC
☒ Laura Matola, CHC	☒ Amy Burns, Phar.D., BCPS	☒ Laura McKeane, EFDA
☒ Gita Yitta, DMD	☐ Athena Goldberg, LCSW	☒ Will Brake, COO
☒ Shannon Meunier	☐	☐
Guests:		
☐		

	Discussion Topics	Discussion Type	Topic Leader	Open/ Close	Company
1.	**Introductions/ Agenda Overview**	**Information Sharing**	**Ms. Matola**	**O**	**AllCare Health Plan Inc., AllCare Advantage, AllCare CCO**
Discussion:	• The June 24, 2020 minutes were reviewed by the Committee. Dr. Rondeau made the motion to approve the minutes. Dr. McArdle seconded the motion to approve the minutes. The motion passed unanimously.				
2.					**AllCare Advantage**
Discussion:	•				
3.	**Member**	**New Item**	**Dr. Burnett**	**C**	**AllCare CCO**
Discussion:	• Dr. Burnett discussed the details of this case with the Committee. Member submitted new patient paperwork to the PCP office in mid-February of this year, and it took until July for PCP to get member scheduled for her new patient appointment. [redacted] A letter was sent by Dr.				

Quality Improvement Committee	August 26, 2020 Time 0700 – 0800am AllCare Health Community Room A

	Burnett on behalf of the QI Committee to the Chief Quality Officer and Chief Medical Director at the PCP advising them of the Committee's concerns regarding this issue. A response letter was received and Ms. Matola displayed the letter for the Committee to review. It was determined that in the future, Dr. Burnett will check-in with PCP's Chief Quality Officer in real-time when problems arise in effort to help expedite and resolve issues sooner. • **Action: No further action required. This case can be closed.**				
4.	**Parity Audit**	**New Item**	**Ms. Matola**	**O**	**AllCare CCO**
Discussion:	• Ms. Matola informed the Committee that AllCare is currently working on the Parity Audit. OHA will be looking at mental health and substance use disorders to ensure that there are no barriers in place between mental health vs. medical and physical health. AllCare's first Parity Audit took place back in CY2018, but was conducted by a different entity. AllCare has been working with Options for Southern Oregon as well as Curry Community Health on this audit. • **Action: AllCare will continue working with Options and Curry Community Health on the audit.**				
5.	**EQR with HSAG**	**Follow Up**	**Ms. Matola**	**O**	**AllCare CCO**
Discussion:	• Ms. Matola informed the Committee that the documents for the EQR (External Quality Review) audit were submitted on August 15th. The onsite audit will be conducted via WebEx/Zoom on September 21st and 22nd. Health Services Advisory Group (HSAG) will be looking at five areas: Care Coordination, Utilization Management, Appeals and Grievance, member rights and responsibilities and member information. Ms. Matola advised that this will be AllCare's second audit with HSAG. AllCare worked with Health Insight until mid CY2018, and then began working with HSAG. • **Action: EQR onsite audit with HSAG will take place via WebEx/Zoom on September 21st and 22nd. The Committee will be kept up to date on the results of the audit.**				
6.	**Oral Health Update**	**Follow Up**	**Dr. Yitta**	**O**	**AllCare CCO**
Discussion:	• Dr. Yitta briefly reminded the Committee the details of a case that was discussed at the June QI meeting. [redacted] The Committee agreed that a letter will be sent to the DCO regarding these concerns. • Ms. McKeane reminded the Committee that AllCare is no longer contracted with ODS, and that [redacted]. In addition, AllCare				

	has finally obtained dental services in Port Orford. Ms. McKeane advised that this is a huge win for members as they have either had to travel to Bandon or Gold Beach to obtain services. Members will be able to be seen by dental hygienists. Currently we are working on obtaining equipment, luckily some of the equipment has been donated. • **Action: Dr. Yitta to write the QI letter [redacted]. The response letter will be brought to the Committee for review once received. In addition, the Committee will continue to be updated on the status of dental services in Port Orford.**				
7.	**2Q2020 Appeals & Grievance Report**	**Follow Up**	**Ms. Matola**	**O**	**AllCare CCO**
Discussion:	• Ms. Matola displayed the CCO 2Q2020 (April 2020 – June 2020) Appeals and Grievance report for the Committee to review. In review of the year to date totals for grievances, it was noted that there were no providers or clinics that stood out. For 2Q, [redacted] was the outlier due to changes in benefits. Ms. Burns explained that when the Stay At Home order was issued by Governor Brown at the beginning of the year, AllCare's [redacted]. AllCare sent notices to member's advising them of the change in services, [redacted]. Ms. Matola advised that additional complaints received during 2Q included complaints against a [redacted]. Ms. Meunier added that internal concerns against [redacted] in the area are better. One in particular has shown significant improvement. • **Action: The Committee will continue to be kept up to date on the Appeals and Grievance report on a quarterly basis.**				
8.	**COVID-19 and Provider Offices**	**New Item**	**Dr. Burnett**	**O**	**AllCare Health Plan, Inc.**
Discussion:	Dr. Burnett informed the Committee that AllCare has received several complaints regarding provider offices not following the required mask guidance. Dr. Burnett advised that AllCare is working with the Health Department to help communicate and educate local provider offices about mask requirements. Face masks are a state and OSHA (Occupational Safety and Health Administration) requirement. AllCare has found that many of the complaints received are not about providers, but rather their staff not following these guidelines. Offices that are found to be non-compliant with the face mask requirements are subject to a hefty fine from OSHA. • **Action: Ms. Ackerman will alert Dr. Candelaria, AllCare Medical Director and the Josephine County Public Health Officer of the offices not following the CDC masking guidance. Dr. Candelaria will make a 'drop in' visit to the office and meet with the health care providers. AllCare will continue tracking and monitoring complaints regarding offices not following face mask guidelines.**				

Quality Improvement Committee	August 26, 2020 Time 0700 – 0800am AllCare Health Community Room A

9.					
Discussion:	•				
10.	**NPI MD**	**Follow - Up**	**Dr. Burnett**	**O**	**AllCare Advantage, AllCare CCO**
Discussion:	• Item not listed on agenda. Dr. Burnett informed the Committee that this provider has a number of cases for outside review. We are currently working with this provider and his office as AllCare has not been satisfied with how their corrective action plan has progressed due to COVID-19. • **Action: AllCare will continue to work with this provider on a corrective action plan. The Committee will be kept up to date on the status.**				
11.	**Quality Metrics**	**Follow-Up**	**Mr. Brake**	**O**	**AllCare CCO**
Discussion:	• Item not listed on agenda. Mr. Brake informed the Committee that the quality metrics have changed multiple times this year due to COVID-19, and twice AllCare's metrics have changed. Mr. Brake stated that AllCare will be "reporting only" this year, and will be using last year's benchmarks as the CY2020 benchmarks. The CY2021 metrics have been finalized. These metrics will be the same as CY2020, but will be adding a language access health equity measure. • **Action: The Committee will continue to be updated on the quality metrics.**				

Future Meetings		Location
September 23, 2020		AllCare Comm. Room A

Respectfully Submitted,

Cynthia Ackerman RN, CHC
Chief Quality Officer

Quality Improvement Committee	October 28, 2020 Time 0700 – 0800am AllCare Health Community Room A

Meeting Purpose:		
Monthly review and oversight of quality improvement activities, issues and quality management projects.		
Members Present:		
☒ Dr. Felicia Cohen, MD	☒ Dr. Mark Rondeau, MD	☒ Dr. Kristin Miller, MD
☒ Dr. Brian Mateja, DO	☒ Lisa Callahan, CPNP	☒ Dr. Mona McArdle, MD
Staff:		
☒ Dr. Kelley Burnett, DO	☒ Dr. Ray Gambrill, MD	☒ Cynthia Ackerman, RN, CHC
☒ Laura Matola, CHC	☒ Amy Burns, Phar.D., BCPS	☒ Laura McKeane, EFDA
☒ Gita Yitta, DMD	☐ Athena Goldberg, LCSW	☐ Shannon Meunier
☐	☐	☐
Guests:		
☒ Mark Kantor, RPh		

	Discussion Topics	Discussion Type	Topic Leader	Open/ Close	Company
1.	**Introductions/ Agenda Overview**	**Information Sharing**	**Ms. Matola**	**O**	**AllCare Health Plan Inc., AllCare Advantage, AllCare CCO**
Discussion:	• The August 26, 2020 minutes were reviewed by the Committee. Dr. Rondeau made the motion to approve the minutes. Dr. Miller seconded the motion to approve the minutes. The motion passed unanimously.				
2.	**Member (Dual Eligible)**	**New Item**	**Dr. Burnett**	**C**	**AllCare Advantage, AllCare CCO**
Discussion:	• Dr. Burnett discussed the details of this case with the Committee. Member expressed concerns to AllCare regarding her access to care with [redacted]. Dr. Burnett informed the Committee that a letter was sent to the Chief Operating Officer at this office. A response letter was received and a copy was provided to the Committee for review. The Committee unanimously agreed that all areas of concern were addressed appropriately. • **Action: No further action required at this time.**				
3.					**AllCare Advantage**
	•				

Quality Improvement Committee	October 28, 2020 Time 0700 – 0800am AllCare Health Community Room A

4.					**AllCare Advantage**
	•				
5.	**ReadyRide Report**	**New Item**	**Ms. Matola**	**O**	**AllCare CCO**
Discussion:	• Ms. Matola reminded the Committee that back in August they were informed that the Committee would soon be reviewing ReadyRide reports and additional documentation as part of NEMT oversight. Ms. Matola displayed the ReadyRide September 2020 Operations Summary Report for the Committee to review. There was a total of 9, 719 rides scheduled, of which 8, 485 were completed. The report was broken down by service mode, service area, trip purpose and service, and call center. The average wait time for the call center is 32 seconds. The report showed a slight decrease in ReadyRide utilization during the start of COVID-19, however these numbers have since risen. It was also noted that ReadyRide services in Curry County have improved. Overall, Ms. Matola stated that ReadyRide has been a great partner to work with, and added that they offered their services to assist with the wildfires in Jackson County at the beginning of September. • **Action: ReadyRide reporting will continue to be brought to the Committee for review and oversight.**				
6.	**Parity Audit**	**New Item**	**Ms. Matola**	**O**	**AllCare CCO**
Discussion:	• Ms. Matola reminded the Committee that the Parity audit is still ongoing. Documents were submitted to HSAG (Health Services Advisory Group) back in August. A virtual visit by HSAG will be conducted tomorrow, October 29th, and will last approximately 2 hours. They will be looking at prior authorizations, provider network, appeals and pharmacy utilization management. They will also be looking to see that mental health and substance use disorder benefits are not more restricted than medical and physical health benefits. Ms. Matola shared that while the agenda that was provided to AllCare for tomorrow's meeting was vague, we are confident that we are going in prepared. • **Action: The Committee will be informed of the audit findings.**				
7.	**EQR Audit**	**New Item**	**Dr. Burnett**	**O**	**AllCare CCO**
Discussion:	• Dr. Burnett informed the Committee that the EQR (External Quality Review) audit with HSAG that was originally scheduled for September has been moved to November 9th and 10th. This is an annual requirement by the Oregon Health Authority. • **Action: The Committee will be kept up to date on the results of the audit.**				
8.	**Performance Improvement Projects**	**New Item**	**Dr. Burnett**	**O**	**AllCare CCO**

Quality Improvement Committee	October 28, 2020 Time 0700 – 0800am AllCare Health Community Room A

Discussion:	• Dr. Burnett informed the Committee that AllCare is currently working on two PIPs (Performance Improvement Projects) that align with Prometheus. The first PIP is regarding improving access to CGMs (Continuous Glucose Monitors) for members with type II diabetes in effort to decrease Emergency Room utilization, lower hospital admissions and improve diabetes control (Triple Aim, Performance Measure). The second PIP is in regards to pediatric asthma in members between the ages of 6 and 18 years old (Performance Measure). Dr. Burnett stated that Care Coordination would be working closer with provider offices to help increase family education and hopefully lead to better medication compliance, decreased ED visits and lower health care costs (Performance measures, Triple Aim). The third PIP will be regarding health equity (CHP). Dr. Burnett stated that internal data shows that the population of our members who are African American have the lowest PCP utilization rates. The goal will be to increase PCP utilization for this population by 5%. • Ms. Ackerman stated that AllCare will need the Committee's approval of the PIPs to move forward, and advised that the PIPs would be reported to the Committee on a quarterly basis. **Ms. Callahan made the motion to approve the PIPs. Dr. Mateja seconded the motion to approve the PIPs. The motion passed unanimously.** **Action: The PIPs will be brought to the Committee on a quarterly basis for review and recommendation.**				
9.	**Oral Health Update**	**Follow-Up**	**Dr. Yitta**	**O**	**AllCare CCO**
Discussion:	• Dr. Yitta reminded the Committee the details of a case involving a quality of care and access to care issue [redacted]. Dr. Yitta advised that a letter was sent to [redacted] regarding her concerns. A response letter was received and a copy was provided for the Committee to review. The Committee agreed that the [redacted] addressed all areas of concern appropriately. • Ms. McKeane gave an update regarding dental services in Curry County. Ms. McKeane stated that beginning December 1, 2020 there will be a dental hygienist working 1-2 days per week in Port Orford. There is no permanent dentist in Port Orford as of yet, but AllCare is working towards this in the coming months. • **Action: The Committee will continue to be updated on the status of dental services in Port Orford.**				
10.	**Behavioral Health Update**	**Follow - Up**	**Dr. Burnett**	**O**	**AllCare CCO**
Discussion:	• Dr. Burnett informed the Committee that the kickoff call for the audit on the [redacted] vendor was yesterday. The call was conducted via Zoom, and included a virtual tour of the facility. • **Action: The Committee will be kept up to date on the status and findings of this audit.**				

Quality Improvement Committee	October 28, 2020 Time 0700 – 0800am AllCare Health Community Room A

11.	**Opioid Trends**	**New Item**	**Mr. Kantor**	**O**	**AllCare Health Plan, Inc.**
Discussion:	• Mr. Kantor displayed a PowerPoint for the Committee to review. Mr. Kantor stated that AllCare continues to monitor claims data surrounding opioid fills. This oversight and monitoring is done to track and document any changes in what we are covering. The amount of IR (Immediate Release) opioids have stayed relatively consistent over the past year, however AllCare did see a large spike in May of this year in the amount of ER (Extended Release) opioids. Mr. Kantor stated that Naloxone goes hand in hand with opioids. Overall, AllCare has noticed an increase in the total number of Naloxone fills from 2017 - 2020. However, in the last year AllCare has seen a slight decrease in this trend. Prescriber taxonomy shows that PCPs are primarily prescribing the Naloxone. • **Action: The Committee will continue to be updated on opioid trends (Statewide PIP, CHP).**				
12.	**COVID-19**	**New Item**	**Dr. Burnett**	**O**	**AllCare Health Plan, Inc.**
Discussion:	• Dr. Burnett stated that COVID-19 is still an ongoing issue throughout the state, and case rates continue to increase. Some states have resulted in opening additional treatment centers for patients due to the increase in cases. Dr. Burnett stated that there are testing events occurring throughout Josephine County this week. Testing will be held in the AllCare Health parking lot this Thursday and Friday and will be open to the general public. The testing will be conducted via drive thru and will not require the individual to exit their vehicle. • **Action: No further action is required at this time.**				
13.	**PBM Audit**	**New Item**	**Ms. Matola**	**O**	**AllCare Health Plan, Inc.**
Discussion:	• Ms. Matola informed the Committee that the PBM audit began last week and was conducted via Zoom and is continuing this week. So far the audit has gone well, however the areas that AllCare anticipated would be issues were proven to be true. Ms. Matola stated that credentialing files for pharmacies would be reviewed today. • **Action: The Committee will continue to be kept up to date on the status of the Medimpact audit.**				
14.	[redacted]	**New Item**	**Ms. Matola**	**O**	**AllCare Health Plan, Inc.**
Discussion:	• Ms. Matola informed the Committee that AllCare has continued to experience issues with [redacted]. Previously [redacted] was placed on a corrective action plan for almost 1.5 years while these billing issues were addressed. The issues stopped for a period of time, but have slowly began to increase once again. AllCare has received an increase in reports of [redacted]. Ms. Matola stated there is a call set up to discuss the issues. At this time we are unsure how to completely resolve this issue, but will work with [redacted] towards a mitigation plan.				

Quality Improvement Committee	October 28, 2020 Time 0700 – 0800am AllCare Health Community Room A

	• **Action: The Committee will continue to be kept up to date on this Laboratory billing issues.**

Future Meetings		Location
December 2, 2020		AllCare Comm. Room A

Respectfully Submitted,

Cynthia Ackerman RN, CHC
Chief Quality Officer

Quality Improvement Committee	December 2, 2020 Time 0700 – 0800am AllCare Health Community Room A

Meeting Purpose:		
Monthly review and oversight of quality improvement activities, issues and quality management projects.		
Members Present:		
☒ Dr. Felicia Cohen, MD	☒ Dr. Mark Rondeau, MD	☒ Dr. Kristin Miller, MD
☒ Dr. Brian Mateja, DO	☒ Lisa Callahan, CPNP	☒ Dr. Mona McArdle, MD
Staff:		
☒ Dr. Kelley Burnett, DO	☒ Dr. Ray Gambrill, MD	☒ Cynthia Ackerman, RN, CHC
☐ Laura Matola, CHC	☒ Amy Burns, Phar.D., BCPS	☒ Laura McKeane, EFDA
☒ Gita Yitta, DMD	☐ Athena Goldberg, LCSW	☐ Shannon Meunier
☐	☐	☐
Guests:		
☒ Steve Buck, Director of Care Coordination	☒ Alan Burgess, APM Manager	

	Discussion Topics	Discussion Type	Topic Leader	Open/ Close	Company
1.	**Introductions/ Agenda Overview**	**Information Sharing**	**Ms. Matola**	**O**	**AllCare Health Plan Inc., AllCare Advantage, AllCare CCO**
Discussion:	• The October 28, 2020 minutes were reviewed by the Committee. Dr. McArdle made the motion to approve the minutes. Dr. Mateja seconded the motion to approve the minutes. The motion passed unanimously.				
2.	**TQS**	**New Item**	**Mr. Burgess**	**O**	**AllCare CCO**
Discussion:	• Mr. Burgess informed the Committee that the Transformation and Quality Strategy (TQS) is an OHA program that AllCare has been participating in for the last few years. OHA recently made changes by adding internal oversight requirements, specifically by the QI Committee. TQS is a program that was created by OHA to help advance healthcare transformation by CCOs. The TQS consists of 15 components that AllCare must address in specific projects. AllCare currently has 13 projects, all of which consist of a lead point person. Unfortunately, due to COVID-19, staff working on the TQS projects have not been able to make a lot of progress. Mr. Burgess stated that in mid-January staff will be meeting to see where exactly the projects are at. The group intends to have what will essentially be a preliminary submission, and will consist of 3 staff members who will use the TQS scoring criteria to grade each project on detail, feasibility and relevance. The group will then take this information and make any final				

	changes as needed. TQS is submitted to OHA once a year, with the next submission due on March 15th, 2021. Mr. Burgess stated that he has stepped in to the role of primary lead for TQS since Mr. Brake left. The goal will be to bring quarterly reporting to the Committee for oversight. • **Action: The Committee will provide oversight of this required quality element and be kept up to date on the status of the TQS projects and submission.**				
3.	**ReadyRide Report**	**Follow Up**	**Ms. Burns**	**O**	**AllCare CCO**
Discussion:	• Prior to the meeting, an email was sent to the Committee containing ReadyRide call audit spreadsheets from February 2020 – September 2020. The February 2020 audit spreadsheet was shared via Zoom for the Committee to review. Ms. Burns informed the Committee that there are 4 components to the NEMT compliance contract with the state: ○ Monitoring: 1 % of ReadyRide Call Center personnel is monitored each month, which includes listening to calls. N/As on the spreadsheet identify where some calls were hang ups. ReadyRide scores well, usually 95%-100%. AllCare will be looking at Spanish calls during the next audit. ○ Customer Surveys: Currently the goal is to receive 10% customer feedback. AllCare is not quite meeting the 10%, however a lot of feedback we have received regarding ReadyRide is positive. ○ Quality Assurance Report: AllCare is still working to collect this data. Overall we are looking at how many rides, call center and reimbursements per month. This report will be brought to the Committee in January. ○ Collecting Incidents: AllCare is still working to collect this data. This will include any accidents or situations in which the member and/or driver could've been hurt. A cumulative report will be brought to the Committee in January, and then brought to the Committee month to month. • **Action: ReadyRide reporting will continue to be brought to the Committee for oversight and monitoring.**				
4.	**Oral Health Update**	**Follow Up**	**Ms. McKeane**	**O**	**AllCare CCO**
Discussion:	• Ms. McKeane informed the Committee that we are still getting reports from members who have lost items due to the Slater and Alameda fires. Approximately 7 members lost their dentures due to the fires and AllCare has assisted in getting them replaced. • **Action: The Committee will continue to be informed of new oral health updates.**				
5.	**Behavioral Health Update**	**Follow Up**	**Dr. Burnett**	**O**	**AllCare CCO**
Discussion:	• Dr. Burnett informed the Committee that this month is the start of several audits for the behavioral health team. These will include audits on [redacted] programs beginning this month and into January.				

	Dr. Burnett stated that these audits will be tackled with a full team approach, not just the behavioral health team. • **Action: Results of the audits will be brought to the Committee for review. In addition, the Committee will continue to be informed of new behavioral health updates.**				
6.	[redacted]	**New Item**	**Dr. Burnett**	**O**	**AllCare Health Plan, Inc.**
Discussion:	• Dr. Burnett informed the Committee that AllCare has received several internal quality improvement concerns (IQIC) regarding [redacted]. In order for a member to be in a [redacted], they must have a [redacted]. Many of the concerns found that services were not being delivered to the members, with no communication from [redacted] informing AllCare that the services had stopped. • Ms. Ackerman proposed that she and Dr. Burnett make outreach to the Executive Director for [redacted]. [redacted] is currently addressing the cases one at a time, however from a care perspective Ms. Ackerman stated that AllCare cannot wait for these cases to be addressed one by one. [redacted] One of AllCare's Utilization Management (UM) Nurses has been identifying these cases. In effort to help with communication, this UM Nurse and the UM Supervisor may start attending weekly meetings with [redacted]. • **Action: The Committee will be informed of the outcome of the call between Ms. Ackerman, Dr. Burnett and Avalon Executive Director.**				
7.	**NPI FNP**	**New Item**	**Dr. Burnett**	**O**	**AllCare Health Plan, Inc.**
Discussion:	• The Credentialing Committee forwarded this provider to the QI Committee for review. Dr. Burnett stated that this provider currently is under a Stipulated Order, and could not provide [redacted] when submitting her application for re-credentialing to AllCare. Ultimately this provider [redacted]. A report was filed with the Oregon State Board of Nursing and is currently under review. • **Action: No further action required at this time.**				
8.	**NPI PT**	**New Item**	**Dr. Burnett**	**O**	**AllCare Health Plan, Inc.**
Discussion:	• The Credentialing Committee forwarded this provider to the QI Committee for review. Dr. Burnett stated that this provider is contracted with AllCare for [redacted] services. AllCare became aware that this provider had issues under his [redacted] resulting in a corrective action plan through the Oregon Board of [redacted]. AllCare cross reported these issues to the Oregon Board of [redacted]. • **Action: No further action required at this time.**				
9.	**NPI DC**	**New Item**	**Dr. Burnett**	**O**	**AllCare Health Plan, Inc.**
Discussion:	• The Credentialing Committee forwarded this provider to the QI Committee for review. Dr. Burnett stated that this provider is under state investigation regarding [redacted]				

	[redacted]. AllCare will continue to monitor this provider and update the Committee on additional findings. • **Action: The Committee will be informed of additional findings.**				
10.	**NPI PT**	**New Item**	**Dr. Burnett**	**O**	**AllCare Health Plan, Inc.**
Discussion:	• The Credentialing Committee forwarded this provider to the QI Committee for review. Dr. Burnett informed the Committee that this provider was recently credentialed with AllCare, however it was discovered that this provider's [redacted]. AllCare will outreach to this office for additional follow up and will update the Committee of any new findings. • **Action: The Committee will be informed of additional findings.**				
11.	**NPI MD**	**Follow Up**	**Dr. Burnett**	**O**	**AllCare Health Plan, Inc.**
Discussion:	• Dr. Burnett reminded the Committee that AllCare currently has this provider on a [redacted]. We are still working with this provider and will continue to update the Committee on new findings and the status of his corrective action plan. • **Action: The Committee will be informed of any new findings and the status of this provider's corrective action plan.**				
12.	**COVID-19**	**Follow Up**	**Dr. Burnett**	**O**	**AllCare Health Plan, Inc.**
Discussion:	• Dr. Burnett stated that the two week state-wide freeze expired today, however OHA released new risk-based guidelines by county. According to this document, Jackson and Josephine Counties are in the extreme category and will remain in this category for the next two weeks. After the two week period OHA will re-evaluate each county's risk level. Due to this, AllCare Health will continue to keep its doors closed to the public, and will allow member's into the building on an appointment only basis. Dr. Burnett stated that once the vaccine is received, the Health Department will be actively involved. Initial storage of the vaccine will be at the hospital. Long Term Care Facility patients and staff will be a high priority to receive the vaccine, followed by other essential workers. Unfortunately AllCare has had some members hospitalized with COVID-19, including fatalities • **Action: The Committee will be informed of any new updates regarding COVID-19.**				
13.	**Jackson County Fire**	**New Item**	**Mr. Buck**	**O**	**AllCare Health Plan, Inc.**
Discussion:	• Mr. Buck informed the Committee that AllCare has received very positive feedback in regards to the outreach calls that took place during the wildfires. AllCare assisted members in need of housing, DME replacement and denture replacements. Many families were displaced as a result of the fires; some families were left homeless, some were living with other families, and others were living in hotels. Currently there are 2 families on AllCare who are homeless due to these fires, and 8 members living in hotels. Ongoing efforts continue to help with sheltering. Red Cross and insurance is covering				

Quality Improvement Committee	December 2, 2020 Time 0700 – 0800am AllCare Health Community Room A

	the cost of the hotel stays, and Red Cross has condensed individuals who were scattered amongst several hotels into one. • **Action: The Committee will be informed of any new updates regarding displaced members due to the wildfires.**				
14.	**Claims/Chart Review Audit Update**	**Follow Up**	**Dr. Burnett**	**O**	**AllCare Health Plan, Inc.**
Discussion:	• Dr. Burnett reminded the Committee that AllCare now has a Medical Chart Auditor. AllCare is required under contract to look for fraud, waste and abuse. If AllCare does not look for this then OHA will, and there are consequences if the state finds examples of fraud, waste and abuse before AllCare. AllCare's Medical Chart Auditor was working on a few targeted audits that have since been addressed and completed, with corrective action plans underway for these providers. Currently we are working on random provider audits, and several have been completed without concern. • **Action: The Committee will be kept up to date on ongoing chart reviews.**				

Future Meetings		Location
January 27, 2021		AllCare Comm. Room A

Respectfully Submitted,

Cynthia Ackerman RN, CHC
Chief Quality Officer

allcare cco

Date: 01/27/2021
Prepared by: Laura Matola, CHC
Director of Compliance and Quality

[redacted]:

Number of Grievance: 0

Timely response: NA

Trends: There were no complaints submitted for 4Q2020 for [redacted]

There were two complaints for the [redacted] Office. Both were in the category of provider rude or inappropriate comments or behavior. Both seemed to be related to COVID-19; one was reschedule of appointments and the second was to changes in the exams.

Per [redacted] **Report**: The volume of grievances has decreased. [redacted] has historically received the majority of grievances through its pt. satisfaction survey process. In May 2020, [redacted] stopped including grievance forms with the pt. satisfaction survey. Instead, the survey now refers the member to contact Member Services with any complaints. This change in process has resulted in a decrease to the amount of grievances received.

Number of NOA-ABD issues: 49

Preservice: 49

Claims: 0

Per [redacted] **Report:** [redacted] continues to follow up on all authorizations that are missing information necessary for making a coverage determination. This additional training to our providers has resulted in a decrease in the number of NOABDs issued for missing information. This number may fluctuate when new [redacted]s are added to the network, however we see a reduction once the office has received additional training

Timely processing for preservice request: 49

Extension Letters: 0

NOA-ABD review:

- Under Reason for Denial:
  - In paragraph two, they are to be listing phone numbers. These numbers are not listed.
  - In letter [redacted] printed on 12/03 on Page 2 the third paragraph "We carefully reviewed the request, but we were not able to approve it. [redacted] treatment that has been requested will require a [redacted] that is not a covered

service in your Oregon Health Plan benefit package, therefore services is denied." The word [redacted] in the second sentence is not capitalized
    - Overall, the NOABD are much improved.
- Email sent to [redacted] Director of Medicaid Services

Reading Level: 6.0, 7.7

Update: 07/01/2020- Laura Matola, Laura McKeane, Cynthia Ackerman held call with [redacted] to discuss the NOABD. [redacted] had updated the NOABD letter that was approved by OHA in mid-May. There was an oversight on [redacted] for not updating the AllCare CCO Template for 2020. They will be getting that corrected. Since there has been the change in the template, [redacted] will be sending AllCare the new template and then all NOABD sent out the third week of May and the month of June for 2Q2020. Once letters are reviewed and follow up call will be scheduled to discuss concerns with today's group with the addition of [redacted] from [redacted].

[redacted]:

Number of Grievance: 1

Timely response: 1

Trends: Since there was only one complaint this quarter, there were no trends identified.

Grievance letter came in at a 6.6 reading level.

Number of NOA-ABD issues: 121

Preservice: 121

Claims: 0

Per :

- **4Q2020** The volume seems average compared to the immediately preceding quarters. We perform interrater reliability audits monthly, to ensure that review criteria are being consistently applied between reviewers.
- **3Q2020** The volume is higher compared to the previous quarters. This is likely due to a change in our [redacted] Director. All service types are dental. We perform interrater reliability audits monthly, to ensure that review criteria are being consistently applied between reviewers.

Timely processing for preservice request: 121

Extension Letters: No

NOA-ABD review: Nice letters, easy to read. All required elements in the letter.

- Denial for non-covered, does not reference the line the service falls on, or what the line coverage is ([redacted]).
- The OHP 3302 Form has been updated to the 03/2020 version.
- The AllCare member services information is still not on the letter. Sent email [redacted]
-

Pervious Review: Email sent to [redacted] for [redacted] on 08/26/2020 to address missing elements such as: not include the AllCare CCO address and phone number; the effective date of the adverse benefit; addressing co-morbid conditions; the provider's right to appeal with written consent from the member; and the providers right to request a contested case hearing. Also, to update to the 3302 dated 03/2020

AllCare Member Service information is still not on the letter and the portion about the provider may request a hearing is not in the letter.

Need to change the title of the letter from Notice of Action- Benefit Denial (NOABD) to Notice of Action - Benefit Denial (also known as Notice of Adverse Benefit Determination)

Reading Level: 6.6, 7.0, 6.8

Update: 08/27/2020

[redacted]

Number of Grievance: 0

Timely response: 0

Trends: N/A

Number of NOA-ABD issues: 2

Preservice: 2

Claims: 0

Timely processing for preservice request: 2

Extension Letters: 0

NOA-ABD review:

- Need to change the title of the letter from Notice of Action- Benefit Denial (NOABD) to Notice of Action - Benefit Denial (also known as Notice of Adverse Benefit Determination)
- Need to update the 3302 form, this is out dated.

Reading Level: 7.0, 7.0

01/27/2021- email was sent to [redacted] with the above mentioned areas for improvement. In addition, a review of the Grievance System Report does not show any types of trends for Appeals or Complaints. There have been no hearings in 2018, 2019 or 2020 for [redacted].

Thank you for the submission of you 4Q2020 Exhibit I. In reviewing your NOABD i noticed a couple of things. 1) the 3302 form attached to the letter is from 2018. There was a new 3302 issued by OHA in 2020. This will need to be updated. 2) the letters titled will need to be updated from Notice of Action- Benefit Denial (NOABD) to Notice of Action - Benefit Denial (also known as Notice of Adverse Benefit Determination). The letters are coming in at a 7.0 reading level (per Word). Is there a way to get this down to 6th grade reading level?
Thank you, Laura

[redacted]: Contract termed with [redacted] as of 06/30/2020.

[redacted] **Services**:

Number of Grievance: All complaints are processed by AllCare CCO.

Timely response: N/A

Trends: N/A

Number of NOA-ABD issues: 60

Preservice: 0

Continuation: 5

Claims: 55

Timely processing for preservice request: 60

Extension Letters: N/A

NOABD review:

- Left () blank for the number of late cancelled [redacted]; Run on sentence [redacted], Missing when the request was received in the letter.
- Keep date format consistent throughout the letter. Some are MM/DD/YYYY other are Month Day, Year.
- The letters submitted did not include the OHP 3302 form- not sure if they were updated or not.
- There is a line that says, “Please talk to your provider about other ways to treat your condition.” This is not appropriate for [redacted] Maybe change it to: “Please follow up with Care Coordination to help you with your [redacted] needs”

Update:

01/27/2021 There was one NOABD left off the denial log. Member had 4 NOABDs, added the missing letter to the NOABD log of the Exhibit I. It was added in red.

12/18/2020- AllCare and [redacted] have a standing workgroup meeting. Letter writing will be added to the agenda for discussion and more real time monitoring. Went over the letter template, the 3302 and the other issues listed above. [redacted] will be sending us NOABD for review prior to sending the letter to the member.

On **June 14, 2019** AllCare worked with [redacted] on how to appropriately write NOA-ABD letters.

The incorrect template was provided to [redacted] and instead of it saying Effective Date of Notice, it said Appeal Resolution Date. [redacted] was provided the corrected template on 06/03/2020 along with a list issue with the 1Q2020 letters.

Reading Level: 9.9, 8.5

[redacted]:

Number of Grievance: 11

Timely response: 11

Trends: There were 7 complaint regarding the [redacted] location. Two were with their medication unit; one was with the medical records and the other four are with various clinicians at [redacted] Three of the other four complaints submitted were against downstream providers ([redacted]). There were no trends in providers.

Number of NOA-ABD issues: 0

Preservice: 0

Continuation of Services: 0

Claims: 0

Timely processing for preservice request: N/A

Extension Letters: N/A

NOABD review: No letters were provided to AllCare to review.

Reading Level: 0

[redacted]:

Number of Grievance: 0

Timely response: 0

Trends: N/A

Number of NOA-ABD issues: 0

Preservice: 0

Claims: 0

Timely processing for preservice request: N/A

Extension Letters: N/A

NOA-ABD review: N/A

Reading Level:

Alternative Payment Model (APM)

a Value Based Payment Program

2020

Methodology and Measure Specifications

-Primary Care & Pediatrics-

AllCare acknowledges that the COVID-19 pandemic has greatly impacted the healthcare landscape. The APM has been modified to reflect that.

Revised: June, 2020

Table of Contents

Quarterly Report Example

Provider Name
PROVIDER XYZ

Member Months
8082

**Quality Report reflects estimated goals. Goals will be updated when OHA releases 2020 measure targets.*

Quality Measures	Goal*	Numerator	Denominator	Estimated # Needed to Meet Measure	YTD Performance	Points Possible	Points Earned YTD
Childhood Immunizations	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Adolescent Immunizations							
Well Child Visits (3 - 6 years old)							
A1c Poor Control							
~~Initiation and Engagement of Substance Abuse Treatment~~							
Smoking Prevalence Reduction							
ED Utilization for Members w/Mental Illness		Per 1,000 Measure	Per 1,000 Measure				
Depression Screening w/ Follow-up Reporting	Y/N	Y	Y	Meeting			
SBIRT Reporting	Y/N	Y	Y	Meeting			
Health Equity	Y/N	Y	Y	Meeting	Y		
Next Available Appt.	Y/N	N	N		N		
BONUS POINTS							
Risk Stratification	Y/N				Y	3	
Total Points						[redacted]	
	Tier 1 (50%)	***16-21 Points***					
	Tier 2 (75%)	***22-27 Points***					
	Tier 3 (100%)	***28+ Points***					

In order to qualify for a measure, a provider must have at least 10 patients in the denominator. If this is not met, the measure will not be factored into your over-all points and your tier level thresholds will be adjusted accordingly.

Childhood Immunization Status

Measure Type: HEDIS

Measurement Period: 1/1/20 -12/31/20

2019 OHA Benchmark: TBD

AllCare Health Improvement Target: TBD

Required elements for denominator: Children who turn **2 years of age** during the measurement year.

Required exclusions for denominator: Members in hospice are excluded from this measure. These members are identified using HEDIS 2019 Hospice Value Set, with claims within the measurement year. (See HEDIS 2019 General Guideline 17 for detail.)

Data elements required numerator: OHA is using HEDIS® 2020 Combination 2 for the CCO incentive and State Quality measure: The number of children who turned **2 years of age** in the measurement year and had all the following specified vaccinations.

- **DTaP** – **at least four DTaP vaccinations** (DTaP Vaccine Value Set), with different dates of service **on or before the child's second birthday**.
- **IPV** – **at least three IPV vaccinations** (Inactivated Polio Vaccine (IPV) Immunization Value Set), with different dates of service **on or before the child's second birthday**.
- **MMR** – Any of the following **on or between the child's first and second birthdays**:
  - At least one MMR vaccination (Measles, Mumps and Rubella (MMR) Immunization Value Set), **OR**
  - One measles and rubella vaccination (Measles Rubella Immunization Value Set), **OR**
  - One measles vaccination (Measles Vaccine Value Set), **OR**
  - One mumps vaccination (Mumps Immunization Value Set), **OR**
  - One rubella vaccination (Rubella Vaccine Administered Value Set).

Note: General Guideline 36 (i.e., the 14-day rule) does not apply to MMR.

ALERT Data

Childhood Immunization Status

(Continued)

OHA omits the HEDIS requirement for the combination of subcategories in the following bullet points, which compensates the effect that ALERT IIS data is unable to provide reliable disease histories.

- **HiB** – **At least three HiB vaccinations** (Haemophilus Influenzae Type B (HiB) Immunization Value Set), with different dates of service **on or before the child's second birthday**.
- Hepatitis B – **At least three hepatitis B vaccinations** (Hepatitis B Immunization Value Set), with different dates of service **on or before the child's second birthday**.
    - One of the three vaccinations can be a newborn hepatitis B vaccination (Newborn Hepatitis B Vaccine Administered Value Set) during the eight-day period that begins on the date of birth and ends seven days after the date of birth. For example, if the member's date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8.
- **VZV** – **At least one VZV vaccination** (Varicella Zoster (VZV) Immunization Value Set), with a date of service **on or between the child's first and second birthdays**.

NOTE: OHA relies on the Public Health Division Immunization Program Registry (ALERT IIS) data which provides records with CVX codes. In 2017, HEDIS incorporated CVX codes into the Value Set Directory Workbook; OHA is adopting the HEDIS numerator CVX codes, with additional inactive and formula unspecified codes that are still in use but verified by ALERT IIS. See table below.

In addition, ALERT IIS data currently does not reliably capture disease history, therefore OHA deviates from HEDIS and does not check the disease histories. Further improvement for ALERT IIS to indicate disease histories might be made in 2019, and OHA will revisit the deviation.

While the ALERT IIS does include MMIS claims/encounter data as one of the registry data sources[1], OHA does not directly calculate the measure from the MMIS/DSSURS claim/encounter data and the CPT/ICD codes in the table below are provided for reference only.

Value Set Name	HEDIS 2020 CVX	OHA additional CVX	From HEDIS 2020 Value Set (reference-only)	
			CPT/HCPCS	ICD10 CM Diagnosis
DTaP Immunization	20, 50, 106, 107, 110, 120	01, 09, 11, 12, 22, 28, 102, 113, 115, 130, 132	90698, 90700, 90721, 90723	

[1] For reference, ALERT IIS follows the CPT to CVX mapping from CMS:
http://www2a.cdc.gov/vaccines/iis/iisstandards/vaccines.asp?rpt=cpt
For more information: http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

Childhood Immunization Status

(Continued)

Value Set Name	HEDIS 2020 CVX		OHA additional CVX	From HEDIS 2020 Value Set (reference-only)	
				CPT/HCPCS	ICD10 CM Dx
Inactivated Polio Vaccine (IPV) Immunization	10, 89, 110, 120		2, 130, 132	90698, 90713, 90723	
Measles, Mumps and Rubella (MMR) Immunization	Members received any of these CVX codes are counted as compliant in the MMR category	03, 94	90707, 90710		
Measles Rubella Immunization		04	90708		
Measles Immunization		05	90705		
Mumps Immunization		07	90704		
Rubella Immunization		06	90706		
Measles					B05.0, B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9
Mumps					B26.0, B26.1, B26.2, B26.3, B26.81, B26.82, B26.83, B26.84, B26.85, B26.89, B26.9
Rubella					B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9
Haemophilus Influenzae Type B (HiB) Immunization	17, 46 – 51, 120, 148		22, 45, 102, 132	90644-90648, 90698, 90721, 90748	

ALERT Data

Childhood Immunizations (Continued)

Value Set Name	HEDIS 2020 CVX	OHA additional CVX	From HEDIS 2020 Value Set (reference-only)	
			CPT/HCPCS	ICD10 CM Dx
Hepatitis B Immunization	08, 44, 45, 51, 110	42, 43, 102, 104, 132	90723, 90740, 90744, 90747, 90748, G0010	
Newborn Hepatitis B Vaccine Administered				ICD10-PCS: 3E0234Z
Hepatitis B				B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51
Varicella Zoster (VZV) Vaccine Administered	21, 94	36, 117	90710, 90716	
Varicella Zoster				B01.0, B01.11, B01.12, B01.2, B01.81, B01.89, B01.9, B02.0, B02.1, B02.21, B02.22, B02.23, B02.24, B02.29, B02.30, B02.31, B02.32, B02.33, B02.34, B02.49, B02.7, B02.8, B02.9

ALERT Data

Childhood Immunizations (Continued)

Required exclusions for numerator: None.

Deviations from cited specifications for numerator:

See Data elements required numerator section above, which include:

1. OHA uses CVX codes in ALERT IIS data. In addition to CVX codes in the HEDIS Value Sets, OHA keeps additional inactive and formula unspecified CVX codes that are still in use but verified by ALERT IIS.
2. Omits the rule not to count vaccinations administered prior to 42 days after birth, due to negligible inconsistencies and occasional issues with the date of birth in eligibility data. As a result, all vaccinations through the child's 2nd birthday are used.
3. OHA counts members given any of the codes in the following value Sets compliant in the MMR category, without requiring a combination of subcategories:
    a. Measles, Mumps and Rubella (MMR) Vaccine Administered
    b. Measles/Rubella Vaccine Administered
    c. Measles Vaccine Administered
    d. Mumps Vaccine Administered
    e. Rubella Vaccine Administered
4. OHA is not including disease histories for the numerator.

What are the continuous enrollment criteria: 12 months prior to the child's 2nd birthday.

What are allowable gaps in enrollment: No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's 2nd birthday.

For More Information: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

Adolescent Immunizations

Measure Type: HEDIS

Measurement Period: 1/1/20 -12/31/20

2019 OHA Benchmark: TBD

AllCare Health Improvement Target: TBD

Required elements for denominator: Adolescents who turn 13 years of age during the measurement year.

Required exclusions for denominator: OHA excludes members who are known to be deceased at the time of metric reporting.

Note this is a clarification of ongoing practice for OHA's immunization metrics production, given the ALERT IIS does not provide immunization records for deceased individuals.

Data elements required numerator:

Meningococcal: **At least one** meningococcal serogroups A, C, W, Y vaccine (Meningococcal Immunization Value Set) with a date of service **on or between the member's 11th and 13th birthdays**.

Tdap: **At least one** tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine (Tdap Immunization Value Set) with a date of service **on or between the member's 10th and 13th birthdays**.

HPV: **At least two** HPV vaccines (HPV Immunization Value Set), with different dates of service **on or between the member's 9th and 13th birthdays**.

- There must be at least 146 days between the first and second dose of the HPV vaccine. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be after July 25. OR,
- At least three HPV vaccines (HPV Vaccine Administered Value Set), with different dates of service on or between the member's 9th and 13th birthdays.

Combination 1: Adolescents who are numerator compliant for both the meningococcal conjugate and Tdap indicators.

Combination 2: Adolescents who are numerator compliant for all three indicators (meningococcal, Tdap, and HPV).

ALERT Data

Adolescent Immunizations (Continued)

NOTE: OHA relies on the Public Health Division Immunization Program Registry (ALERT IIS) data which provides records with CVX codes. In 2017, HEDIS incorporated CVX codes into the Value Set Directory Workbook and OHA is now adopting the HEDIS numerator CVX codes, with additional inactive and formula unspecified codes that are still in use but verified by ALERT IIS. See table below.

In addition, ALERT IIS data currently does not reliably capture disease history, therefore OHA deviates from HEDIS and does not check the disease histories. While the ALERT IIS does include MMIS claims/encounter data as one of the registry data sources1 , OHA does not directly calculate the measure from the MMIS/DSSURS claim/encounter data and the CPT/ICD codes in the table below are provided for reference only.

Vaccination Category	HEDIS 2020 CVX	OHA additional CVX	From HEDIS 2020 Value Set CPT (reference-only)
Meningococcal Immunization	108, 114, 136, 147, 167	32, 103, 148, 162, 163, 164	90734
Tdap Immunization	115	9, 11, 35, 112, 113, 138, 139, 142	90715
HPV Immunization	62, 118, 137, 165		90649, 90650, 90651

ALERT Data

Required exclusions for numerator: None. OHA does not apply the optional exclusions in HEDIS specifications.

What are the continuous enrollment criteria: 12 months prior to the adolescent's 13th birthday.

What are allowable gaps in enrollment: No more than one gap in enrollment of up to 45 days during the 12 months prior to the adolescent's 13th birthday.

For More Information: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (NQF 1516)

Measure Type: Other. HEDIS-like – Computed using administrative claims only; HEDIS notes administrative data-only method should be used for the commercial population.

Measurement Period: January 1, 2020 – December 31, 2020

2020 OHA Benchmark: TBD

AllCare Health Improvement Target: TBD

Required elements for denominator: Members age 3-6 years as of December 31 of the measurement year.

Required exclusions for denominator: Members in hospice are excluded from this measure.

Data elements required numerator: At least one well-child visit during the measurement year.

Well-Care Value Set		
CPT	**HCPCS**	**ICD-10 Diagnosis***
99381-99385, 99391-99395, 99461	G0438, G0439	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

*Diagnosis codes do not have to be primary.

**Note: Z02.xx ICD-10 codes are not covered under OHP administrative rules or on the Prioritized List as of 10/01/2019, however this measure does include denied claims.

Required exclusions for numerator: Do not count visits billed with a telehealth modifier (Telehealth Modifier Value Set) or billed with a telehealth POS code (Telehealth POS Value Set).

Telehealth Modifier Value Set
Modifier
95, GT

Telehealth POS Value Set
Modifier
02

What are the continuous enrollment criteria: The measurement year.

What are allowable gaps in enrollment: No more than one gap in continuous enrollment of up to 45 days during the measurement year.

Claims

Diabetes: HbA1c Poor Control
(CMS122v8)

Measure Type: eCQM

Measurement Period: January 1, 2020 – December 31, 2020

2019 OHA Benchmark: 23.4%

2019 AllCare Health Improvement Target: TBD

Data elements required denominator: Patients 18-75 years of age with diabetes with a visit during the measurement period

Note: Only patients with a diagnosis of Type 1 or Type 2 diabetes should be included in the denominator; patients with a diagnosis of secondary diabetes due to another condition should not be included.

Required exclusions for denominator: Patients whose hospice care overlaps the measurement period

Data elements required numerator: Patients whose most recent HbA1c level (performed during the measurement period) is **>9.0%.**

Patient is numerator compliant if the most recent HbA1c level **>9%**, if the most recent HbA1c result is missing, or if there are no HbA1c tests performed and results documented during the measurement period. If the HbA1c test result is in the medical record, the test can be used to determine numerator compliance.

Note: If there is a test result **>9%** recorded in the electronic health record, then the numerator criteria is satisfied. A test can be used to determine numerator compliance if the reporting provider has documentation of the test in the patient's record, regardless of who ordered or performed the test. However, this does not mean traditional chart review is required, or allowed, as part of determining numerator compliance. Numerator compliance should still be determined through the EHR-based reporting.

Required exclusions for numerator: None.

Deviations from cited specifications for numerator: None.

EHR/Provider-Reported Data

Cigarette Smoking Prevalence (NQF0028e/ CMS138v8)

Measure Type: OHA- developed

Measurement Period: January 1, 2020 – December 31, 2020

Data Source: Electronic Health Records

2020 OHA Benchmark: 26.6%

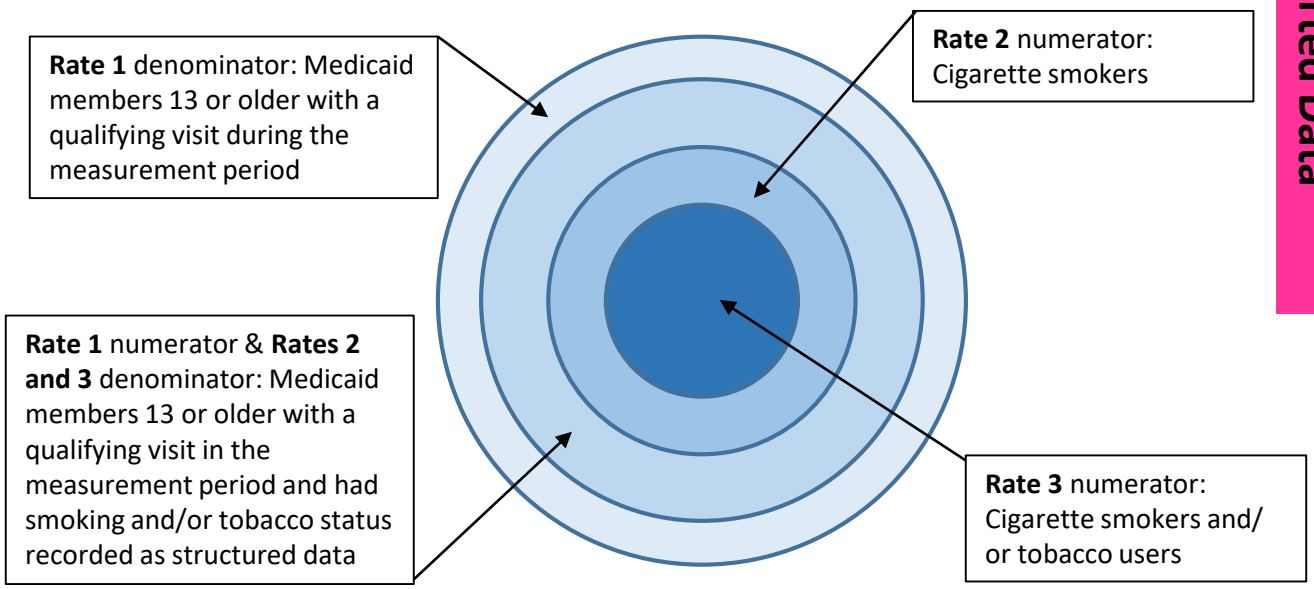
2020 AllCare improvement target: N/A

Measure Components and Scoring

The intent of the measure is to address tobacco prevalence, including cigarette smoking and use of other tobacco products, such as chew, snuff, and cigars. The measure excludes use of e-cigarettes, marijuana, and nicotine replacement products such as patches.

Three rates are reported for this measure. The measure first looks for (1) the rate of screening for smoking and/or tobacco use and then looks for separate rates for (2) cigarette smoking and (3) tobacco use. The tobacco use rate includes use of cigarettes and other tobacco products, such as snuff and chew.

EHR/Provider-Reported Data



Cigarette Smoking Prevalence (Continued)

Rate 1:

Data elements required denominator: Unique Medicaid members 13 years old or older by the beginning of the measurement year, who had a qualifying visit with the provider during the measurement period. See *Appendix 1* for identifying qualifying visits.

If a patient is seen by the provider more than once during the measurement period, for the purposes of measurement, the patient is only counted once in the denominator.

Only CCO Medicaid members are counted in this measure; open card Medicaid members are not.

Data elements required numerator: Unique members age 13 years or older who had a qualifying visit with the provider during the measurement period, who have their smoking and/or tobacco use status recorded as structured data.

> **Note**: Cigarette smoking and/or tobacco use status must be recorded during the measurement year or the year before. It does not need to be recorded on the date of the qualifying visit, but the recorded status cannot be older than 24 months. For the 2020 measurement year, this means any status recorded prior to January 1, 2019, should not be included.
>
> **Note**: If smoking or tobacco use status has been recorded multiple times from several providers within the same practice, use the most recent status on record from that practice, even if the individual saw multiple providers. If reporting at the practice level, then the individual will be in the denominator and the numerator once.
>
> If smoking or tobacco use status has been recorded multiple times across multiple practices, reporting depends on the ability to de-duplicate individuals across multiple practices in the data submission. Because of feasibility concerns, OHA does not require de-duplication across all practices at this time. If reporting this measure at the practice level, the individual will be in the denominator and numerator once per practice, but may be in multiple practices' data.

EHR/Provider-Reported Data

Cigarette Smoking Prevalence (Continued)

Note: This metric does not require recording smoking or tobacco status at every visit. Nonetheless, sometimes a patient's smoking or tobacco use status may be recorded at multiple visits. In that case, only the most recent screening, which has a documented status of smoking or tobacco use or non-use, will be used to satisfy the measure requirements. This table illustrates some examples, where Visit 1 and Visit 2 occur in the measurement year or year prior:

Patient's Status Recorded at Visit 1	Patient's Status Recorded at Visit 2	How Patient Counts in Rate 2 (smoking)	How Patient Counts in Rate 3 (tobacco)
Current every day smoker	Former smoker; snuff use	Not counted in Rate 2 numerator (because most recently recorded status indicates tobacco use but doesn't indicate smoking)	Counted in Rate 3 numerator (because of snuff use)
Current every day smoker	Snuff use	Not counted in Rate 2 numerator (because most recently recorded status indicates broader tobacco, but doesn't indicate smoking)	Counted in Rate 3 numerator (because of snuff use)
Current every day smoker	Status not recorded	Counted in Rate 2 numerator (based on status at visit 1)	Counted in Rate 3 numerator (because of smoking as a subset of broader tobacco use)
Current every day smoker	Former smoker	Not counted in Rate 2 numerator (because most recent status indicates patient doesn't smoke)	Not counted in Rate 3

EHR/Provider-Reported Data

Cigarette Smoking Prevalence (Continued)

Rate 2:

Data elements required denominator: Unique Medicaid members age 13 years or older who had a qualifying visit with the provider during the measurement period and who have their smoking and/or tobacco use status recorded as structured data (Rate 1 numerator).

Data elements required numerator: Of patients in the Rate 2 denominator, those who are cigarette smokers. The current cigarette smoker rate includes all of the following categories:

- Current every day smoker
- Current some day smoker
- Smoker, current status unknown
- Heavy tobacco smoker
- Light tobacco smoker

Additionally, any combination of "yes" responses based on the individual EHR's functionality for recording cigarette smoking status as structured data that identifies cigarette smokers also qualifies as a positive numerator event.

Numerator Exclusions: See below

Rate 3:

Data elements required denominator: Unique Medicaid members age 13 years or older who had a qualifying visit with the provider during the measurement period and who have their smoking and/or tobacco use status recorded as structured data (Rate 1 numerator).

Data elements required numerator: Of patients in the Rate 3 denominator, those who are cigarette smokers and/or tobacco users.

Those Medicaid members ages 13 years and older, who had their tobacco use status recorded as structured data within the EHR who are current tobacco users.

The current tobacco user rate should include all of the above cigarette smoking categories and any other use of tobacco products, as documented in the individual EHR's functionality. For example, any other categories within the EHR that identify patients who use cigars, snuff, chew, strips, sticks, gum, etc.

EHR/Provider-Reported Data

Cigarette Smoking Prevalence (Continued)

Numerator Exclusions: See below

Required exclusions for numerator – Rates 2 and 3:

- Members with missing smoking or tobacco use status are excluded from Rates 2 and 3. OHA will monitor Rate 1 (screening) to determine whether this exclusion is potentially incentivizing providers to not record smoking status. For additional information on this exclusion, please see the January 28, 2016, slides and notes from the Metrics Technical Advisory Group (TAG) meeting at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metrics-Technical-Advisory-Group.aspx
- **This measure does not assess use of e-cigarettes and marijuana (medical or recreational). Use of those products should be excluded**. This measure is focused on cigarettes and other tobacco products. Additional clarification may be needed with providers or modifications made to EHRs to ensure that providers and systems are asking about and documenting cigarette smoking and/or tobacco use separately from e-cigarette and marijuana use.
- Likewise, patients who are using nicotine replacement therapy (NRT) should also be excluded from the numerator (unless they are also still using cigarettes and/or other tobacco products).

What are the continuous enrollment criteria: For now, OHA does not use continuous enrollment criteria for EHR-based measures; the "eligible as of the last date of the reporting period" rule may be used to identify beneficiaries.

What are allowable gaps in enrollment: N/A

EHR/Provider-Reported Data

Cigarette Smoking Prevalence (Continued)

Appendix 1: Qualifying Visits (Rate 1 denominator)

One of the following options for identifying the tobacco prevalence denominator must be used, and the denominator option must be documented.

1) If a Meaningful Use Report is available, use the Denominator Encounter Criteria for the MU Smoking Status Objective:

Office Visit – Office visits include separate, billable encounters that result from evaluation and management services provided to the patient and include:

1. Concurrent care or transfer of care visits
2. Consultant visits, or
3. Prolonged Physician Service without Direct (Face-To-Face) Patient Contact (tele-health).

A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider.

Notes: Specific E&M codes would need to be defined by those pulling the data. There may be Meaningful Use queries/reports that they could use, but it wouldn't ensure a transparent or standard process (especially for data validation).

2) Code sets included in NQF0028/CMS 138, plus visit codes for adolescents:

The denominator criteria for NQF0028 may be used to identify visit types. Because that measure looks for patients age 18 or older, however, additional work is needed to pick up the denominator population age 13-17.

EHR/Provider-Reported Data

Cigarette Smoking Prevalence (Continued)

Denominator criteria for Tobacco Use: Screening and Cessation Intervention (NQF 0028/ CMS 138) contain the following value sets for encounters.

Value Set Name	
Annual Wellness Visit	Preventive Care Services - Group Counseling
Health & Behavioral Assessment - Individual	Preventive Care Services – Other
Health and Behavioral Assessment – Initial	Preventive Care Services-Individual Counseling
Health and Behavioral Assessment, Reassessment	Preventive Care Services-Initial Office Visit, 18 and Up
Home Healthcare Services	Psych Visit - Diagnostic Evaluation
Occupational Therapy Evaluation	Psych Visit – Psychotherapy
Office Visit	Psychoanalysis
Ophthalmological Services	Speech and Hearing Evaluation
Preventive Care Services - Established Office Visit, 18 and Up	

Additional visit types are appropriate for the adolescent population. Please note that although these visit types may pick up 12-year-olds, the measure looks for CCO members aged 13 and older.

Type of Visit	**Code**
Preventive Care Visits, ages 12-17	CPT 99384, 99394

EHR/Provider-Reported Data

Disparity Measure: Emergency Department Utilization for Individuals Experiencing Mental Illness

Measure Type: HEDIS, with OHA modifications

Measurement Period: January 1, 2020 – December 31, 2020

2020 OHA Benchmark: 86.5/1,000 member months

2020 AllCare Health Improvement Target: TBD

Data elements required denominator: 1,000 member months of the adult members enrolled with the organization, who are identified as having experienced mental illness. The adult members are identified as age 18 or older at the end of the measurement year. OHA uses claims from the measurement year, and the two years preceding the measurement year (a rolling look back period for total of 36 months), and the members who had two or more visits with any of the diagnoses in the Members Experiencing Mental Illness Value Set below are identified for inclusion in the denominator:

Members Experiencing Mental Illness Value Set

ICD-10 CM Diagnosis: F200, F201, F202, F203, F205, F2081, F2089, F209, F21, F23, F24, F250, F251, F258, F259, F28, F29, F3010, F3011, F3012, F3013, F302, F303, F304, F308, F309, F310, F3110, F3111, F3112, F3113, F312, F3130, F3131, F3132, F314, F315, F3160, F3161, F3162, F3163, F3164, F3170, F3171, F3172, F3173, F3174, F3175, F3176, F3177, F3178, F3181, F3189, F319, F320, F321, F322, F323, F324, F325, F328, F329, F330, F331, F332, F333, F3340, F3341, F3342, F338, F339, F348, F349, F39, F42, F4310, F4311, F4312, F603

To note, the denominator members are identified on an individual-basis. A member could be included in the measure due to a history of qualifying mental illness claims in the 36-month look back period from any of the organizations in OHP with which they have coverage at the time. Once the members are identified, their length of enrollment (member months) within the measurement year is attributed according to the organizations they have enrolled with for the same year for the denominator. The mental illness claims in the 36-month look back period do not need to match the organization(s) to which the member has enrolled with during the measurement year.

Disparity Measure: Emergency Department Utilization for Individuals Experiencing Mental Illness (Continued)

Required exclusions for denominator: Members in hospice are excluded from this measure.

Deviations from cited specifications for denominator: None.

Data elements required numerator: Number of emergency department visits from the denominator members (members experiencing mental illness), during the enrollment span with the organization within the measurement year. Count each visit to an ED that does not result in an inpatient encounter once; count multiple ED visits on the same date of service as one visit. Emergency Department visits are specified by the following codes:

ED Value Set	
CPT	UB Revenue
99281-99285	0450, 0451, 0452, 0456, 0459, 0981

OR

ED Procedure Code Value Set		ED POS Value Set
CPT		POS
Total of 5,824 CPT codes are included. See HEDIS 2019 Value Set Dictionary for detail	With	23

Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set).

Disparity Measure: Emergency Department Utilization for Individuals Experiencing Mental Illness (continued)

Required exclusions for numerator: Mental health and chemical dependency services are excluded, using the following codes. Note OHA began applying the exclusions at the claim line level in measurement year 2016. OHA keeps all paid claim lines (i.e., unless the entire claim was denied, the paid lines pass through the algorithm and are picked up for this exclusion).

Mental and Behavioral Disorders Value Set
Principal ICD-10 CM Diagnosis
Total of 724 diagnosis codes are included. See HEDIS 2020 Value Set Dictionary for detail

OR

Psychiatry Value Set
CPT
90785, 90791, 90792, 90832 – 90834, 90836 – 90840, 90845 – 90847, 90849, 90853, 90863, 90865, 90867 - 90870, 90875, 90876, 90880, 90882, 90885, 90887, 90889, 90899

OR

Electroconvulsive Therapy Value Set	
CPT	**ICD-10 PCS Procedure**
90870	GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ, GZB4ZZZ

Deviations from cited specifications for numerator: None.

What are the continuous enrollment criteria: Member must be continuously enrolled for 60 days (2 months) before the IESD through 48 days after the IESD (109 total days), with no gaps.

What are allowable gaps in enrollment: None.

Claims

Screening for Depression and Follow-Up Plan
(NQF 0418/CMS 2v8)

Measure Type: eCQM

Data Source: Electronic Health Records

Measurement Period: January 1, 2020 – December 31, 2020

2019 OHA Benchmark: N/A

2019 AllCare Health Improvement Target: N/A

Data elements required denominator: All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period.

Required exclusions for denominator: Patients with an active diagnosis for depression or a diagnosis of bipolar disorder

Denominator Exceptions: Any of the following criteria also remove patients from the denominator:

Patient Reason(s):
- Patient refuses to participate OR

Medical Reason(s):
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.
  OR
- Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium

Deviations from cited specifications for denominator: None.

Data elements required numerator: Patients screened for depression *on the date of the encounter or up to 14 days prior to the date of the encounter* using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.

The following Grouping Value Sets are used to identify follow-up planning:
- Referral for Depression Adolescent (2.16.840.1.113883.3.600.537)
- Referral for Depression Adult (2.16.840.1.113883.3.600.538)
- Additional evaluation for depression – adolescent (2.16.840.1.113886.3.600.1542)
- Additional evaluation for depression – adult (2.16.840.1.113883.3.600.1545)

EHR/Provider-Reported Data

Screening for Depression and Follow-Up Plan
(Continued)

- Follow-up for depression – adolescent (2.16.840.1.113883.3.600.467)
- Follow-up for depression – adult (2.16.840.1.113883.3.600.468)
- Depression medications – adolescent (2.16.840.1.113883.3.600.469)
- Depression medications – adult (2.16.840.1.113883.3.600.470)
- Suicide Risk Assessment (2.16.840.1.113883.3.600.559)

Guidance notes: A depression screen is completed on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, either additional evaluation for depression, suicide risk assessment, referral to a practitioner who is qualified to diagnose and treat depression, pharmacological interventions, or other interventions or follow-up for the diagnosis or treatment of depression is documented on the date of the positive screen.

Depression screening is required once per measurement period, not at all encounters; this is patient based and not an encounter based measure.

Screening Tools:
- The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record.
- The depression screening must be reviewed and addressed in the office of the provider, filing the code, on the date of the encounter.
- The screening should occur during a qualified encounter
- Standardized depression screening tools should be normalized and validated for the age appropriate patient population in which they are used.

Follow-Up Plan: The follow-up plan must be related to a positive depression screening, example: "Patient referred for psychiatric evaluation due to positive depression screening." Examples of a follow-up plan include but are not limited to:

- Additional evaluation or assessment for depression such as psychiatric interview, psychiatric evaluation, or assessment for bipolar disorder.
- Completion of any Suicide Risk Assessment such as Beck Depression Inventory or Beck Hopelessness Scale.
- Referral to a practitioner or program for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression.

EHR/Provider-Reported Data

Screening for Depression and Follow-Up Plan
(Continued)

- Other interventions designed to treat depression such as psychotherapy, pharmacological interventions, or additional treatment options.
- Pharmacologic treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression is advised. Consideration of each patient's prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect.

Required exclusions for numerator: None.

Definitions – In addition, the eCQM specifications provide definitions of these terms:

Screening: Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Standardized Depression Screening Tool: A normalized and validated depression screening tool developed for the patient population in which it is being utilized. Examples of depression screening tools include but are not limited to:

Adolescent Screening Tools (12-17 years)

- Patient Health Questionnaire for Adolescents (PHQ-A)
- Beck Depression Inventory-Primary Care Version (BDI-PC)
- Mood Feeling Questionnaire(MFQ)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Patient Health Questionnaire (PHQ-9)
- Pediatric Symptom Checklist (PSC-17)
- PRIME MD-PHQ2

Adult Screening Tools (18 years and older)

- Patient Health Questionnaire (PHQ9)
- Beck Depression Inventory (BDI or BDI-II)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Depression Scale (DEPS)
- Duke Anxiety-Depression Scale (DADS)
- Geriatric Depression Scale (GDS)
- Cornell Scale for Depression in Dementia (CSDD)
- PRIME MD-PHQ2

Screening for Depression and Follow-Up Plan
(Continued)

- Hamilton Rating Scale for Depression (HAM-D)
- Quick Inventory of Depressive Symptomatology Self-Report (QID-SR)
- Computerized Adaptive Testing Depression Inventory (CAT-DI)
- Computerized Adaptive Diagnostic Screener (CAD-MDD)

Perinatal Screening Tools

- Edinburgh Postnatal Depression Scale
- Postpartum Depression Screening Scale
- Patient Health Questionnaire 9 (PHQ-9)
- Beck Depression Inventory
- Beck Depression Inventory-II
- Center for Epidemiologic Studies Depression Scale
- Zung Self-rating Depression Scale

Follow-Up Plan: Documented follow-up for a positive depression screening must include one or more of the following:

- Additional evaluation or assessment for depression
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

EHR/Provider-Reported Data

Alcohol and Drug Misuse Screening, Brief Intervention and Referral to Treatment (SBIRT)

Measure Type: OHA-developed

Data Source: Electronic Health Records

Measurement Period: January 1, 2020 – December 31, 2020

2019 OHA Benchmark: N/A

2019 AllCare Health Improvement Target: N/A

Measure Components and Scoring:

Two rates are reported for this measure:

1. The percentage of patients who received age-appropriate screening and
2. The percentage of patients with a positive full screen who received a brief intervention, a referral to treatment, or both

Screening in an ambulatory setting is required once per measurement year. This measure does not require screening to occur at all encounters.

Rate 1

Data elements required denominator: All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period.

Required denominator exclusions and exceptions: See below.

Data elements required numerator: Patients who received an age-appropriate screening, using an SBIRT screening tool approved by OHA, during the measurement period **AND** had either a brief screen with a negative result or a full screen.

> **Note**: This measure leaves flexibility for clinical preferences on whether to do a brief screen before a full screen. Although a negative brief screen is numerator compliant, a positive brief screen, by itself, is not numerator compliant. If a patient has a positive brief screen, then a full screen must be completed for numerator compliance on Rate 1. A full screen is numerator compliant, regardless of the result.
>
> **Note**: Approved SBIRT screening tools are available on the HSD-Approved Evidence-Based Screening Resources/ Tools (SBIRT) page: https://www.oregon.gov/oha/HSD/AMH/Pages/EBTools.aspx . The name of the screening tool used must be documented in the medical record, but it does not need to be captured in a queryable field.

EHR/Provider-Reported Data

SBIRT (Continued)

The clinician should interpret the age-appropriate screening tool to determine if the result is positive or negative. Where the screening tool includes guidance on interpreting scores, the clinician should consult that guidance. This is the same approach used to identify positive or negative results for depression screening in NQF0418/ CMS2. There may be instances in which it is appropriate for clinicians to use their discretion in interpreting whether a result is positive or negative, such as for patients reporting use of topical medicinal marijuana.

Note: The screening(s) and result(s) must be captured as queryable structured data in the EHR.

Required exclusions for numerator: SBIRT services received in an emergency department (Place of Service 23) or hospital setting (POS 21).

EHR/Provider-Reported Data

Rate 2

Data elements required denominator: All patients in Rate 1 denominator who had a positive full screen during the measurement period.

Required denominator exclusions and exceptions: See below.

Data elements required numerator: Patients who received a brief intervention, a referral to treatment, or both that is documented within 48 hours of the date of a positive full screen.

Note – Brief Intervention: Brief interventions are interactions with patients that are intended to induce a change in a health-related behavior. They are short, one-on-one counseling sessions ideally suited for people who use substances or drink in ways that are harmful or abusive. Examples of brief interventions include assessment of the patient's commitment to quit and offer of pharmacological or behavioral support, provision of self-help material, or referral to other supportive resources.

As explained by SAMHSA:

> "Brief interventions are evidence-based practices designed to motivate individuals at risk of substance abuse and related health problems to change their behavior by helping them understand how their substance use puts them at risk and to reduce or give up their substance use. Healthcare providers can also use brief interventions to encourage those with more serious dependence to accept more intensive treatment within the primary care setting or a referral to a specialized alcohol and drug treatment agency.
>
> "In primary care settings, brief interventions last from 5 minutes of brief advice to 15-30 minutes of brief counseling. Brief interventions are not intended to treat people with

SBIRT (Continued)

serious substance dependence, but rather to treat problematic or risky substance use. Skillfully conducted, brief interventions are essential to successful SBIRT implementation. The two most common behavioral therapies used in SBIRT programs are brief versions of cognitive behavioral therapy and motivational interviewing, or some combination of the two."

https://www.integration.samhsa.gov/clinical-practice/sbirt/brief-interventions

A brief intervention of less than 15 minutes can count for Rate 2 numerator compliance. Because reimbursement codes for brief intervention services may require services of at least 15 minutes, such codes would undercount services that qualify for the Rate 2 numerator. Although clinics may bill for SBIRT services when appropriate, this measure (unlike the earlier claims based CCO SBIRT measure) does not require use of billing codes to determine whether screening or a brief intervention or referral occurred. Documentation in the medical record (e.g., through checkboxes, flowsheets, or other structured data) that a brief intervention was completed is sufficient.

Note – Referral to Treatment: A referral is counted for Rate 2 numerator compliance when the referral is made. Given the challenges of documenting whether a referral was completed (that is, whether the patient actually saw the provider to whom the patient was referred), numerator compliance is not dependent on referral completion.

Required exclusions for numerator: SBIRT services received in an emergency department or hospital setting.

Denominator Exclusions and Exceptions – Rate 1 and Rate 2

Required exclusions for denominator: Patients with:

Exclusions
Active diagnosis of alcohol or drug dependency
Engagement in treatment
Dementia or mental degeneration
Limited life expectancy
Palliative care (includes comfort care and hospice)

EHR/Provider-Reported Data

SBIRT (Continued)

Note: As with the earlier, claims-based version of this measure, SBIRT screening and intervention services are designed to prevent Oregon Health Plan members from developing a substance abuse disorder or for early detection. These services are not intended to treat members already diagnosed with a substance abuse disorder or those members already receiving substance abuse treatment services.

The exclusions for active diagnosis of alcohol or drug dependency, dementia or mental degeneration, limited life expectancy, and palliative care apply if they occur before the qualifying encounter (that is, before a visit that puts the patient in the denominator for Rate 1).

The exclusion for engagement in treatment applies if the patient was engaged in treatment before the qualifying visit and up to one year before the start of the measurement year.

Denominator Exceptions: Any of the following criteria also remove patients from the denominator.

Exception
Patient Reason(s) Patient refuses to participate
Medical Reason(s) Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status. OR Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium

Note: For this SBIRT measure, these exclusion criteria may be captured using the SNOMED-CT codes in the value sets listed below or otherwise captured in a queryable field, such as a checkbox for noting patient refusal of screening. In other words, as the measure steward for this CCO SBIRT measure, OHA uses the same concepts but is less stringent than the measure steward for the depression screening and follow-up measure (NQF0418/ CMS2) about how data is captured for these denominator exceptions.

Note: These exceptions could be applied at different points in the SBIRT process. For example, if the patient refuses screening at any point before the needed screening is completed, the patient would be excepted from Rate 1. Because a positive full screen is required for a patient to be counted in Rate 2, a patient who is an exception for Rate 1 would not be counted in Rate 2.

EHR/Provider-Reported Data

SBIRT (Continued)

- Patient refuses brief screen. = Exception. Patient is not counted in rate 1.
- Patient completes brief screen, which is negative. = Process complete, and patient is numerator compliant for Rate 1.
- Patient completes brief screen, which is positive. Patient then completes full screen. = Process complete for rate 1, and patient is numerator compliant. (If full screen is positive, proceed to evaluate brief intervention or referral for rate 2.)
- Patient completes brief screen, which is positive. Patient then refuses full screen, either before starting or partway through. = Exception. Patient is not counted in rate 1.
- Patient completes full screen, which is positive. Patient then refuses brief intervention or referral to treatment. = Patient is numerator compliant for rate 1 but is not counted for rate 2.

Deviations from cited specifications for denominator: None.

Deviations from cited specifications for numerator: None.

What are the continuous enrollment criteria: For now, OHA does not use continuous enrollment criteria for EHR-based measures; the "eligible as of the last date of the reporting period" rule may be used to identify beneficiaries.

What are allowable gaps in enrollment: n/a

Health Equity

Please note that this measure has changed.

1. ***It is no longer a "bonus measure."***
2. ***The new structure of the measure is designed to fulfill the curriculum requirements set forth by OHA's Cultural Competency Continuing Education criteria.***

Measure Purpose
To promote access and delivery of services in a culturally competent manner to all AllCare Health, Inc. Member's, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

Per OAR 943-090-0010 Cultural Competence is defined as "a life-long process of examining values and beliefs and developing and applying an inclusive approach to health care practice in a manner that recognizes the context and complexities of provider-patient communication and interaction and preserves the dignity of individuals, families, and communities."

Measure Formula:
Provider or Practice Manager attests that at least 70% of office staff have completed one of the trainings listed below:

ALL STAFF

https://www.lgbthealtheducation.org/

Clinical Care for Transgender and Gender Non-conforming Patients
https://www.lgbthealtheducation.org/courses/clinical-care-for-transgender-and-gender-non-conforming-patients/

Behavioral Health Care for Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) People
https://www.lgbthealtheducation.org/courses/behavioral-health-care-for-lesbian-gay-bisexual-transgender-and-queer-lgbtq-people/

Affirming LGBT People through Effective Communication
https://www.lgbthealtheducation.org/courses/affirming-lgbt-people-through-effective-communication/

EHR/Provider-Reported Data

Health Equity (continued)

FREE TRAININGS FOR MEDICAL PROVIDERS:

https://thinkculturalhealth.hhs.gov/education

A Physician's Practical Guide to Culturally Competent Care
https://thinkculturalhealth.hhs.gov/education/physicians

Target Audience:
- Physicians
- Physician Assistants
- Nurse Practitioners
- Any direct service provider interested in learning about culturally and linguistically appropriate Services

FREE TRAINING FOR ADMINISTRATORS:

https://thinkculturalhealth.hhs.gov/education

The Guide to Providing Effective Communication and Language Assistance Services
https://thinkculturalhealth.hhs.gov/education/communication-guide

Target Audience:
- Health care providers (or those providing direct care and services)
- Health care administrators
- Health care executives
- Social Determinants of Health providers

TRAUMA INFORMED CARE

Trauma Informed Oregon provides online training modules regarding trauma informed care. TIO's Introduction to TIC Online Training Modules include four self-directed modules that walk you through the basics of trauma informed care, as well as an introduction and closing video. Each module includes a content video, an additional Voices from the Community video that highlights how trauma informed care is being implemented in a specific community, additional resources that you can read to further your learning, questions that can be used for personal reflection, and a content quiz followed by a certificate of completion. Practices must complete all four modules to qualify for the Health Equity bonus.

https://traumainformedoregon.org/tic-intro-training-modules/

https://www.allcarehealth.com/doctors-providers/resources/health-equity

Next Available Appointment

Measure Type: AllCare CCO

Data Source: Provider reported

Measurement Period: January 1, 2020 – December 31, 2020

2019 OHA Benchmark: N/A

2019 AllCare Health Improvement Target: N/A

Measure Components and Scoring:

This information is included on the Provider Profile that you submit quarterly to AllCare.

EHR/Provider-Reported Data

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Provider Profile (EXAMPLE)

Name: Leroy Brown

Individual NPI: 12345678

Specialty: Primary Care

Language(s) Spoken: English

Open to new patients:

CCO: Yes
Medicare Advantage: Yes

Days until next available appointment:
AllCare CCO: 2 Days
Medicare Advantage: 2 Days

Provider Capacity: 230

PCP: Dr. Smith

The age ranges this provider treats:
Newborns:
(0-60 days)

Pediatrics:
(2 months – 17 years)

Adults:
(18 – 64 years)

Geriatrics:
(65+ years)

BONUS MEASURE: Risk Stratification

Introduction

AllCare Health CCO is pleased to introduce our initial Risk Stratification Report to our primary care/pediatric providers that are current participants in the AllCare APM. We are rolling this out in 2020 under a pilot program. Our intention is to build awareness and understanding of risk stratification as a concept. The longer term goal is to bend the cost curve from improvements in the population health management of our collective patients. The 2020 expectation of APM participants is also addressed.

Purpose of Risk Stratification

Risk Stratification in the primary care setting has been shown to help practices better understand their patient populations' needs and may improve health outcomes and reduce expenditures by targeting and tailoring care to high-need patients.

The potential benefits of risk stratification for population health management have led national programs such as the Comprehensive Primary Care (CPC) initiative (and the subsequent CPC+ model) to require participating practices to risk stratify their empaneled populations. OHA has included rollout of risk stratification as a required element of the new five-year CCO 2.0 contract that became effective 1/1/2020.

Ultimately, risk stratification is one of the first steps for allocating resources for more intensive care management for high-risk and rising risk patients. Studies have shown that a high percentage of the healthcare spend in a given population is a result of a relatively small percentage of the population. For instance, recently published data shows that the top 1% of highest cost patients incur approximately 30% of the healthcare spend. Likewise, the top 10% of highest cost patients incur approximately 70% of the healthcare spend.

2020 Expectations

AllCare is implementing risk stratification this year with the express purpose of introducing the concept to you and to get the report out to clinics. We would like for you to become familiar with the contents of the report and begin to experiment with how you might leverage the information in the report to help manage your assigned patients. That said, the basic requirements to attain success in the measure for 2020 include:

- Attestation at the end of the year that you are familiar with the report and have begun using the information in managing your population.
- Complete a survey on risk stratification that will be sent out near the end of the year. The survey will include questions on how useful the information in the report is, what additional information might be of value, and how you used the report in your practice. Sharing of the feedback will be provided with best practices highlighted.