



# TRANSFORMATION AND QUALITY STRATEGY

March 2019

Respectfully Submitted To:

THE OREGON HEALTH  
AUTHORITY

In Partial Fulfillment of  
Contractual Obligations

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# OHA Transformation and Quality Strategy (TQS) CCO: Advanced Health

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## Section 1: Transformation and Quality Program Information

### A. CCO governance and program structure for quality and transformation:

- i. Describe your CCO's quality program structure, including your grievance and appeal system and utilization management review:

#### Advanced Health

##### Structure and Context of the Organization

Advanced Health contracts with Oregon Health Authority (OHA) as a Coordinated Care Organization (CCO) to provide services for Oregon Health Plan (OHP) members under the health plan services contract. Based in Coos Bay, Advanced Health provides physical, behavioral, and dental health services to members in Coos and Curry counties.

Advanced Health's equity partners are Southwest Oregon Independent Practice Association (SWOIPA), ADAPT Treatment Services, Advantage Dental, Bay Area Hospital, Bay Clinic, North Bend Medical Center, Coos County, and Coquille Valley Hospital District.

Advanced Health delegates dental services to Advantage Dental; mental health services to Coos Health and Wellness and Curry Community Health; non-emergency medical transportation to Bay Cities Brokerage; pharmacy services to Med Impact, and all remaining medical services to SWOIPA. SWOIPA, in turn, delegates substance use disorder services to ADAPT. Advanced Health's business management services are provided by DOCS Management Services.

##### Leadership and Commitment

Management provides evidence of its commitment to the development, implementation, and continual improvement of the Quality Assurance Program by:

- Communicating to the organization the importance of meeting member needs for effective, equitable, understandable, and respectful services, as well as statutory and regulatory requirements;
- Ensuring that member needs and expectations are determined and fulfilled in a manner that is responsive to cultural beliefs, preferred languages, health literacy, and other communication needs with the aim of improving member satisfaction;
- Planning the processes and activities needed for the Quality Assurance Program;
- Conducting an annual Quality Program Evaluation;
- Establishing an annual Transformation and Quality Strategy and Work Plan;
- Ensuring availability of resources;
- Defining organizational roles, responsibilities, and authorities; and,
- Planning actions to address risks and opportunities.

##### Structure of the Quality Program

Advanced Health members are best served by a Quality Assurance Program designed to provide robust methods for process measurement and analysis to assure early detection of discrepancies and continual performance improvement.

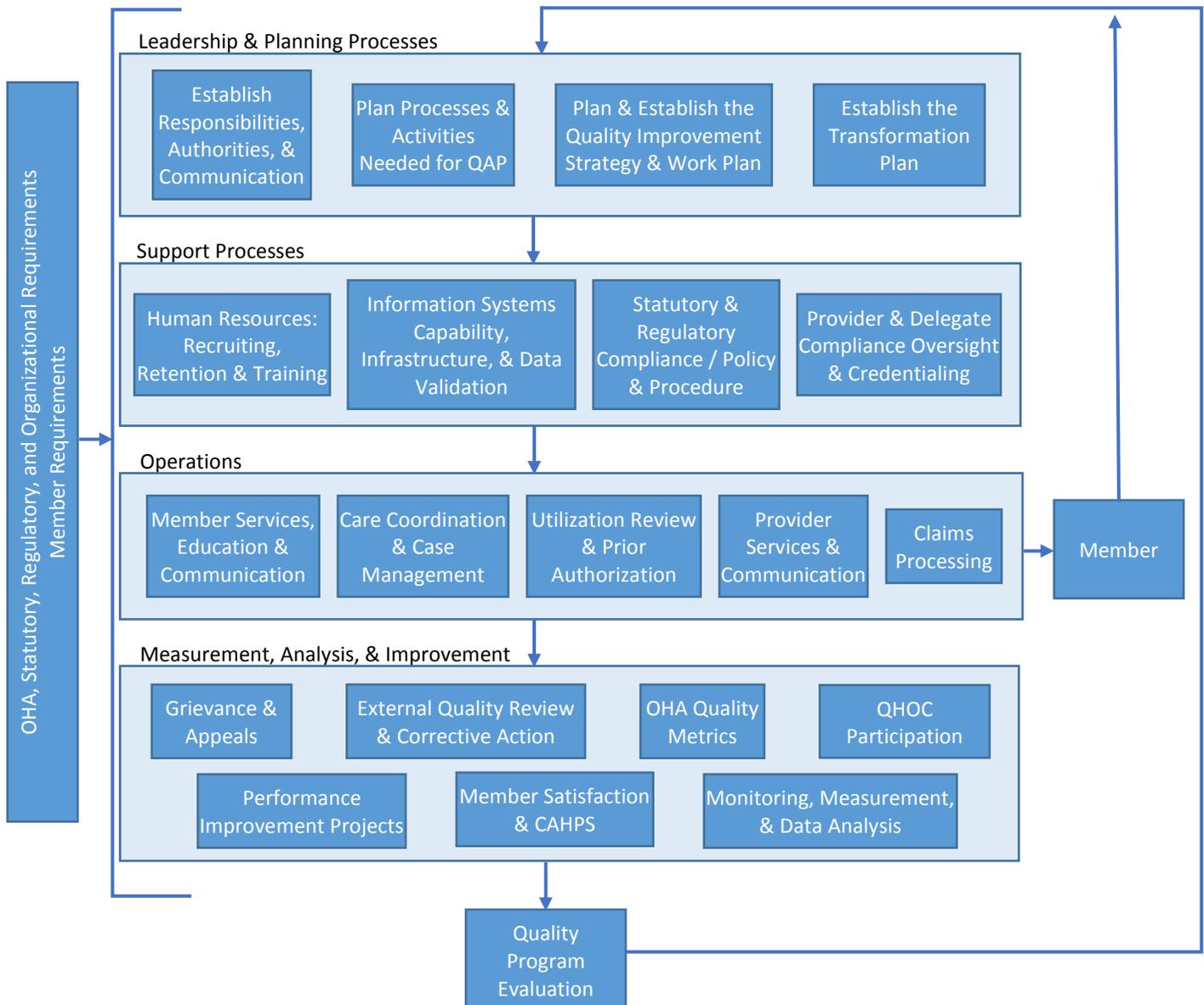
##### Scope

Advanced Health is a Coordinated Care Organization, contracted with the Oregon Health Authority to administer the benefit for Oregon Health Plan members in Coos and Curry Counties. Advanced Health maintains a network of providers and delegates for primary physical health, behavioral health, dental health, specialty services, hospital services, chemical dependency services, and transportation services.

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## Quality Assurance Program Processes and Interactions

The interaction between the processes of the Quality Assurance Program (QAP) is illustrated in the following process flow chart.



## Performance Evaluation and Improvement

Advanced Health has planned and implemented the following monitoring, measurement, and analysis activities in order to demonstrate that services provided to members conform to requirements and that the Quality Assurance Program, including the Transformation and Quality Strategy and Work Plan, performs as expected. The results of the monitoring, measurement, and analysis activities are used to improve the effectiveness of the Quality Assurance Program.

## Participation as a Member of the OHA Quality and Health Outcomes Committee (QHOC)

Advanced Health is committed to participation and attendance at the monthly Quality and Health Outcomes Committee. Advanced Health's Director of Quality as well as the Behavioral Health Director from Coos Health and Wellness regularly attend the meetings held in Salem. Other CCO employees, delegates, and providers may

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participate, either in-person or by phone, depending on the topic of the meeting or the learning collaborative session.

### External Quality Review and Corrective Action

Advanced Health participates in annual External Quality Reviews conducted by an External Quality Review Organization, as required by the Oregon Health Authority. Any findings from the EQR generate corrective action or improvement plans to eliminate the cause or causes of the problem and prevent recurrence. The corrective action or improvement plan includes a determination of the root cause, actions to address the root cause, and verification that the actions taken were effective.

### Utilization Review

A robust program of Utilization Review is in place to ensure that high quality, Medically Appropriate services are delivered to all members, including those with special health care needs. A number of mechanisms are in place to monitor for both under- and over-utilization of services.

See below for description of the function and make-up of these committees, including their methods of monitoring for both under- and over-utilization of services.

- Quality, Accountability, and Utilization Review Committee
- Clinical Advisory Panel
- Pharmacy and Therapeutics Committee

### Medical Services Department Activities

The Medical Services Department includes Utilization Review and Intensive Case Management functions. This team reviews prior authorizations to ensure that treatments follow the Prioritized List of Health Services and the associated guidelines to assure that services are medically appropriate. The list of services requiring prior authorization is reviewed annually for opportunities to reduce administrative burden on providers while still ensuring that care is delivered locally when possible, in a cost-effective manner, and consistent with medical evidence. The authorization process ensures that members have access to second opinions when desired, and all members (including those with special healthcare needs) may have direct access to a specialist when medically appropriate. Members in need of assistance accessing appropriate care can be referred to Intensive Case Management by their PCP or specialist provider, by other members of the CCO team, or at the members' request.

The Medical Services Department monitors performance to ensure that requests are handled in a timely and consistent manner. A data dashboard is in place to allow monitoring of number of authorization requests received, average time to completion, percent approved or denied, and the types of requests seen. That data is used to inform staffing decisions and prior authorization requirements. Attention is focused on high risk, high dollar interventions.

### Grievance and Appeal System

Advanced Health maintains a comprehensive Member Grievance System policy and procedure, including robust processes addressing Grievances, Notice of Adverse Benefit Determination, Appeals, Contested Case Hearings, requests for expedited Appeals or Expedited Contested Case Hearings, continuation of benefits, documentation requirements, and quality improvement review. Advanced Health reviews the policy and procedure annually, revising as needed to ensure the documented process accurately reflects the implemented process and meets all federal, state, and contract requirements. The Advanced Health policy and procedure are submitted annually to OHA for review and feedback. The Grievance and Appeal System is also part of the regular External Quality Review cycle and is reviewed at least every three years through that process.

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Advanced Health works closely with organizations to which portions of the Grievance and Appeal System are delegated to ensure the processes of the delegated entities meet the requirements of the Advanced Health policy and procedure. Delegate Grievance System policies and procedures are reviewed at least annually for compliance with federal, state, CCO contract, and Advanced Health requirements. Grievance System records and data collected from delegated entities are reviewed at the time of collection and all information from delegates is incorporated into the quarterly Grievance System report submitted to OHA.

### Program Evaluation & Improvement Strategy and Work Plan

The entire Quality Assurance and Performance Improvement Program is reviewed and evaluated at least once per year to ensure its continuing suitability, adequacy, and effectiveness in satisfying the requirements of the Oregon Health Authority and Advanced Health's goals and objectives. This evaluation includes assessing opportunities for improvement and the need for changes to the Quality Assurance Program. The Quality Program Evaluation is prepared by the Director of Quality in collaboration with key subject matter experts and reviewed by the CEO, the Quality, Accountability, and Utilization Review Committee, the Interagency Quality and Accountability Committee, and the CCO Board of Directors.

Input to the Quality Program Evaluation includes, but is not limited to, the following information:

- Results of External Quality Review
- Member complaints and the grievance system
- Status of current improvement efforts and suggestions for new improvement efforts
- Status of CCO quality incentive measures and other CCO performance measures
- Quality and appropriateness of care for members, especially those with special health care needs
- Improvement in an area of poor performance in care coordination for members with SPMI
- Monitoring and enforcement of consumer rights and protections
- Compliance of the fraud, waste, and abuse prevention program
- Utilization data
- Contracted delegate and provider monitoring results and findings

Output of the Quality Program Evaluation informs the Transformation and Quality Strategy and Work Plan for the coming year and includes decisions and actions related to:

- Improvement of the effectiveness of the Quality Assurance Program and its processes
- Improvement of member services related to requirements
- Resource needs

### Performance Improvement Process

Advanced Health continually improves the effectiveness of the Quality Assurance Program through review by the Quality, Accountability, and Utilization Review committee and other committees, participation in OHA Quality and Health Outcomes Committee meetings, participation in OHA Transformation Center technical assistance and learning collaborative opportunities, analysis of data, external quality review, and internal quality program evaluation.

OHA determines and/or approves contractual requirements for all CCOs related to Performance Improvement Projects (PIPs), Transformation and Quality Strategy components, Quality Incentive Measures, and other performance measures. Advanced Health conforms to these requirements and incorporates these improvement projects as well as other projects into its annual Transformation and Quality Strategy and Work Plan.

In managing the Transformation and Quality Strategy and Work Plan, Advanced Health employs a variety of process improvement tools, including PDSA, DMAIC, impact analysis, project management, and other lean tools. The process improvement method(s) used depend on the needs of the specific project and the capabilities of the team planning and implementing the improvements.

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Process improvement priorities are determined with consideration to a variety of sources, including but not limited to:

- OHA Requirements: Performance Improvement Project focus areas, Transformation and Quality Strategy components, Quality Incentive Measures, other performance measures, and other contractual requirements
- Advanced Health's strategic plan
- External Quality Review results
- Member complaints and grievance reports
- Cultural and linguistic needs of Advanced Health members
- Delegate and provider compliance
- Delegate, provider, and community partner feedback
- Annual Quality Program Evaluation
- Other statutory and regulatory requirements

- ii. Describe your CCO's organizational structure for developing and managing its quality and transformation activities (please include a description of the connection between the CCO board and CAC structure):

### Organizational Roles and Responsibilities

The CEO has the authority and responsibility to make appropriate changes to the Quality Assurance Program and to communicate the requirements of the QAP to personnel. Every level of management shares the responsibility to ensure proper maintenance and performance of the Quality Assurance Program. A brief overview of key titles and their responsibilities related to the quality assurance program is provided below.

#### ***Board of Directors***

- Representative of equity partners, community partners, and community stakeholders
- Guides, controls, and directs the organization through the adoption and review of annual strategic plans, the annual budgeting process, and written policies
- Oversees the performance of the organization
- Reviews and authorizes the Quality Assurance Program
- Ultimately responsible for the quality of clinical services provided to members

#### ***Chief Executive Officer/Chief Quality Officer***

- Facilitates business planning and develops appropriate strategies to attain annual strategic objectives
- Reviews activity reports and financial statements to determine progress and status in attaining quality, performance, and compliance objectives
- Ensures adequate resource availability
- Ensures the promotion and awareness of member needs and contract requirements throughout the organization
- Directs development, implementation, and improvement of the Quality Assurance and Performance Improvement Program
- Reports directly to the Board of Directors

#### ***Chief Compliance Officer***

- Ensures contractual obligations as well as statutory and regulatory requirements are met
- Oversees the development, review, and revision of the compliance plan
- Implements the compliance plan
- Audits and monitors contracted delegates and providers
- Opens and performs preliminary investigations regarding Waste, Fraud, and Abuse and makes referrals to OPAR or MFCU as required

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### ***Chief Medical Officer***

- Ensures services are medically appropriate, high quality, cost-effective, and in accordance with Oregon Health Authority (OHA) Coordinated Care Organization (CCO) contract and related Oregon Administrative Rules (OAR) and the Code of Federal Regulations (CFR)
- Oversees member Appeal and Contested Case Hearings processes
- Ensures assigned staff adhere to medical policy and member benefits

### ***Director of Quality***

- Gathers data and prepares annual Transformation and Quality Strategy for review
- Develops, implements, and communicates quality improvement strategies throughout the organization as well as to delegate and provider network, community partners, and other stakeholders
- Assists with the annual External Quality Review process
- Implements, promotes, reviews, and continually improves the effectiveness of the Quality Assurance Program.

### ***Directors and Managers***

- Oversee successful operation of assigned area of responsibility to ensure production efficiency, quality of service, and cost-effective management of resources
- Coordinate business practices and procedures to optimize operations
- Ensure training of new and existing employees
- Support efforts to improve the effectiveness of the Quality Assurance Program
- Provide direction to their staff

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### Committees

Advanced Health's Quality Assurance and Performance Improvement oversight structure is vested in a series of collaborative, yet distinct and well-defined standing committees. Each committee is characterized by a charter that defines the committee's purpose, goals, schedule of meetings, scopes of authority, membership composition, and member responsibilities. The standing committees that participate in Quality Assurance and Performance Improvement processes are described below.



#### ***Interagency Quality and Accountability Committee***

This committee is chaired by the Advanced Health Director of Quality and attended by representatives of delegate organizations, as well as community partners and providers. The Interagency Committee meets monthly. The purpose of this committee is to provide a platform for collaboration and coordination between Advanced Health's leadership, delegate organizations, and community partners purposed at achieving the Triple Aim: improved outcomes in individual and population health; enhancement of the patient's experience of care; and, cost efficacy.

#### ***Quality, Accountability, and Utilization Review Committee***

This is an internal Advanced Health committee, attended by representatives from all departments. The QA&UR Committee meets monthly. The purpose of this committee is to provide an internal staff process for monitoring, evaluating, and revising the annual Quality Assurance and Performance Improvement (QAPI) program, including developing and implementing process improvement strategies. This committee supports data-driven decision making and development of a culture of quality through the review of data reports that support OHA contract compliance, achievement of Advanced Health's strategic plan, advances in individual and population health, enhancement of the member's experience of care, and cost efficacy.

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### ***Clinical Advisory Panel***

The Clinical Advisory Panel is chaired by Advanced Health's Chief Medical Officer and membership includes providers representative of behavioral health, physical health, dental health, and substance use treatment. The CAP usually meets twice per month. The CAP provides input on clinical programs and policies with the goal of achieving the Triple Aim: improved outcomes in individual and population health; enhancement of the patient's experience of care; and, cost efficacy. The Clinical Advisory Committee provides perspective of practicing clinicians to Advanced Health. The Clinical Advisory Committee also oversees Advanced Health's credentialing and re-credentialing process and makes credentialing recommendations to the board of directors.

### ***Pharmacy and Therapeutics Committee***

The Pharmacy and Therapeutics Committee meets at least quarterly. Committee membership includes Advanced Health providers representing various specialties (e.g. family practice, internal medicine, OB/GYN, pediatrics, mental health etc.) and may also include community partners (e.g. Bay Area Hospital) and pharmacists. The Pharmacy and Therapeutics Committee is responsible for maintaining a formulary providing the most cost-effective drug therapies to Advanced Health members and ensuring compliance with DMAP rules and regulations.

### ***Consumer Advisory Councils***

Advanced Health has established two Consumer Advisory Councils, one in Coos County and one in Curry County. Both councils hold monthly meetings. Membership includes a broad spectrum of representatives, including Advanced Health members and their families, health providers, partner organizations, and other key community representation. Over 50% of the councils are individuals enrolled with Advanced Health, their families, or personal representatives. The purpose of these councils is to provide the voice of the consumer to advise Advanced Health and its governing body in its efforts to meet the Triple Aim of better health, better care, and lower costs.

### ***Community Health Improvement Plan Committees***

The Consumer Advisory Council (CAC) provided input and recommendations for the Community Health Improvement Plan (CHIP) Committee structure. The Coos CAC approved the formation of five CHIP subcommittees to address the priorities identified from the Coos County Community Health Assessment. The Curry CAC approved three priority work areas identified from the Curry County Community Health Assessment. Each subcommittee is responsible to develop an implementation plan for achieving the goals and objectives outlined by the CHIP. Progress reports are presented for approval to the respective CAC and then to the Advanced Health Board of Directors. The five priority areas are: increase access to care providers, decrease tobacco initiation and use, obesity reduction and prevention, suicide prevention, and increase timeliness of prenatal care. Advanced Health has recently hired a CHIP coordinator to support the activities of the CHIP committees in Curry county.

### **iii. Describe how your CCO uses its community health improvement plan as part of its strategic planning process for transformation and quality:**

The information from the Community Health Assessment and the Community Health Improvement Plan inform the TQS by helping to align community priorities with CCO and OHA priorities. The Community Health Assessment provides data to promote evidence-based interventions and to determine how and where resources and efforts should be allocated to best meet community needs.

- Improve organization and community coordination and collaboration
- Increase knowledge about public/community depth and interconnectedness of activities and services.
- Identify strengths and weaknesses to address quality and transformation efforts

The 2018 Community Health Assessments for Coos and Curry Counties were completed in collaboration with a wide array of community partners with the intention of creating a common Community Health Assessment that

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meets the needs of all the participating partners and offers a shared platform for developing collaborative Community Health Improvement plans designed to align priorities and objectives. More detailed information on the process for developing the Community Health Improvement Plan can be found beginning on page 23 of this document.

- iv. Describe how your CCO is working with community partners (for example, health systems, clinics, community-based organizations, local public health, community mental health programs, local government, tribes, early learning hubs) to advance the TQS:  
Advanced Health is comprised of community partners who have equity in the CCO and/or representation on our board of directors. In addition to our equity partners, Advanced Health works with a multitude of agencies in the community. Some examples include, but are not limited to:

- Bay Area Hospital: Our largest district hospital and equity partner. The CCO Director of Pharmacy Services participates in the hospital P&T committee and a hospital representative is invited to the CCO P&T committee. A care manager and Medical Director attend daily hospitalist huddles and weekly care management meetings. The hospital has participated in our Quality Innovation Incubator Fund.
- Public Health: County Public Health Directors participate in our Community Advisory Committees, CHIP, and CHA. The CCO supports interagency collaboration between public health Targeted Case Management programs and local providers, DHS, and school districts. Advanced Health is the only CCO to host the OHA/CDC Prescription Drug Overdose Prevention Grant and employs the grant coordinator. The CCO Director of Quality participates in the Advisory Committee for the local Public Health Modernization Grant as well as the Coos County AFIX Collaborative facilitated by Coos County Public Health.
- Tribes: The Coquille Tribal Clinic became CCO contracted providers and have partnered in opioid reduction, tobacco cessation, and workforce development projects, among others. Advanced Health is working toward a contract with the Confederated Tribes of Coos, Lower Umpqua, and Siuslaw.
- Local Mental Health: Advanced Health has convened workgroups to improve collaboration between hospital, pediatricians, and mental health agencies to help youth in crisis, and has supported the development of a youth drop-in center. The CCO has supported the development and spread of Integrated Behavioral Health in the community.
- Housing advocates: Advanced Health is working with community partners to support the development of affordable housing as well as emergency shelter. We have a “medical respite” program with a local shelter that allows homeless members to stay in the shelter following a hospitalization or surgery, allowing them a clean place to sleep, eat, and receive support services without having to vacate the premises during the day.
- Critical Access Hospitals: Coquille Valley Hospital is an equity partner. CCO staff provide coaching and support to hospital affiliated practices to meet quality metrics and to provide high quality care to our members.
- Southwest Oregon Community College: Advanced Health advocated for SOCC to develop its Traditional Healthcare Worker training program. We funded tuition for community partners who wished to have employees receive training and filled all available slots in the first cohort, with plans to provide coordination and financial support to subsequent cohorts. Our Care Management Team mentors nursing students in a Care Management rotation.
- Professional Education: Advanced Health provides faculty and a rotation site for Pharmacy students from OSU College of Pharmacy, and supports rotations with community partners training medical, nursing, physician assistant, and nurse practitioner students.

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### B. Review and approval of TQS

- i. Describe your CCO's TQS development process, including review, development and adaptation, and schedule:

Much of the process for the TQS analysis, development, and planning is described in the above sections regarding the Program Evaluation & Improvement Strategy and Work Plan and the Performance Improvement Process. The Director of Quality worked with the key personnel and committees described above beginning in the third quarter of 2018 through January of 2019 to select the list of projects and programs to be included in the TQS to highlight the work of Advanced Health and that best address the required TQS components and subcomponents. These projects and programs include priorities that align with the Community Health Improvement Plan, CCO quality metrics, PCPCH standards, CPC+ program metrics, contract requirements, current and future Performance Improvement Projects, as well as other statutory and regulatory requirements.

The TQS projects and programs were presented for discussion and feedback beginning in November of 2018 to several of the committees involved in the quality program: Interagency Quality and Accountability Committee, Quality, Accountability, and Utilization Review Committee, and the Clinical Advisory Panel. The Consumer Advisory Councils have been working on the Community Health Improvement Plan process since mid-2018, and that information was incorporated in the presentations to the other committees. The information was presented to the Advanced Health Board of Directors for review in January 2019.

In February and March of 2019, additional details, data, activities, and targets were collected from the project or program leaders. Final versions of sections were finalized with relevant executive leadership and other personnel involved as needed, including the functions discussed above in the Organizational Roles and Responsibilities section.

## Section 2: Transformation and Quality Program Details

- A. **Project or program short title:** [Utilization Review Project 1: Reducing preventable emergency department visits](#)

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

- B. **Primary component addressed:** [Utilization review](#)

- i. Secondary component addressed: Severe and persistent mental illness
- ii. Additional component(s) addressed: [Integration of Care](#); [HIT: Health Information Exchange](#); [HIT: Analytics](#); [Access: Timely](#); [Access: Quality and Appropriateness of Care for All Members](#); [Access: Availability of Services](#)
- iii. If *Integration of Care* component chosen, check all that apply:  
 Behavioral health integration  Oral health integration

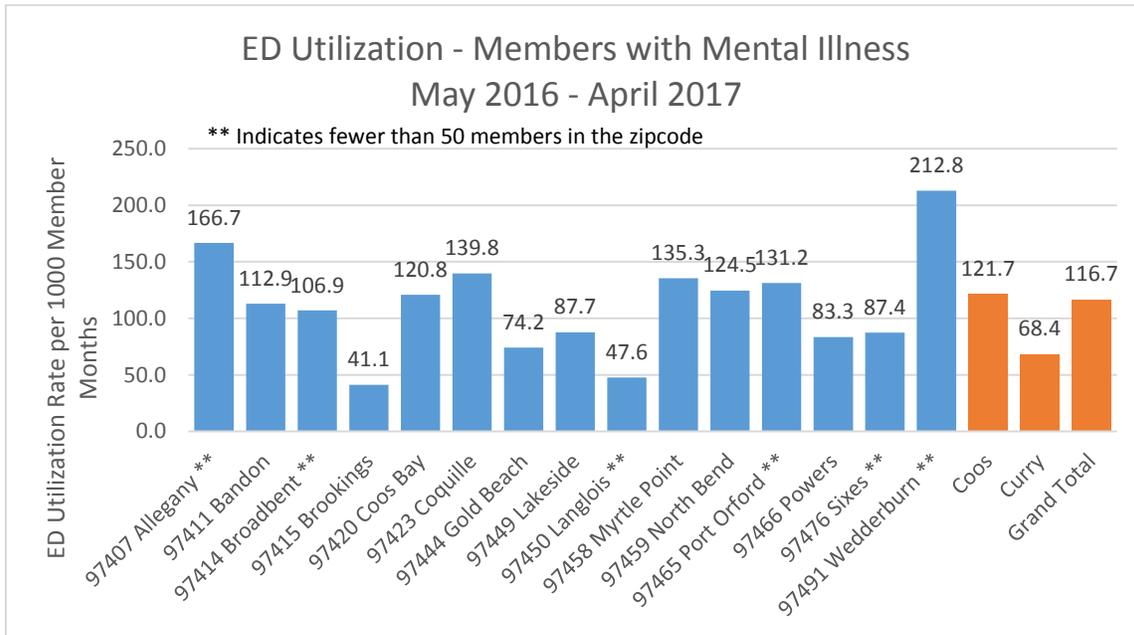
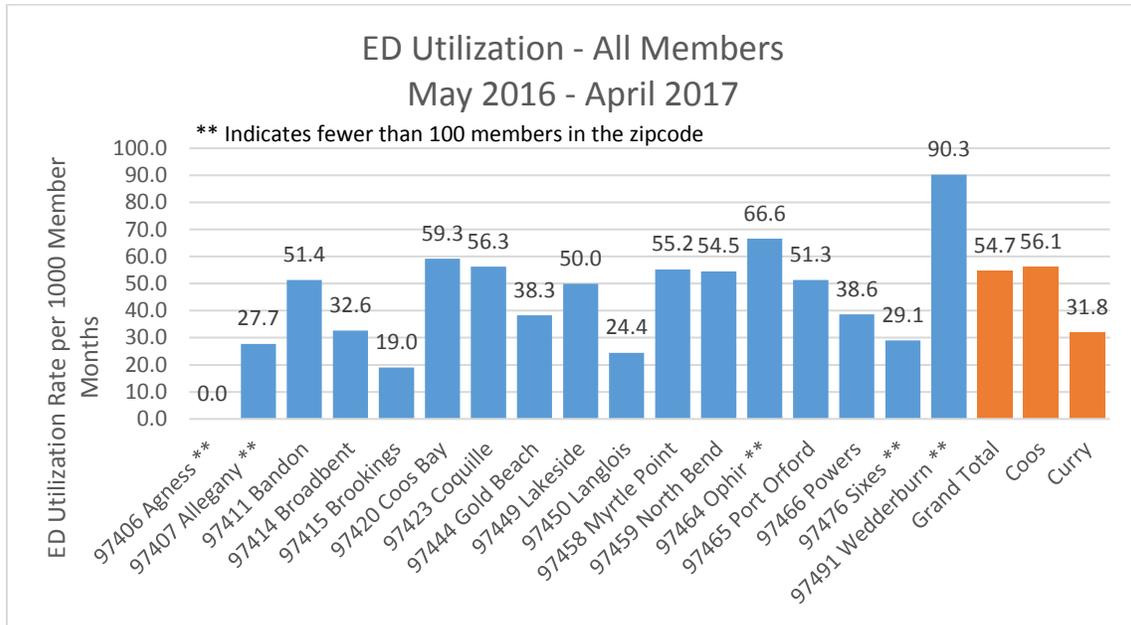
- C. **Primary subcomponent addressed:** [Choose an item.](#)

- i. Additional subcomponent(s) addressed: [Add text here](#)

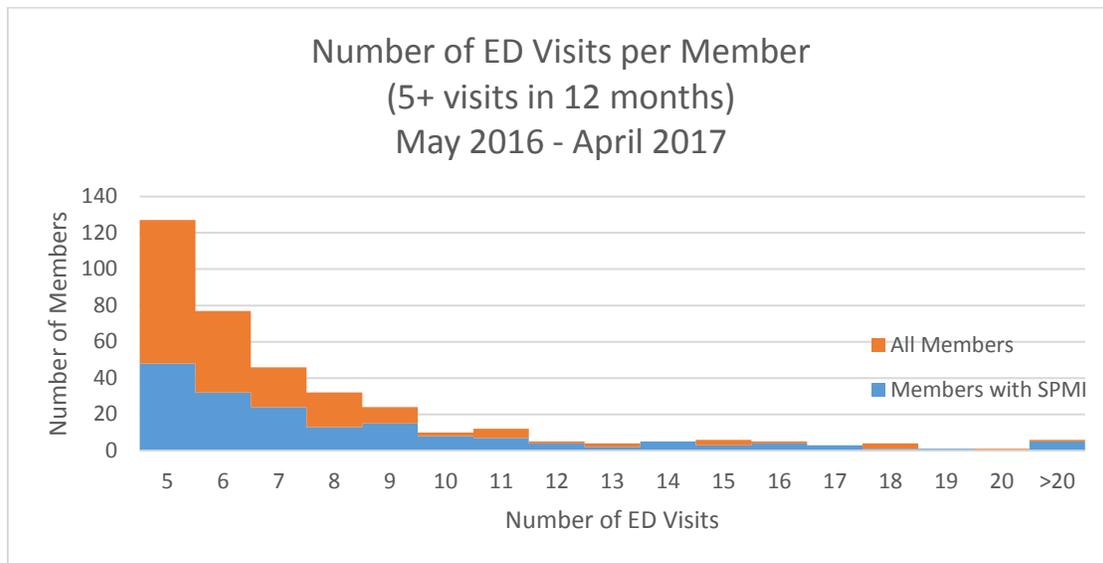
- D. **Background and rationale/justification:**

Advanced Health has analyzed available ED utilization data in a variety of ways to better understand the potential drivers of over-utilization. There appears to be higher utilization of the ED in Coos County than in Curry County, for all members and for members with mental illness. The rates of utilization for members with mental illness are significantly higher than for the adult population as a whole, potentially indicating additional barriers or gaps for those members and opportunity to improve care coordination and integration to better serve their needs.

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Diagnosis data from claims reveals that several conditions, such as urinary tract infection and upper respiratory infection, which would be more appropriately addressed in a primary care or urgent care setting, are consistently in the top ten list of most common diagnoses. Advanced Health is planning to perform additional analysis to determine other patterns or clusters of use. Identifying these patterns or member populations would allow us to design targeted interventions to better meet these members needs and ensure they are receiving needed care.

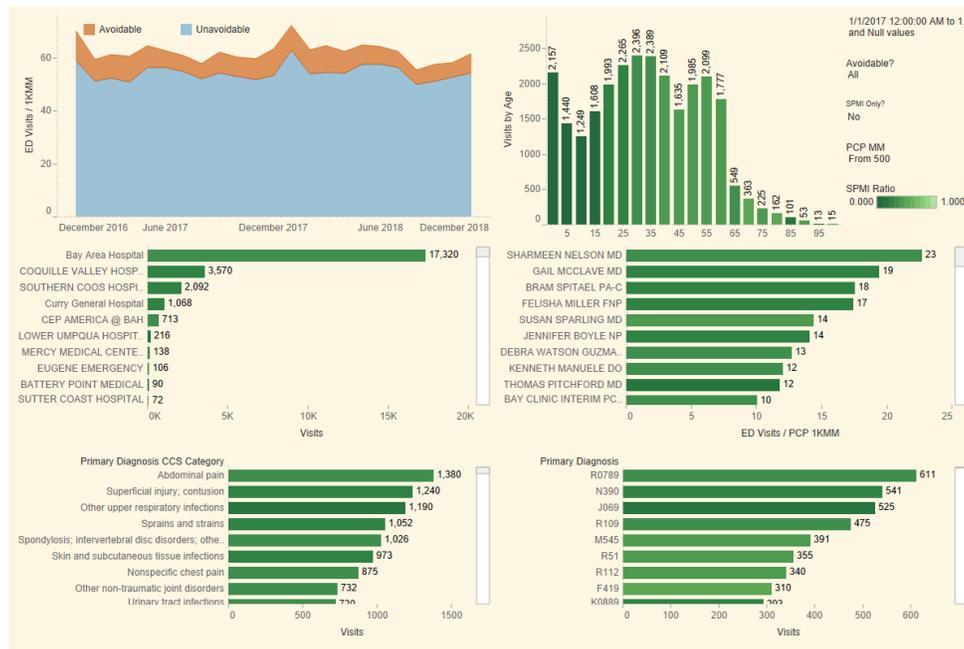
Some of the current interventions and programs are highlighted below:

- Several of the Quality Innovation Incubator Fund projects for 2016, 2017, and 2018 were aimed at increasing the use of primary care health care teams, including navigators and care managers to expand the reach of our primary care providers. Most of these programs supported through the Incubator Fund became fully operational in 2017 and we should begin to see the results of these projects in 2018.
- Advanced Health care management staff participate with a community care management group that includes representation from clinics in our provider network and community partners in both Coos and Curry counties. This group meets twice a month to share best practices to coordinate care across the continuum of health care services and community resources, as well as consult on particular cases as needed.
- Two large clinics in Advanced Health's provider network, Bay Clinic and North Bend Medical Center, are participating in the CPC+ program. In 2017 these clinics began monitoring and working to improve their rate of 7 day follow up after an ED visit for their patient populations.
- Advantage Dental, Advanced Health's delegate for oral health services, used Premanage to monitor for ED visits related to oral health concerns. Case Management staff reach out to members and work to connect them with their primary care dentist for follow up and management of their oral health needs.
- Advanced Health implemented Premanage for intensive case management staff in mid-2017. Premanage is a health information exchange solution focused on emergency department and hospital admissions. It allows a ED and hospital admissions personnel to receive care plan information when a patient is admitted. It also allows case management personnel to receive notifications when a patient is admitted to the ED or hospital for an inpatient stay. Advanced Health's IT manager is facilitating implementation of Premanage within the Advanced Health provider network.
- Advanced Health is working through contract negotiations to implement a capitated payment arrangement with a local critical access hospital as a value-based payment model to potentially reduce avoidable ED visits. This arrangement would have the benefit of continuing to support the financial health of the critical access hospital, while at the same time, provide a financial incentive to pilot strategies to encourage clinically appropriate use of medical resources.

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In 2018, Advanced Health formally adopted reducing ED utilization as a Performance Improvement Project (PIP) topic with progress monitored and reported quarterly to OHA as a contract deliverable. Efforts focused on improving coordination between all the current interventions in progress within the provider network, delegate organizations, and community partners. We have been working through the Interagency Delegate and Provider Quality Committee as well as the Clinical Advisory Panel to better understand the trends in utilization, determine potential root causes behind the trends, determine the impacts of current interventions, and develop new interventions for implementation.

Below is a view of our new ED Utilization dashboard for all members and all ED visits from January 2017 through November 2018. This Tableau dashboard allows us to dynamically analyze and rapidly filter the displayed data.



In reviewing the ED utilization rates by assigned primary care provider, we have found that the providers with the highest rates are primarily providers with small panels and providers who are new to our network. Because the rate is displayed as a number of ED visits per 1000 member months, when a provider is new or carries a small patient panel, they have a small denominator number of member months to be included in the metric calculation. These rates calculated with small denominators are not credible and so are not useful for determining interventions.

Also, when reviewing the ED utilization rates by assigned primary care provider, we find that the rate is strongly correlated with the type of primary care practice (pediatric, family medicine, or internal medicine) and the risk stratification value of the provider's panel. Some care must be exercised when using these rates to design interventions, but they may be useful to monitor effectiveness of interventions applied across organizations or between similar practices.

When the dashboard is filtered to focus on the avoidable ED visits, the most common primary diagnosis categories are:

1. Upper respiratory infections
2. Urinary tract infections
3. Back pain
4. Ear infections
5. Headaches

For members under the age of five:

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1. Upper respiratory infections (#2 in Q3 report)
2. Ear infections (#1 in Q3 report)
3. Eye infections

For members age 5 to 19:

1. Upper respiratory infections
2. Ear infections
3. Urinary tract infections

For members age 20 to 39

1. Urinary tract infections
2. Upper respiratory infections
3. Back pain
4. Headache

When the dashboard is filtered to focus on members experiencing mental illness, the most common primary diagnosis categories are:

1. Abdominal pain
2. Back pain
3. Nonspecific chest pain
4. Sprains and strains (#5 in Q3 report)
5. Headache (#6 in Q3 report)
6. Superficial injury, contusion (#7 in Q3 report)
7. Skin and subcutaneous tissue infections (#4 in Q3 report)

For members experiencing mental illness the most common avoidable primary diagnosis categories are:

1. Back pain
2. Urinary tract infections
3. Headache
4. Upper respiratory infections

### **E. Project or program brief narrative description:**

Advanced Health has and continues to support a number of initiatives aimed at reducing the number of preventable Emergency Department (ED) visits. Potentially preventable ED visits are those that could be more appropriately addressed through primary care or urgent care. Advanced Health monitors ED use through the Ambulatory Care: Emergency Department Utilization and the Disparity Measure: Ed Utilization for Members with Mental Illness quality performance measures used by OHA, as well as tracking other data such as primary diagnosis, other chronic conditions including serious and persistent mental illness diagnoses, age, location of visit, and all the other filters available on the monthly OHA rolling dashboard report. Through these mechanisms of utilization review, it is apparent that the ED is being over-utilized in our service area. Advanced Health is working to reduce preventable ED visits in the interests of ensuring our members receive the right care, at the right time, and in the right place with appropriate coordination, continuity, and use of medical resources and services.

In 2019 Advanced Health plans to engage a physician champion to help move the work forward and develop a program to engage more providers and to improve pathways to care for members using the emergency department for non-

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emergency services. The physician champion, in collaboration with Advanced Health Quality Department staff, the Chief Medical Officer, Bay Area Hospital, and other providers and clinics will develop an ED Stewardship program to potentially include a Community Health Worker care navigator in the emergency department to connect Advanced Health members to appropriate follow up care with their primary care home.

### F. Activities and monitoring for performance improvement:

**Activity 1 description** : Establish a physician champion for the ED Stewardship program.

Short term or  Long term

**Monitoring activity 1 for improvement:** Physician champion engaged in the project

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not complete	Complete	2/2019	Complete	2/2019

**Activity 2 description:** Develop role for Community Health Worker care navigator.

Short term or  Long term

**Monitoring activity 2 for improvement:** Explore and evaluate current processes in place to identify specific gaps in the system that could be addressed by this position and develop a job description.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not complete	Complete	4/2019	Complete	4/2019

**Monitoring activity 2 for improvement:** Complete data analysis and reporting in support of the ED stewardship program, such as identifying members at risk for ED visits and ED utilization rates by assigned PCP.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not complete	Complete	5/2019	Complete	5/2019

**Monitoring activity 2 for improvement:** Hire the position and pilot the process.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not complete	Start pilot	6/2019	Evaluate pilot	1/2020

**Activity 3 description** : Document, plan new interventions, and coordinate current interventions through the Performance Improvement Process (PIP) with quarterly reports to OHA.

Short term or  Long term

**Monitoring activity 3 for improvement:** Monitor Ambulatory Care: Emergency Department Utilization rate per 1000 member months for all members

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Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
53.0 visits per 1000 MM (CY 2017) 52.5 visits per 1000 MM (Nov17-Oct18)	51.9 visits per 1000 MM (CY 2018)	12/2018 (reported by OHA in 6/2019)	51.0 visits per 1000 MM (CY 2019)	12/2019 (reported by OHA in 6/2020)

**Monitoring activity 3 for improvement:** Monitor Disparity Measure: Emergency Department Utilization for Members with Mental Health Conditions, rate per 1000 member months

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
110.2 visits per 1000 MM (CY 2017) 106.9 visits per 1000 MM (Nov17-Oct18)	106.9 visits per 1000 MM (CY 2018)	12/2018 (reported by OHA in 6/2019)	103.7 visits per 1000 MM (CY 2019)	12/2019 (reported by OHA in 6/2020)

### A. Project or program short title: [Grievance System Project 1: Member grievance system improvements](#)

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

### B. Primary component addressed: [Grievance and appeal system](#)

- iv. Secondary component addressed: Access
- v. Additional component(s) addressed: [Health Equity: Cultural Competency](#)
- vi. If *Integration of Care* component chosen, check all that apply:
  - Behavioral health integration
  - Oral health integration

### C. Primary subcomponent addressed: [Choose an item.](#)

- ii. Additional subcomponent(s) addressed: [Access: Cultural Considerations](#); [Access: Quality and appropriateness of care for all members](#); [Access: Second Opinions](#)

### D. Background and rationale/justification:

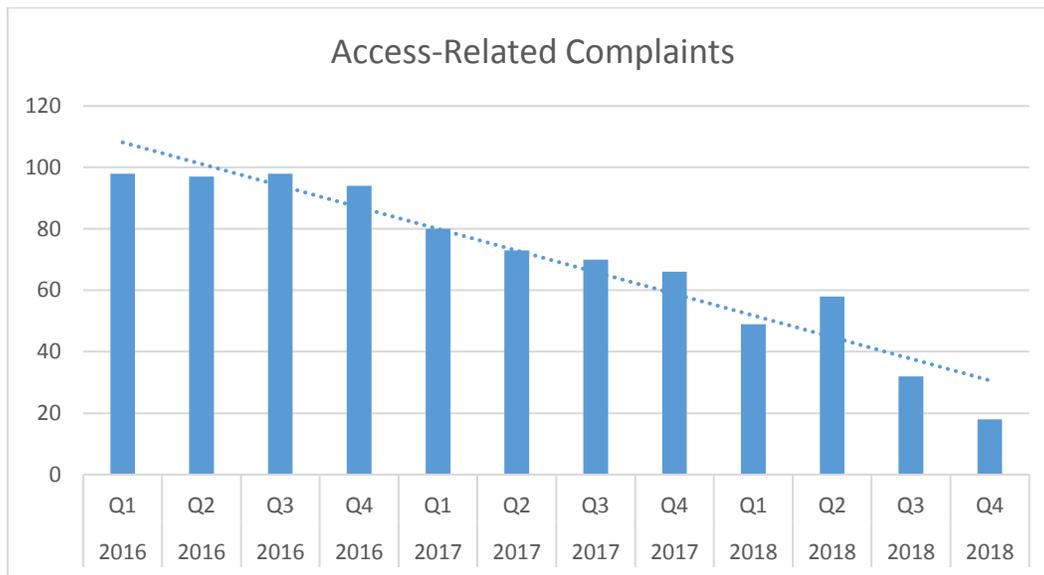
Advanced Health has undertaken several quality improvement efforts aimed at decreasing the rate of member complaints, especially those related to access and interactions with provider and plan. Advanced Health added a new RN Health Services Coordinator (HSC) to the quality team in the fourth quarter of 2016 to coordinate and lead these improvement efforts. One of the primary responsibilities for this position is to work directly with members to navigate through their appeal and/or hearing process to assist them in obtaining covered services that will meet their needs. The Health Services Coordinator also leads the Grievance and Appeals Committee and the PCP Assignment Committee to identify and work on system-level issues affecting our members that lead to grievances. The Grievance and Appeals Committee is an interdisciplinary team that works collaboratively to reduce grievances and appeals filed by our members through data collection, monitoring, and process improvement, as well ensuring administrative and contract requirements related to grievances and appeals are met. The PCP Assignment Committee is an interdisciplinary team that specifically works on improving access to PCP services for Advanced Health members.

The RN Health Services Coordinator is also one of the individuals at Advanced Health who was chosen to complete the Adverse Childhood Event (ACE) Master Trainer course with ACE Interface. (See section the section describing the South Coast Together program, beginning on page 40 for more information on the community ACE initiative.) As an ACE

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Master Trainer and an advocate for trauma-informed care, the Health Services Coordinator is well positioned to ensure our Member Grievance System is responsive to the needs of our members and to monitor the details of all complaints, appeals, and hearing requests for issues related to cultural considerations and health equity. She also uses these principles to assist provider offices that are generating a high rate of complaints related to patient-provider interactions. Offices are offered evaluation, coaching, and support to improve their interactions with patients. Understanding of ACEs and trauma-informed practices helps providers and their staff to have better working relationships with our members.

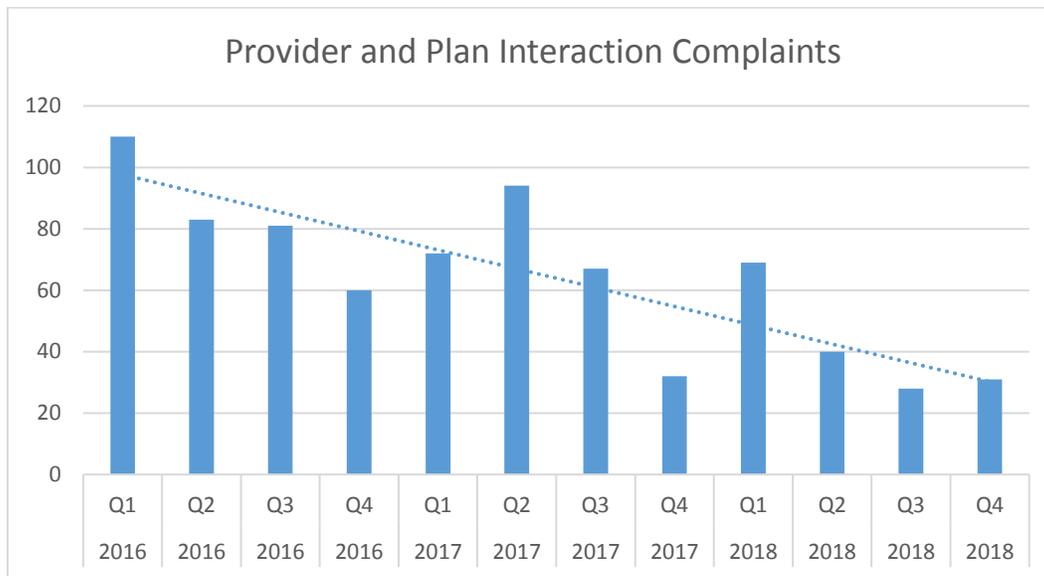
Some effects from the work from these committees are evident in the decrease of our access complaints in 2017 and 2018. PCP access is an issue affecting all patients in the region, not just Advanced Health members. In fact, we continue to have better access for our members than patients with traditional Medicare or even commercial insurance. In 2017, access complaints decreased by 25% compared to calendar year 2016. Access complaints decreased by a further 46% in 2018 compared to 2017.



Evidence has shown that health plans which promote access and continuity with PCPs are likely to experience higher patient satisfaction with their primary care practitioner relationships.

In addition to reduction in access complaints, Advanced Health saw a decrease in complaints related to interaction of members with their providers. Complaints in this category dropped 20% from 2016 to 2017, and another 37% from 2017 to 2018.

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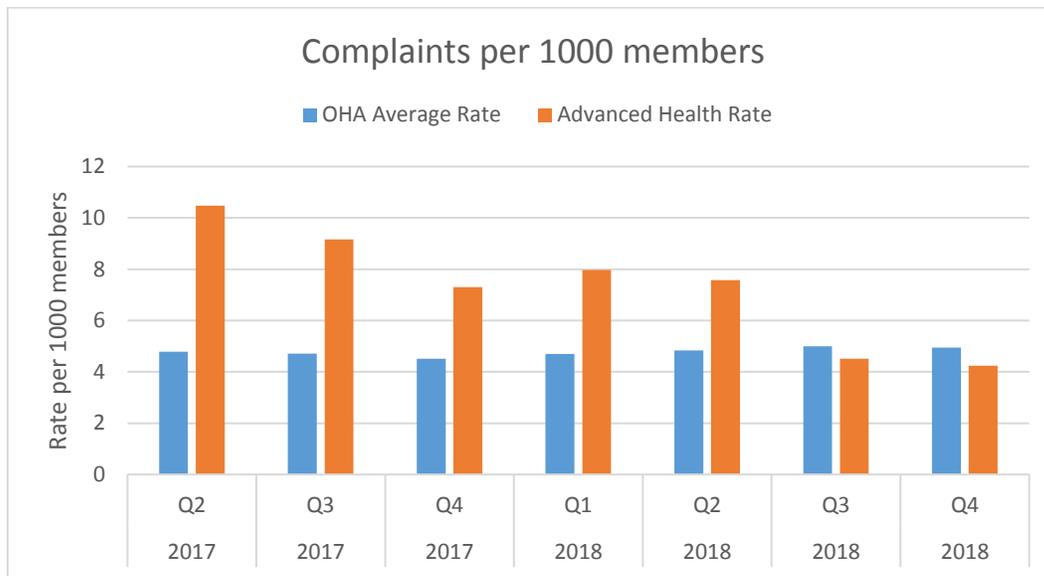


The Health Services Coordinator monitors the details of all complaints weekly and is working to streamline the process of collecting complaint and resolution information from delegated entities. Complaints and appeals are monitored closely for any issues related to obtaining a second opinion, member billing, consumer rights, health equity, and fraud, waste, and abuse. Any trends and actions taken are discussed in the quarterly Analysis of Grievances report submitted to OHA.

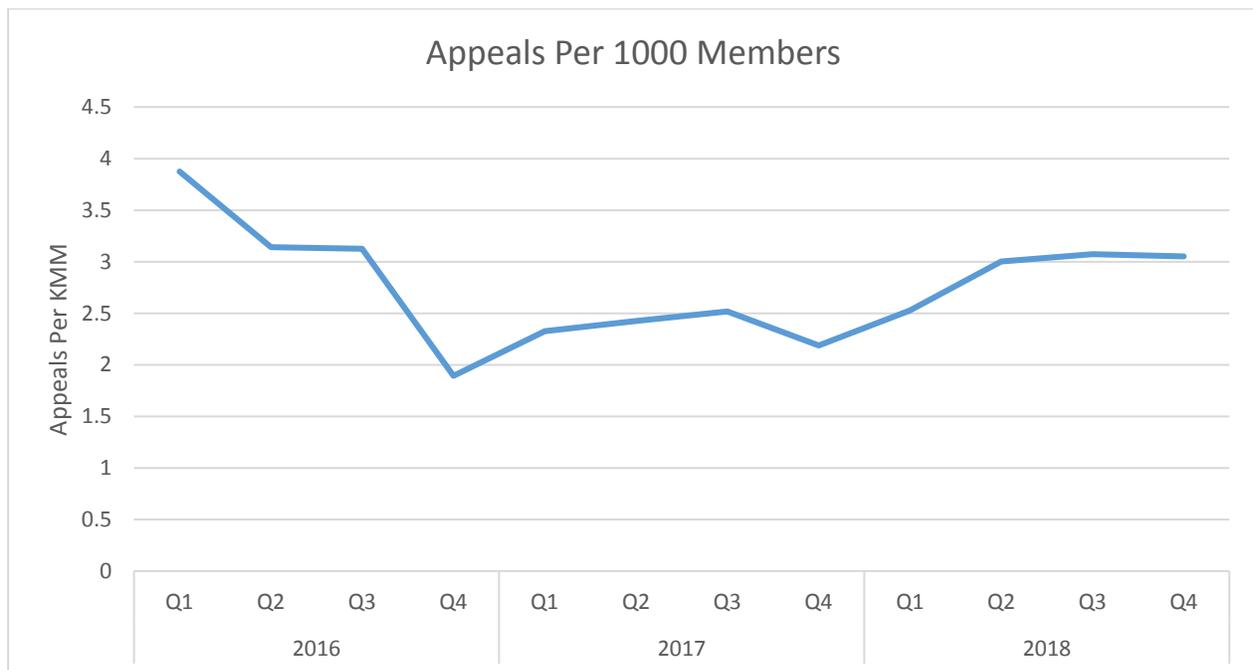
In the third quarter of 2017 the Health Services Coordinator identified three appeals related to second opinions. The prior authorization process for these services was reviewed and while the information provided for two of them did not clearly state that it was an authorization request for a second opinion, one was noted as a second opinion. Additional guidance was provided to utilization review staff to err on the side of approval for services that appear to be for a second opinion. No other such appeals have been filed since, and the Health Services Coordinator will continue to monitor for appeals or complaints related to second opinions.

As a result of this work, Advanced Health had a complaint rate similar to the statewide average during the second half of 2018. The OHA average rate included in the chart below was taken from the Oregon Health Plan Section 1115 quarterly and annual reports available online at <https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/2017-2022-Quarterly-Annual-Reports.aspx>. Advanced Health will continue to monitor complaint capture and resolution processes to ensure members are able to access the system. Advanced Health will also continue to monitor data for trends and offer feedback and support to delegates, clinics, and individual providers as needed to address member concerns and drive improvements.

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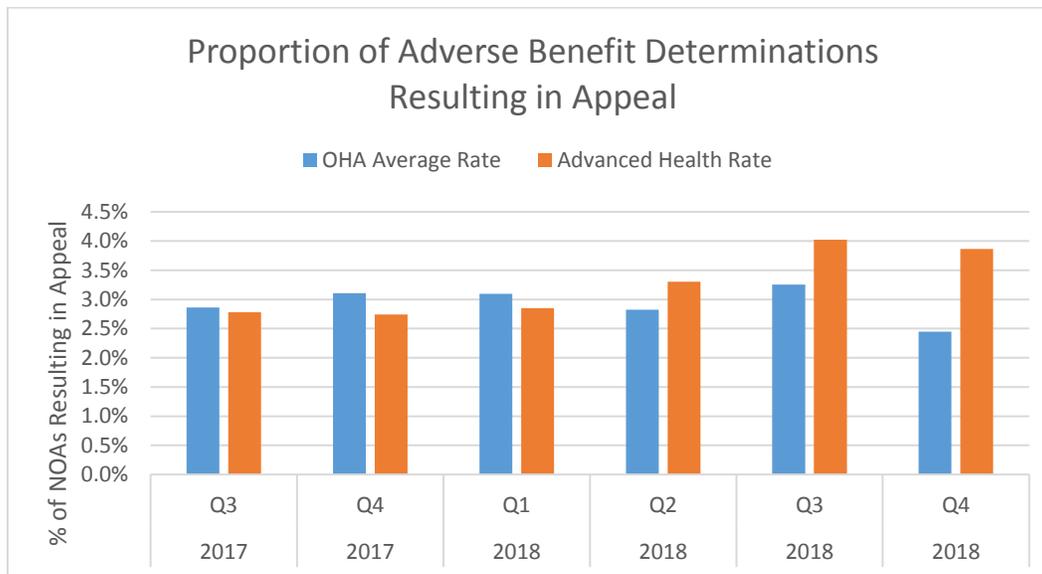


With the data showing that the Advanced Health complaint rate has improved, the Grievance and Appeals Committee plans to turn their attention in 2019 to the Appeals process. Advanced Health regularly monitors many aspects of the Appeals process and we have noted an increase in the rate of appeals per 100 members in the latter portion of 2018, demonstrated in the chart below. While the rate of appeals in 2018 remained lower than the rate in 2016, it increased by 23% from 2017.



Also, when we compare Advanced Health data to data from the Oregon Health Plan Section 1115 quarterly and annual reports (website noted above), we find that the Advanced Health rate of appeals is higher than the average reported by OHA. Advanced Health's proportion of Notices of Adverse Benefit Determination that result in an Appeal were similar to the state average in late 2017 and early 2018, however, the proportions began to diverge in late 2018.

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### E. Project or program brief narrative description:

In 2019, Advanced Health staff, including the HSC, Medical Director, Director of Quality, provider services team, and the Grievance and Appeal committee will develop and implement interventions to begin addressing the higher than average rate of Appeals per 1000 members. As described above, we have noted a potential upward trend in the rate of Appeals per 1000 members as well as the proportion of Notices of Adverse Benefit Determination that result in an Appeal. The Grievance and Appeal committee will look closer at the available data and perform a root cause analysis. The results of the root cause analysis will be used to develop an action plan for improvement to the process to better meet the needs of Advanced Health members.

The Health Services Coordinator (HSC) and the Grievance and Appeal committee will continue to monitor the process changes implemented in 2017 and 2018 aimed at improving members' access and interactions with providers to ensure the improvements are sustained through 2019 and beyond.

### F. Activities and monitoring for performance improvement:

**Activity 1 description:** RN Health Services Coordinator will provide quarterly complaint reports to providers. CCO staff (HSC, Medical Director, or Provider Services) will meet with providers and staff with high rates of complaints to discuss strategies and offer assistance to implement improvements.

Short term or  Long term

**Monitoring activity 1 for improvement:** Quarterly reports delivered to providers.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0 reports distributed for 2019	2 reports distributed	8/2019	4 reports distributed	2/2020

**Monitoring activity 1 for improvement:** Quarterly rate of member complaints per 1000 member months. (Total number of complaints for the calendar quarter divided by the average monthly enrollment for the quarter times 1000.) This is the complaint rate reported by all CCOs in the quarterly grievance system report.

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Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Baseline: 7.3 complaints per 1000 members in Q4 2017  Current: 4.2 complaints per 1000 members in Q4 2018	<5 grievances per 1000 members	12/2019 (Q4 2019 rate to be reported in 2/2020)	<5 grievances per 1000 members	12/2019 (Q4 2019 rate to be reported in 2/2020)

**Activity 2 description:** The Grievance and Appeals committee will complete a root cause analysis and develop an action plan to address the rising rate of Appeals per 1000 members.

Short term or  Long term

**Monitoring activity 2 for improvement:** Complete a root cause analysis

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not complete	Complete	5/2019	Complete	5/2019

**Monitoring activity 2 for improvement:** Prioritize interventions to address the root cause(s) identified and develop an action plan to be monitored by the Grievance and Appeal Committee

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not complete	Complete	7/2019	Complete	7/2019

### A. Project or program short title: [Social Determinants of Health Project 1: Community Health Assessment and Community Health Improvement Plan](#)

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

### B. Primary component addressed: [Social determinants of health](#)

- vii. Secondary component addressed: Health equity
- viii. Additional component(s) addressed:
- ix. If *Integration of Care* component chosen, check all that apply:
  - Behavioral health integration
  - Oral health integration

### C. Primary subcomponent addressed: [Health Equity: Data](#)

- iii. Additional subcomponent(s) addressed: Health Equity: Cultural Competency

### D. Background and rationale/justification:

In 2017 and 2018 Advanced Health's Community Advisory Councils (CACs) worked with the CCO and community partners to align the efforts of the CCO, Federally Qualified Health Centers, hospitals, public health agencies, social services organizations, and the residents of the communities they serve to develop a shared community health assessment (CHA); one for Coos County and one for Curry County. Creating the CHA includes collecting, analyzing, and synthesizing primary and secondary data sources, and facilitating a process to identify and prioritize significant health

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needs facing the community. The scope of the project includes the Social Determinants of Health as well as the partnering organizations’ state, federal, and accreditation requirements.

Advanced Health retained a consultant to work with the Community Advisory Councils in planning and revising the Community Health Assessments and Community Health Improvement Plans (CHPs). They also considered ways to align with and support the Transformation and Quality Strategy.

Advanced Health and partners relied on the Social Determinants of Health framework from the Henry J Kaiser Family Foundation, included below, to inform the Community Health Assessment process.

### Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

**Health Outcomes**  
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations



In addition to the framework, most partners have state, federal, or accreditation requirements. The collaborating organizations combined and analyzed their various requirements in order to create a cohesive specification for the CHA to meet all the partners’ needs. Some of the requirements include:

- Section 501(r) in the Internal Revenue Code was created by the Affordable Care Act and requires that tax-exempt 501(c)(3) health care institutions complete a community health needs assessment at least once every 3 years to assist hospitals and organizations to better understand the needs and assets of the communities to facilitate collaboration that results in measurable improvements in the community’s health and well-being.
- Department of Health and Human Services – Health Resources and Services Administration requires FQHCs to complete Form 9: Need for Assistance Worksheet.
- Public Health Accreditation Board (PHAB) encourages local public health agencies to achieve accreditation by meeting a set of standards that document the department’s capacity to deliver the core public health functions outlined in the “Ten Essential Public Health Services.” The reaccreditation process demonstrates that the health department focuses on the use of the required capacities, accountability, and continuous quality improvement.

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- The CCO requirements are to create a plan for addressing community health needs that build on community resources and skills while emphasizing innovation, including, but not limited to: 1) emphasis on disproportionate, unmet, health-related needs, 2) emphasis on primary prevention, 3) building a seamless continuum of care, 4) building community capacity, and, 5) developing collaborative governance to achieve community benefit.

The CHAs for both Coos and Curry counties were completed in 2018 and each includes data and assessments related to:

- Demographics
- Economic stability
- Neighborhood and physical environment
- Education
- Food
- Community
- Health care system
- Health behaviors
- Health outcomes

The 2018 Coos Community Health Assessment is available on the Advanced Health website:

[http://advancedhealth.com/wp-content/uploads/2018/07/Coos\\_CHA\\_7-6-18.pdf](http://advancedhealth.com/wp-content/uploads/2018/07/Coos_CHA_7-6-18.pdf)

The 2018 Curry Community Health Assessment is available on the Advanced Health website:

[http://advancedhealth.com/wp-content/uploads/2018/06/CurryCHA\\_FinalCopy.pdf](http://advancedhealth.com/wp-content/uploads/2018/06/CurryCHA_FinalCopy.pdf)

Following the approval and release of the CHAs, Advanced Health staff, the CACs, and a wide range of community partners began the process of developing the Community Health Improvement Plans (CHPs). The CHP will outline the strategies and metrics chosen to support improved health in the community. In the first stage of development, the CHP steering committee worked to choose three to five strategic priorities that would be meaningful to the community and align with the goals of the participating organizations. Once the priorities were selected, community input on potential strategies was gathered in late 2018.

The priorities selected for the Coos CHP are:

- Community and Families
- Health Equity
- Access and Capacity
- Community Outreach and Engagement

The priorities selected for the Curry CHP are:

- Health Systems and Capacity
- Health Equity
- Communities and Families

### **E. Project or program brief narrative description:**

Advanced Health, the Coos and Curry Community Advisory Councils, and other community partners, as discussed above, have coordinated efforts to update both the Coos and Curry Community Health Assessments in 2018. The partnering organizations intend to coordinate aligned Community Health Improvement Plans (CHPs) to address the identified needs. This approach will allow each entity to approach areas relevant to their core work and regulatory requirements, while also creating a platform for collaboration around health improvement plans and activities that leverage collective resources to improve the health and well-being of Coos and Curry county communities.

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### F. Activities and monitoring for performance improvement:

**Activity 1 description:** Develop a collaborative Community Health Improvement Plan (CHP) for Coos County from the data and priorities presented in the 2018 Coos County Community Health Assessment.

Short term or  Long term

**Monitoring activity 1 for improvement:** CHP developed and approved by the Coos CAC.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not approved	Approved	12/2019	Approved	12/2019

**Activity 2 description:** Develop a collaborative Community Health Improvement Plan (CHP) for Curry County from the data and priorities presented in the 2018 Curry Community Health Assessment.

Short term or  Long term

**Monitoring activity 2 for improvement:** Curry CHP developed and approved by the Curry CAC.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not approved	Approved	12/2019	Approved	12/2019

### A. Project or program short title: [PCPCH Project 1: Patient-Centered Primary Care Home \(PCPCH\) Learning Collaborative](#)

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

### B. Primary component addressed: [Patient-centered primary care home](#)

- x. Secondary component addressed: Integration of care (physical, behavioral and oral health)
- xi. Additional component(s) addressed: [Access, CLAS Standards and Provider Network](#)
- xii. If *Integration of Care* component chosen, check all that apply:
  - Behavioral health integration
  - Oral health integration

### C. Primary subcomponent addressed: [Choose an item.](#)

- iv. Additional subcomponent(s) addressed: [Access: Cultural Considerations; Access: Timely](#)

### D. Background and rationale/justification:

Advanced Health had conducted a performance improvement project around PCPCH enrollment in 2014 and 2015 with a core strategy of providing technical assistance to clinics to attain PCPCH recognition. By 2016, 88.6% of Advanced Health members were receiving primary care services at a Tier 3 PCPCH recognized clinic.

In 2017 the recognition standards for PCPCH were revised and the tier structure was expanded from three levels to five. The change to the tier structure precipitated a change to the OHA PCPCH Enrollment measure calculation. With the threshold for the PCPCH measure remaining at 60% and the new calculation methodology, it became impossible for a CCO to meet the measure if the clinics in their provider network remained at Tier 3.

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In 2017 the Access to Care Community Health Improvement Plan Subcommittee formed the PCPCH Learning Collaborative and worked to engage representatives from interested clinics in both Coos and Curry counties, including Bay Clinic, North Bend Medical Center, Waterfall Community Health Center, Coast Community Health Center, Curry Community Health, and Curry Health Network. At the beginning of 2017, all these clinics were recognized as Tier 3 PCPCH clinics. The PCPCH Learning Collaborative, led by Advanced Health's Quality Improvement Specialist and the Community Engagement Team, built and shared tools to assist fellow collaborative members to achieve higher levels of PCPCH recognition.

By the end of 2017, Bay Clinic, North Bend Medical Center's Coos Bay clinic, Coast Community Health Center, Curry Health Network, and Curry Medical Center of Curry Health Network had all attained Tier 4 PCPCH recognition. The North Bend Medical Center offices in Myrtle Point, Coquille, Bandon, and Gold Beach, and Waterfall Community Health Center had all maintained Tier 3 PCPCH recognition.

In 2018, the PCPCH Learning Collaborative met quarterly and included discussion topics such as, supply and demand, empanelment, and care team models. Some clinics planning to attest to a higher tier in early 2019 held focused work sessions with the Quality Improvement Specialist to review relevant standards, processes, and documentation requirements. Also in 2018, Advanced Health added another Tier 4 PCPCH recognized clinic to the contracted provider network in Curry County, expanding access for Advanced Health members living in the area.

For the 2019 measurement year, the OHA Metrics and Scoring Committee raised the threshold for the PCPCH quality incentive measure to 68.0%. Advanced Health's 2018 PCPCH quality measure rate was 68.8%. While this is slightly above the threshold set for 2019 performance, Advanced Health remains committed to improving the members' experience of care through ensuring timely access to culturally appropriate and responsive care, and the PCPCH model is one vehicle to promote these values. PCPCH clinics in Coos and Curry county are working to offer more integrated services, including behavioral health and oral health. Clinics are focusing on enhancing processes for patient outreach and engagement.

### E. Project or program brief narrative description:

One focus area of the 2015-2018 Coos County Community Health Improvement Plan is to increase access to care providers. This priority was identified from the Coos County Community Health Assessment, reviewed and approved by the Coos County Community Advisory Council. The subcommittee/workgroup tasked with increasing access to care chose as one of their strategies to form a PCPCH learning collaborative to support local clinics and providers in attaining PCPCH recognition and reaching their target recognition levels. This strategy also aligns with OHA's PCPCH Enrollment quality performance metric for CCOs, the PCPCH area of focus in the Transformation Plan, and with several requirements for clinics participating in the CPC+ program.

### F. Activities and monitoring for performance improvement:

**Activity 1 description:** Support clinics in achieving their PCPCH recognition goals for 2019.

Short term or  Long term

**Monitoring activity 1 for improvement:** PCPCH Recognition level for North Bend Medical Center, Coos Bay location

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Tier 4 (Dec 2018)	5 Star	12/2019	5 Star	12/2019

**Monitoring activity 1 for improvement:** PCPCH Recognition level for North Bend Medical Center, Myrtle Point location

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Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Tier 4 (Dec 2018)	Tier 4	12/2019	Tier 4	12/2019

**Monitoring activity 1 for improvement:** PCPCH Recognition level for North Bend Medical Center, Coquille location

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Tier 3 (Dec 2018)	Tier 4	12/2019	Tier 4	12/2019

**Monitoring activity 1 for improvement:** PCPCH Recognition level for North Bend Medical Center, Bandon location

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Tier 3 (Dec 2018)	Tier 4	12/2019	Tier 4	12/2019

**Monitoring activity 1 for improvement:** PCPCH Recognition level for North Bend Medical Center, Gold Beach location

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Tier 3 (Dec 2018)	Tier 3	12/2019	Tier 3	12/2019

**Monitoring activity 1 for improvement:** PCPCH Recognition level for Bay Clinic

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Tier 4 (Dec 2018)	5 Star	12/2019	5 Star	12/2019

**Monitoring activity 1 for improvement:** PCPCH Recognition level for Waterfall Community Health Center

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Tier 3 (Dec 2018)	Tier 4	12/2019	Tier 4	12/2019

**Monitoring activity 1 for improvement:** PCPCH Recognition level for Coast Community Health Center

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Tier 4 (Dec 2018)	5 Star	12/2019	5 Star	12/2019

**Monitoring activity 1 for improvement:** PCPCH Recognition level for Curry Community Health

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Tier 4 (Dec 2018)	Tier 4	12/2019	Tier 4	12/2019

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**Monitoring activity 1 for improvement:** PCPCH Recognition level for Curry Health Network, Curry Medical Center

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Tier 4 (Dec 2018)	Tier 4	12/2019	Tier 4	12/2019

**Monitoring activity 1 for improvement:** Advanced Health PCPCH Enrollment quality measure performance

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
67.8% (Dec 2017) 68.8% (Dec 2018)	72%	12/2019	72%	12/2019

### A. Project or program short title: [Value-Based Payment Models Project 1: Value-Based Payment Models](#)

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

### B. Primary component addressed: [Value-based payment models](#)

- xiii. Secondary component addressed: Special health care needs
- xiv. Additional component(s) addressed: [Utilization Review, Patient-Centered Primary Care Homes, HIT: Analytics; Access: Quality and appropriateness of care furnished to all members](#)
- xv. If *Integration of Care* component chosen, check all that apply:
  - Behavioral health integration
  - Oral health integration

### C. Primary subcomponent addressed: [Choose an item.](#)

- v. Additional subcomponent(s) addressed: [Add text here](#)

### D. Background and rationale/justification:

Advanced Health is committed to implementing value-based payment methodologies that align with health outcomes and advance transformation of the health care delivery system to achieve the triple aim of improving patient experience of care, improving health outcomes, and controlling health care costs. A majority of Advanced Health's payments already have a link to quality or value through payment methodologies such as PMPM capitation payments for primary health care services or payments based on quality measure performance.

Advanced Health has consistently included providers throughout the development of its value-based payment models. Payment models are first conceptualized by the Chief Executive Officer and the Chief Medical Officer, and from there, are forwarded to the Clinical Advisory Panel for review, revision, and recommendation. The recommendations from the Clinical Advisory Panel are presented to two governing boards for review, revision, and ultimately approval or rejection. The Advanced Health board of directors (which includes physicians as well as representatives of mental health, substance use, hospital, and dental services) and the Southwest Oregon Independent Practice Association board of directors (comprised entirely of physicians – reviewing payments that are pertinent to physical health) must both approve the new payment model prior to implementation.

Current APMs include:

1. Long-standing model of capitation to primary care providers. All capitated providers are at risk for primary care spending; most participating providers are at risk for total cost of care for the population, with up- and down-side risk. Capitation provides an up-front payment for the management of an identified population of patients.

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2. Capitation is balanced by a risk-return model based on RVUs performed and total cost of care for the population. This balances the up-front capitated payments and provides a balanced approach so not to encourage under- or over-utilization.
3. Capitation agreement with most utilized hospital. Incentivizes appropriate use of services and development of community-based solutions. Includes a withhold amount which can be earned by controlling expenses.
4. Quality payments: The Quality Incentive Funds are paid to providers through a combination of financial reward for past performance and strategic investment in new programs aimed at meeting quality goals. Recognition of quality measures as an important funding stream has led practices to invest in quality improvement staff, processes and tools that have improved our performance over time.

Advanced Health will continue to develop, test, and ultimately implement additional payment methods that incentivize access to care, especially for members with chronic conditions or special health care needs.

In 2017 Advanced Health, with the oversight and input of the Clinical Advisory Panel, developed, tested, and monitored two complimentary value-based metrics designed to improve access to primary care while also rewarding providers who care for high-risk patients with chronic health conditions or other special health care needs. The access portion of the metric required providers to maintain a patient panel above a minimum threshold and to also maintain a relatively low rate of patient complaints about access to care. The risk portion of the metric was based on risk values associated with diagnoses documented in claims data to determine population risk. The Director of Financial Planning and Analytics developed guidance for providers and staff about the measures, quarterly performance reports, and improvement tools for the PCPs.

There were several goals for the model, including:

- Encourage timely access and availability of services as measured through the CAHPS survey data
- Improve continuity and coordination of care for members with high-risk chronic conditions and special health care needs
- Reduce access-related member complaints
- Reduce preventable emergency department visits through improved PCP access
- Increase the documentation and treatment of members' chronic conditions

Results from monitoring the risk and access metrics in 2017 showed:

- 25% reduction in the number of access-related complaints in 2017 compared to 2016.
- No apparent impact on emergency department utilization. More data analysis needs to be completed following the OHA's release of the final 2017 performance data.
- Several providers opened their panels to new patients in order to meet the minimum threshold and several offices instituted new procedures to reduce access complaints.
- Increase in the number of high-risk diagnoses documented in claims, indicating those conditions were assessed or affected the care and treatment received by the member
- CAHPS survey data for 2017 is not yet available for analysis.

Results from monitoring the Quality Incentive Payments showed:

- Providers have recognized this as an important revenue stream with appropriate staff time/attention resulting in continued improvements.
- The Clinical Advisory Panel adjusted some payment recommendations to reflect differences in difficulty of achieving the measures and strategic importance based on difference from benchmark. (E.g. complex and critical measures such as childhood immunization receive higher payments than straightforward measures already at high rates, such as developmental screening.
- Strategic investments were made via the Quality Innovation Incubator fund including, but not limited to: Pediatric behavioral health integration, Pediatric Care Coordinator, Quality Improvement staff at small clinics, One Key Question spread of implementation, HIT analytics enhancements at both the clinic and the CCO level, and a Community Paramedic program.

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Beginning in 2018, Advanced Health adjusted these balancing metrics to focus more on rewarding providers for treating and documenting their patients' chronic conditions. The access complaint component of the balanced metric was removed and replaced by a metric measuring chronic condition treatment and documentation directly. The panel complexity measure was refined and maintained.

### E. Project or program brief narrative description:

In 2019, Advanced Health will achieve compliance with CCO 2.0 value-based payment requirements. Advanced Health must begin CCO 2.0 with contracts meeting the value-based payment requirements defined by the Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017" (<https://hcp-lan.org/apm-refresh-white-paper/>). Contracts must comply with level 2C of the LAN-APM Framework (<http://hcp-lan.org/workproducts/apm-framework-onepager.pdf>).

Initially, Advanced Health plans to target the 2C and 3B categories in the framework. This will require transitioning many fee-for-service contracts to pay-for-performance models, in which providers are paid fee-for-service with bonuses for quality performance. This will also require the transitioning of some fee-for-service contracts to shared savings and downside risk models.

Many of Advanced Health's current APMs will need to be adjusted to meet the specific requirements of the CCO 2.0 contract. This will include adding language to incorporate more quality measures in Advanced Health's hospital capitation APM.

### F. Activities and monitoring for performance improvement:

**Activity 1 description:** In total, Advanced Health must begin 2020 with 20% of projected provider payments meeting the minimum value-based payment requirements (level 2C).

Short term or  Long term

**Monitoring activity 1 for improvement:** Add text here

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
TBD	20%	12/2019	20%	12/2019

### A. Project or program short title: [HIT Project 1: Quality performance measure and other dashboards](#)

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

### B. Primary component addressed: [Health information technology](#)

- xvi. Secondary component addressed: Health equity
- xvii. Additional component(s) addressed: [Utilization Review, Access](#)
- xviii. If *Integration of Care* component chosen, check all that apply:
  - Behavioral health integration
  - Oral health integration

### C. Primary subcomponent addressed: [HIT: Analytics](#)

- vi. Additional subcomponent(s) addressed: [Health Equity: Data; Access: Second Opinions; Access: Availability of Services](#)

### D. Background and rationale/justification:

In 2015, Advanced Health implemented Tableau for data visualization and performance measure tracking. We began by monitoring performance on claims-based quality incentive measures and using the information to provide feedback to providers and to identify champions and best practices. Dashboards to monitor other internal processes such as prior authorization requests and claims processing, among others were added. In 2016 and 2017 Advanced Health began to include more demographic data filters for race, ethnicity, language, age, and zip code to the quality measure dashboards as a means to monitor for potential health disparities, and to better inform culturally and linguistically appropriate quality improvement strategies.

In 2018 additional refinements and improvements were made to existing dashboards and new measures were added. Existing quality measure dashboards were updated to meet the 2018 measure specifications. Additional quality measure dashboards were added to track the dental sealants, initial prenatal visits, two-year-old immunization status, and emergency department (ED) utilization. The dashboard for ED utilization includes the ability to filter by the specifications of the ED utilization disparity metric published by OHA, as well as avoidable visits and primary diagnosis categories among other elements. Additional utilization review and management dashboards were created to monitor Hepatitis C treatment utilization, requests for second opinions, and requests for spinal MRIs. Other additions to the suite of Tableau-based analysis and monitoring tools include an overview of member enrollment trends, overall utilization trends, hospital trends, and claims/encounter data submission.

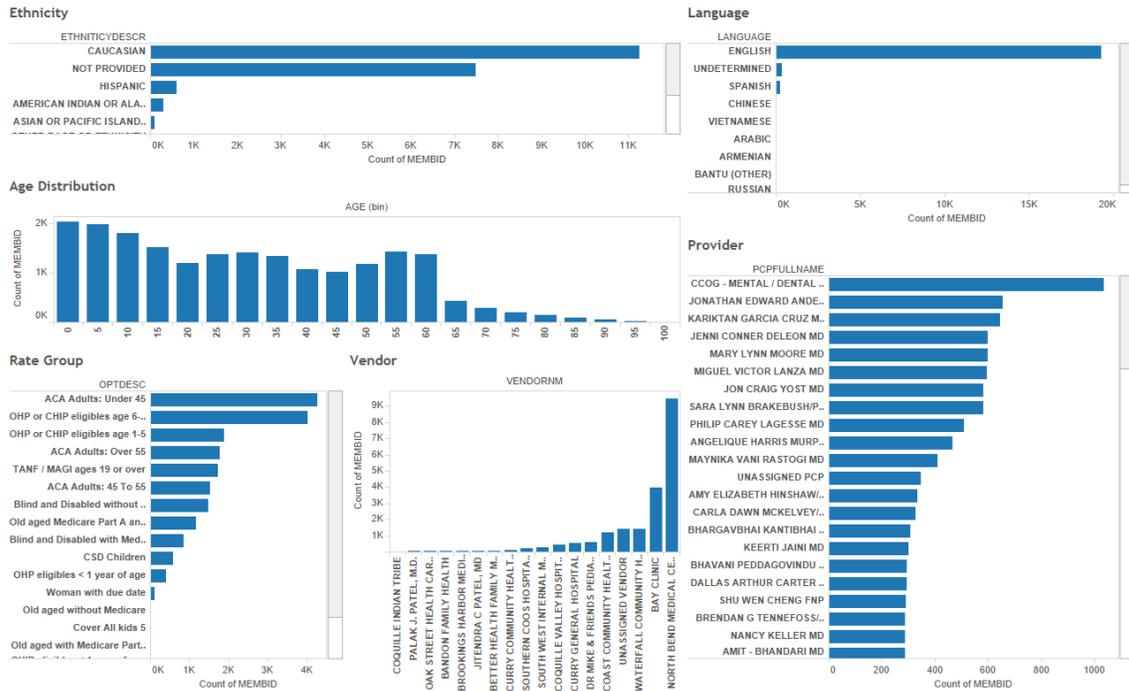
The dashboards for quality performance measures and other processes are used by Advanced Health to plan and monitor the results of process improvements related to attaining the CCO quality incentive measure targets and to support implementation and monitoring of performance improvement projects (PIPs). The quality dashboards are also used to give feedback to providers and clinics on their performance and how it compares to their peers.

Other dashboards for operational processes like claims and utilization review are used to monitor information such as compliance with required timeframes, volume of transactions, productivity, and service utilization. Any concerning trends can be identified early for investigation and resolution. Areas for process improvement are identified and the outcome of any process changes are monitored to ensure the changes were effective. Below are samples of some of the different dashboards used by Advanced Health staff.

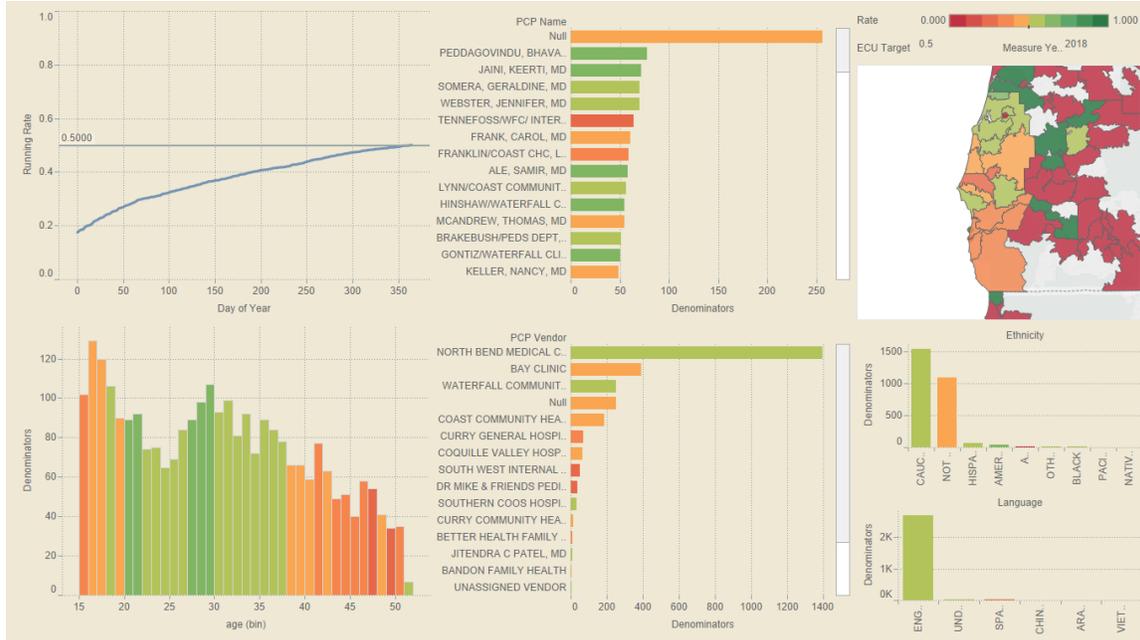
# OHA Transformation and Quality Strategy (TQS) CCO: Advanced Health

## Member demographics

### WOAH Demographics

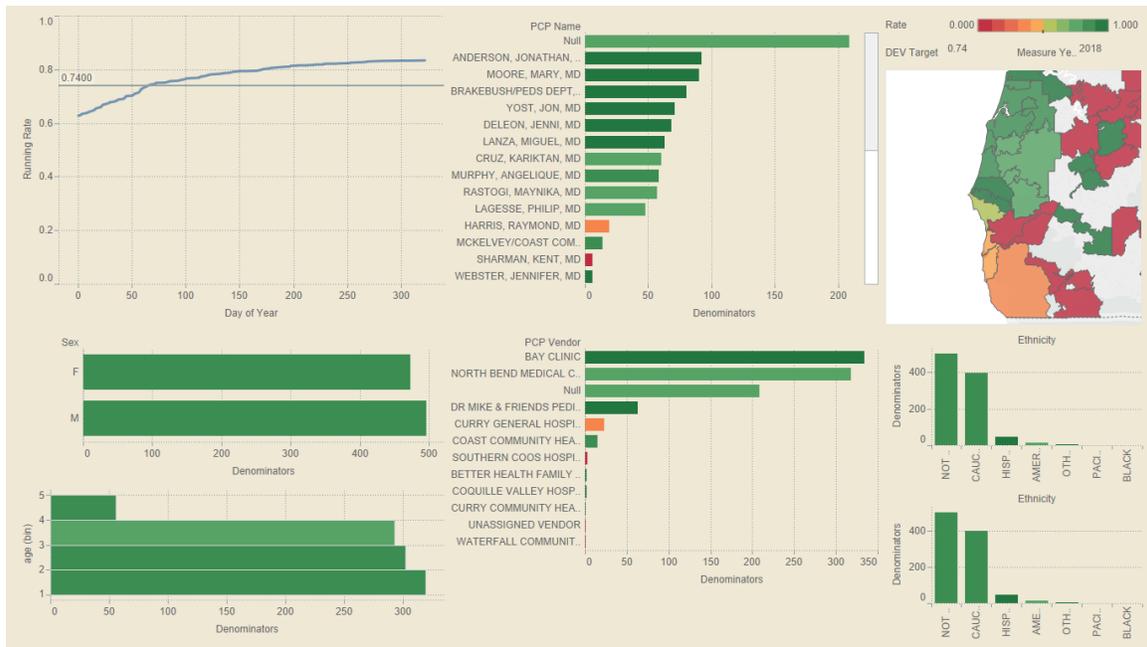


## Effective Contraceptive Use

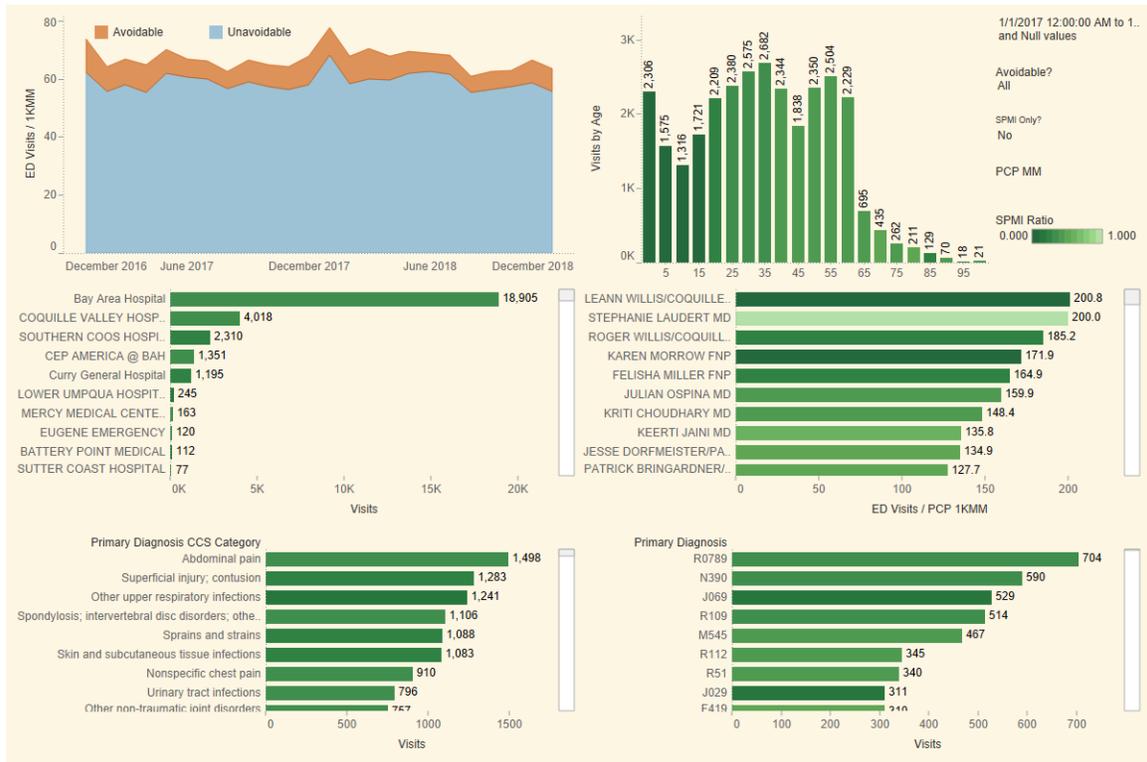


# OHA Transformation and Quality Strategy (TQS) CCO: Advanced Health

## Developmental Screening

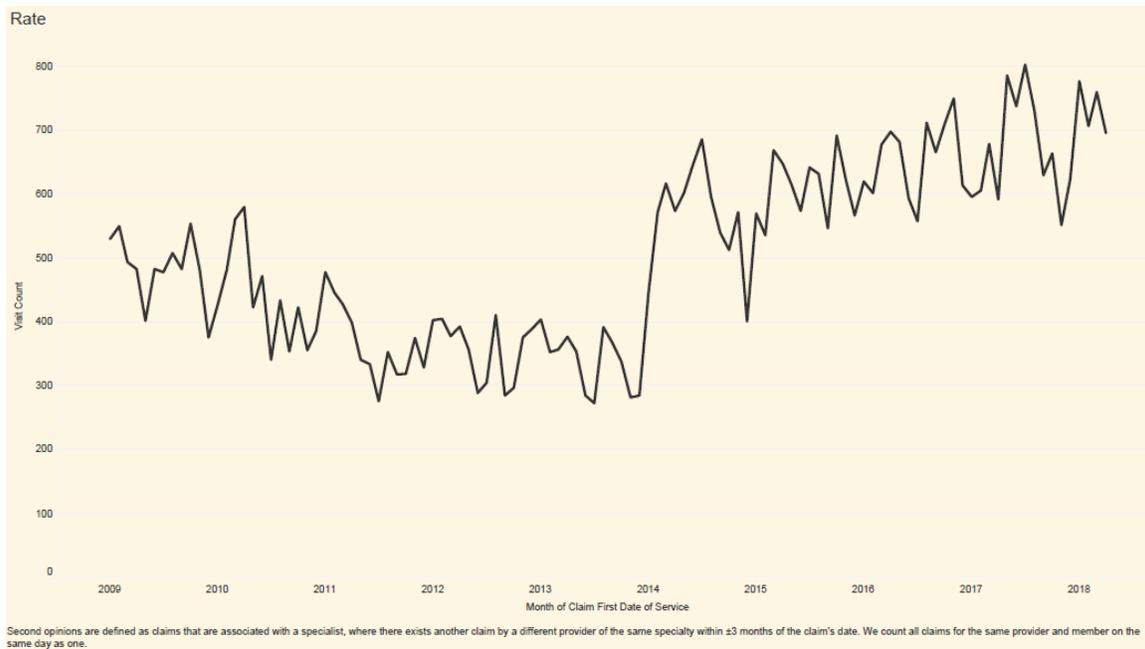


## Emergency Department Utilization



# OHA Transformation and Quality Strategy (TQS) CCO: Advanced Health

## Second Opinion Monitoring



### E. Project or program brief narrative description:

Data Analytics staff at Advanced Health maintain a suite of data dashboards for various departments to monitor performance. In 2019 Data Analytics staff will work with department managers to revise current dashboards as needed as well as develop new tools for monitoring quality performance, key operational metrics, and compliance.

### F. Activities and monitoring for performance improvement:

**Activity 1 description:** Update quality performance tracking and other dashboards for 2019.

Short term or  Long term

**Monitoring activity 1 for improvement:** Update current quality measure dashboards to meet 2019 measure specifications.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not updated	Updated	3/2019	Updated	3/2019

**Monitoring activity 1 for improvement:** Develop and release new dashboard to monitor the Oral Evaluations for Adults with Diabetes quality measure.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not released	Released	4/2019	Released	4/2019

**Monitoring activity 1 for improvement:** Develop and release new dashboard to monitor for timely postpartum care.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)

## OHA Transformation and Quality Strategy (TQS) CCO: Advanced Health

Not released	Released	5/2019	Released	5/2019
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**Monitoring activity 1 for improvement:** Revise Service Authorization dashboard to monitor expedited authorization requests by number of hours to complete review.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not complete	Complete	5/2019	Complete	5/2019

**Monitoring activity 1 for improvement:** Develop and release new dashboard to monitor performance on the 2019 statewide PIP metric: New Opioid Patients Days Supply of First Opioid Prescription.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not complete	Complete	6/2019	Complete	6/2019

### A. Project or program short title: [Integration Project 1: Oral health integration for members with diabetes](#)

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

### B. Primary component addressed: [Integration of care \(physical, behavioral and oral health\)](#)

- xix. Secondary component addressed: Special health care needs
- xx. Additional component(s) addressed: [Severe and Persistent Mental Illness; Access: Availability of Services](#)
- xxi. If *Integration of Care* component chosen, check all that apply:
  - Behavioral health integration
  - Oral health integration

### C. Primary subcomponent addressed: [Choose an item.](#)

- vii. Additional subcomponent(s) addressed: [Add text here](#)

### D. Background and rationale/justification:

Advanced Health has a relatively low rate of oral health assessments for members with a diagnosis of diabetes compared to the Oregon State average for CCOs. In 2015, Advanced Health's rate was 14.1% compared to the state rate of 24.2%. And in mid-2016, Advanced Health's rate was 13.9% compared to the state rate of 24.1%. The state-wide benchmark for this measure in 2019 is 28.0%, which is the 2017 CCO 75th percentile.

Evidence shows that patients with diabetes who have good oral health care have improved HbA1c blood sugar control. In turn, diabetic patients with better controlled HbA1c levels have better outcomes for their oral health care. Periodontal disease outcomes and diabetic health outcomes are linked.

Early in 2018 Advanced Health sponsored a collaborative quality improvement project between Advantage Dental and Coos Health and Wellness to make dental assessments more accessible to patients with severe and persistent mental illness. Advanced Health delegated dental services to Advantage Dental and behavioral health services in Coos county to Coos Health and Wellness. Through this collaborative project, an Advantage Dental advanced practice hygienist provided dental assessments for clients engaged with behavioral health services at Coos Health and Wellness. Advantage Dental seeks to provide services to vulnerable populations in a setting that is more comfortable to the patient by increasing participation in screenings and prevention in the community setting. The Advantage Dental risk-based care and medical management strategy, when employed in the community setting reduces barriers to access, allows for identification of

## OHA Transformation and Quality Strategy (TQS) CCO: Advanced Health

emergent oral health issues, and establishes a care coordination pathway for individuals to receive needed care and prevention. The partnership with Coos Health and Wellness provides an opportunity to serve individuals in the environments they are already comfortable in.

In October of 2018, Coos Health and Wellness began implementation of the Physical Health Integration Team (PHIT), integrating physical health services into the behavioral health services setting. The program aims to make physical health services more accessible to patients, especially those with special health care needs, who may not otherwise be well-engaged with the health care system or who are high utilizers of services. The goal is to meet the patients' immediate care needs in a culturally-appropriate and trauma-informed setting, while also working to connect patients to their primary care homes as needed. In the first few months of operation of this program, feedback from patients and staff has been overwhelmingly positive. There is great opportunity to integrate the services of the advanced practice hygienist into the program and to include a focus on patients with diabetes as well as severe and persistent mental illness to improve their access to comprehensive, integrated, whole-person care.

### E. Project or program brief narrative description:

Advanced Health will work with Advantage Dental, the primary care provider network, and behavioral health providers to create pathways for better information sharing and care coordination and integration for shared patients with diabetes. Advanced Health will also work with Advantage Dental and local dental providers to provide education to local primary care providers on the benefits of regular oral health evaluations to patients with chronic diseases, especially diabetes. We will also explore additional opportunities to integrate care, especially for vulnerable populations such as those with serious and persistent mental illness. Advanced Health will analyze available data and monitor throughout the course of the performance improvement project for potential health disparities that need to be addressed through additional or modified interventions.

### F. Activities and monitoring for performance improvement:

**Activity 1 description:** Provide monthly updates of progress to primary care providers (PCPs) and primary care dentists (PCDs) to promote care coordination and integration for shared patients with diabetes.

Short term or  Long term

**Monitoring activity 1 for improvement:** Develop patient-level report with relevant contact information for PCP and PCD.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not complete	Complete	3/2019	Complete	3/2019

**Monitoring activity 1 for improvement:** Distribute updates to PCPs and PCDs monthly, including patient-level information as well as overall progress toward performance target.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0 updates	3 updates	6/2019	9 updates	12/2019

**Activity 2 description:** Support Coos Health and Wellness and Advantage Dental in integrating oral health into the PHIT program in the behavioral health setting with a focus on connecting patients with a diabetes diagnosis to care with their primary care dentist.

Short term or  Long term

## OHA Transformation and Quality Strategy (TQS) CCO: Advanced Health

**Monitoring activity 2 for improvement:** Develop method to identify patients receiving services at Coos Health and Wellness who also have a diagnosis of diabetes.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not complete	Complete	5/2019	Complete	5/2019

**Monitoring activity 2 for improvement:** Monitor rate of oral evaluations for the identified population to evaluate effectiveness of the program and evaluate for potential health disparities.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not complete	Complete	7/2019	Complete	7/2019

**Activity 3 description:** Work with Advantage Dental, the primary care provider network, and behavioral health providers to create pathways for better information sharing and care coordination and integration for shared patients with diabetes.

Short term or  Long term

**Monitoring activity 3 for improvement:** Work with local dental provider and Advantage Dental to develop and present PCP education around oral health care for patients with diabetes.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not complete	Complete	12/2019	Complete	12/2019

**Monitoring activity 3 for improvement:** Work with local PCPs and clinics through the Interagency Quality Committee or a separate workgroup to develop, pilot, evaluate, and spread best practices for referral and care coordination pathways for shared patients.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Best practice referral workflow not available	Pilot and evaluate workflow	11/2019	Best practice referral workflow available	3/2020

**A. Project or program short title:** [HIT Project 2: Member Engagement in Health Information Technology](#)

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

**B. Primary component addressed:** Health information technology

- xxii. Secondary component addressed: Access
- xxiii. Additional component(s) addressed: [Add text here](#)
- xxiv. If *Integration of Care* component chosen, check all that apply:
  - Behavioral health integration
  - Oral health integration

## OHA Transformation and Quality Strategy (TQS) CCO: Advanced Health

### C. Primary subcomponent addressed: HIT: Patient engagement

viii. Additional subcomponent(s) addressed: Access: Availability of Services; Access: Cultural Considerations

### D. Background and rationale/justification:

Advanced Health worked in 2018 to engage members in their clinical health through health information technology by promoting patient portal enrollment and use. The strategies used focused around including more information to members through materials like the member handbook and the website. We were able to collect some data from clinics on the overall enrollment and utilization rates for their respective patient portals, however the rates include the entire patient population and cannot be filtered by payer or by provider. We will continue to support and promote patient portal enrollment and utilization, however changes related to the Advanced Health population are very difficult to measure with the data that is available.

When evaluating additional opportunities for patient engagement through health information technology, Advanced Health landed on two options for implementation in 2019: Walk with Ease and the National Diabetes Prevention Program. Because of the remote and rural nature of the Coos and Curry county communities, there are many Advanced Health members who would benefit from virtual, on-demand access to programs such as these.

Walk with Ease is a program developed by the Arthritis Foundation that can reduce pain and improve overall health. The program offers a virtual option as well as in in-person community format. More detailed information is available from the Arthritis Foundation at <https://www.arthritis.org/living-with-arthritis/tools-resources/walk-with-ease/about.php>.

The National Diabetes Prevention Program is an evidence-based program for patients with prediabetes that emphasizes prevention and empowerment. Studies show the program greatly reduces the risk that patients will develop diabetes, resulting in fewer than expected cases of diabetes as well as fewer patients needing anti-hypertensive or anti-lipid prescription medications. The National Diabetes Prevention Program can be made available to patients in clinical or community settings; there are also electronic platforms available.

### E. Project or program brief narrative description:

Advanced Health will promote and support member engagement in clinical health and wellness through implementation of two online programs in 2019. Members will be connected to the virtual Walk with Ease program through the Advanced Health wellness benefit. Members with who meet the clinical guidelines for the National Diabetes Prevention Program will have an online option available to them. These virtual program offerings will promote easier access to evidence-based programs through health information technology.

### F. Activities and monitoring for performance improvement:

**Activity 1 description:** Add the Walk with Ease program to the Advanced Health wellness benefit.

Short term or  Long term

**Monitoring activity 1 for improvement:** Create a landing page the Wellness section of the Advanced Health website with information about the Walk with Ease program, including the online option.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not complete	Complete	3/2019	Complete	3/2019

**Monitoring activity 1 for improvement:** Explore mechanisms to capture data related to member utilization and access to the virtual Walk with Ease program. Determine if there is a viable method of monitoring utilization for the Advanced Health population.

## OHA Transformation and Quality Strategy (TQS) CCO: Advanced Health

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not complete	Complete	3/2019	Complete	3/2019

**Activity 2 description:** Implement an online option for participation in the National Diabetes Prevention Program available to Advanced Health members who meet the clinical criteria.

Short term or  Long term

**Monitoring activity 2 for improvement:** Evaluate suppliers of online Diabetes Prevention Programs and select a vendor to contract with for services. Complete the contracting process.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not complete	Vendor selected	3/2019	Complete	5/2019

**Monitoring activity 2 for improvement:** Develop and implement a process of member identification, outreach, and engagement to launch the online Diabetes Prevention Program and enroll an initial cohort of members.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0 members enrolled	25 members enrolled	12/2019	50 members enrolled	6/2020

**Monitoring activity 2 for improvement:** Develop and implement an ongoing referral process for members to access the online Diabetes Prevention Program. Referral pathways may include PCPs, case management, and self-referral.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not complete	Complete	12/2019	Complete	12/2019

### A. Project or program short title: [Social Determinants of Health Project 2: South Coast Together](#)

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

### B. Primary component addressed: [Social determinants of health](#)

- xxv. Secondary component addressed: CLAS standards and provider network
- xxvi. Additional component(s) addressed: [Health Equity: Cultural Competence](#)
- xxvii. If *Integration of Care* component chosen, check all that apply:
  - Behavioral health integration
  - Oral health integration

### C. Primary subcomponent addressed: [Choose an item.](#)

- ix. Additional subcomponent(s) addressed: [Add text here](#)

### D. Background and rationale/justification:

The findings from the Adverse Childhood Experiences (ACE) study are the largest public health discovery of our time. The evidence linking childhood traumas to adverse health outcomes makes it clear that finding ways to mitigate and prevent

## OHA Transformation and Quality Strategy (TQS) CCO: Advanced Health

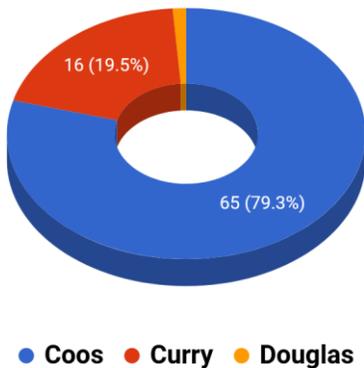
trauma is key to improving the health of the community. The Master Training program and Self-Healing Communities Initiative from ACE Interface have been adopted in other state and are showing early evidence of improved outcomes.

In June 2017 Advanced Health began convening community-wide planning meetings with broad cross-sector representation, including CCO delegates and providers, as well as other community partners from early childhood education, K-12 education, the local community college, juvenile department, CASA, and domestic violence prevention, among others. The goal of these early meetings was to obtain buy-in from community stakeholders and secure funding to support the initiatives. Community agencies were recruited to contribute to a funding partnership and to nominate a staff member or partner to participate in the ACE Master Trainer program. Twelve individuals were selected from throughout Coos and Curry counties and completed the ACE Master Training. These Master Trainer candidates are now available to train in pairs and raise awareness about ACE in the community. After they have completed their training and presentation requirements, they will become certified ACE Master Trainers

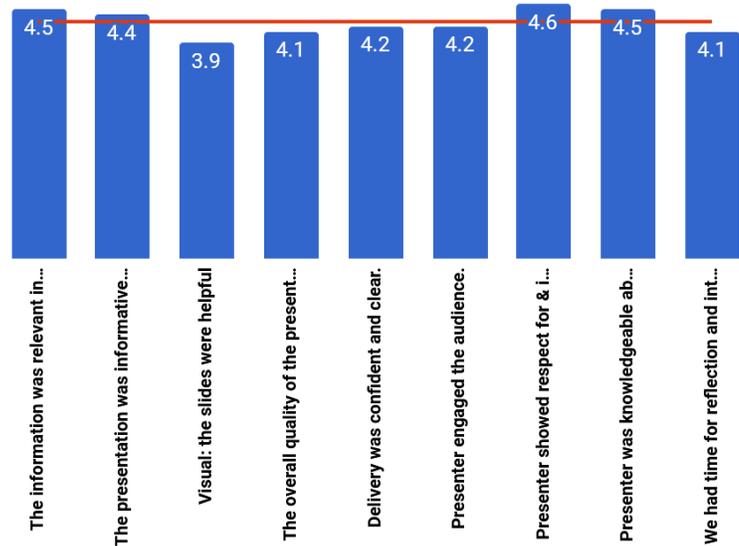
In November 2017 a steering committee and a metrics committee were seated to provide a cross-sector community infrastructure to guide the initiative and produce a comprehensive implementation and measurement plan for Coos and Curry counties. In 2018 a communications committee was established, and the program adopted the name South Coast Together and a logo to use on public materials and communications.

Throughout 2018, the project focused on raising community awareness and promoting education around ACEs and Trauma-Informed care. Two of the Master Trainer candidates completed the required amount of training hours and gained their ACE Master Trainer certification. Over 1,200 individuals in Coos, Curry, and Douglas county received training with reports of high impact on the training evaluations. Key informant interviews were conducted with thirty participants and focused on four topics: community overview, community partnerships and leadership, how people and organizations make decisions, and how the community learns and improves. The steering committee also provided input on perceptions of population challenges at various stages in life and served as a focus group to inform understanding of prevailing beliefs about the dynamics that contribute to those challenges. The information from the key informant interviews and input from the steering committee was synthesized by the consultants from Ace Interface into an assessment report including recommendations for continued action.

Classes per County

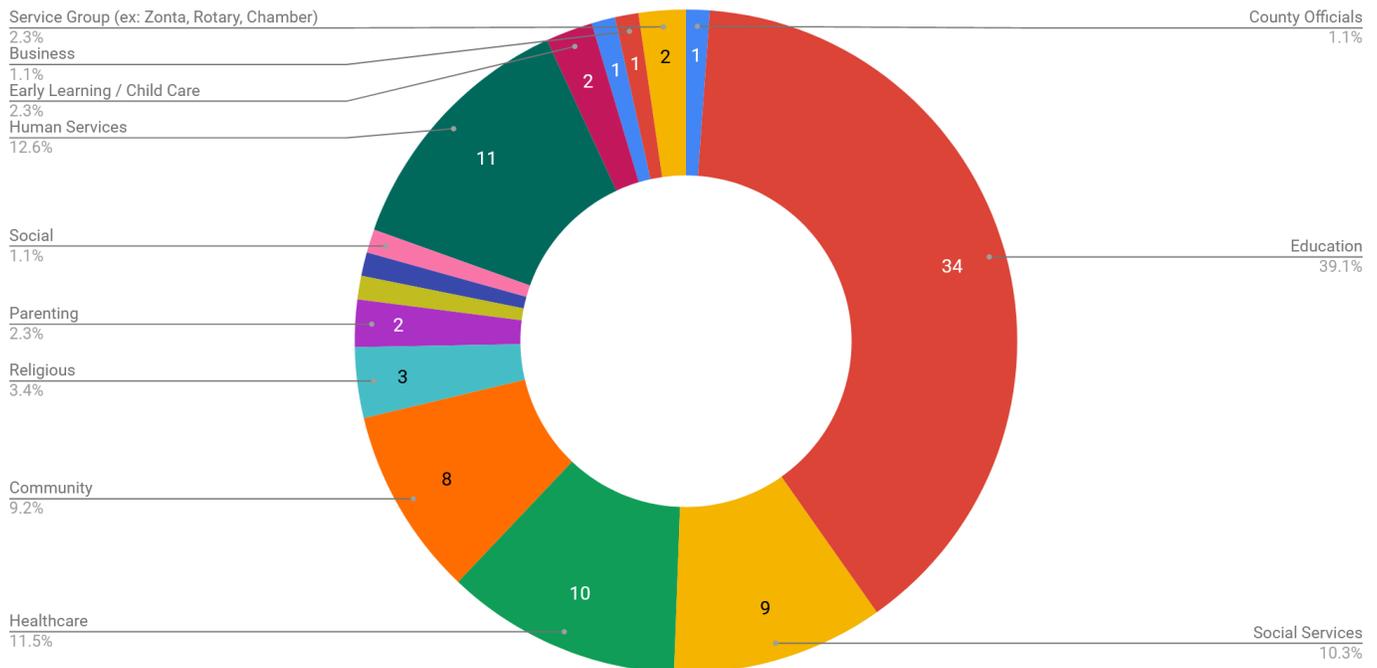


Presentation Quality Scores



# OHA Transformation and Quality Strategy (TQS) CCO: Advanced Health

## Sectors



### E. Project or program brief narrative description:

South Coast Together chose The Self-Healing Communities Initiative as the framework for the communities of Coos and Curry Counties to work toward building resiliency to mitigate the effects of ACE for those who have already experienced trauma and to prevent traumas for future generations. Efforts to promote community awareness of ACEs and Trauma-Informed practices across a broad swath of sectors will continue and presenters will continuously adjust in response to feedback from the community members, organizations, and service systems receiving training.

### F. Activities and monitoring for performance improvement:

**Activity 1 description:** Raise awareness about ACE in the community, across all sectors, including health care, education, law enforcement, social services, parent groups, spiritual communities, and local tribes.

Short term or  Long term

**Monitoring activity 1 for improvement:** Number of training sessions completed

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0 sessions 12/2017 82 sessions 2/2019	110	12/2019	110	12/2019

**Monitoring activity 1 for improvement:** Number of Master Trainers who have completed their certification

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
2 12/2018	5	6/2019	8	12/2019

## OHA Transformation and Quality Strategy (TQS) CCO: Advanced Health

**Monitoring activity 1 for improvement:** Number of Presenters trained by Master Trainers to present the core talk

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0 in 2018	15	6/2019	15	6/2019

**Monitoring activity 1 for improvement:** Train a cohort of community members to lead meaningful conversations using the Family Café model: a structured, trauma-informed format to engage with community members to inform service system improvements.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0 Family Café facilitators trained	40 Family Café facilitators trained	2/2019	40	2/2019

**Monitoring activity 1 for improvement:** Recruit trained Family Café facilitators and support them in hosting Family Café sessions throughout the community with conversation themes designed to inform service system improvements.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0 Family Café sessions	20 Family Café sessions	12/2019	20 Family Café sessions	12/2019

**A. Project or program short title:** [Utilization Project 2: Promote utilization of preventive health services in support of the health aspects of kindergarten readiness](#)

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

**B. Primary component addressed:** [Utilization review](#)

- xxviii. Secondary component addressed: Access
- xxix. Additional component(s) addressed: [Health Information Technology: Analytics](#)
- xxx. If *Integration of Care* component chosen, check all that apply:
  - Behavioral health integration
  - Oral health integration

**C. Primary subcomponent addressed:** [Access: Quality and appropriateness of care furnished to all members](#)

- x. Additional subcomponent(s) addressed: [Access: Timely](#)

**D. Background and rationale/justification:**

Advanced Health partners with community organizations working in the arena of early childhood development and early learning to support their work and improve the health of the community members that we serve. Children and early learning was one of the assessment areas for the recently completed Community Health Assessments. Advanced Health has also been watching the work of the Health Aspects of Kindergarten Readiness Technical Workgroup in an effort to be prepared for the potential quality measures and quality program changes to support improvement efforts. The workgroup's website (<https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/KR-Health.aspx>) details information from

## OHA Transformation and Quality Strategy (TQS) CCO: Advanced Health

past meetings as well as a final report ([https://childinst.org/wp-content/uploads/2018/09/HAKR\\_Technical\\_Workgroup\\_Report\\_2\\_20\\_19\\_Final.pdf](https://childinst.org/wp-content/uploads/2018/09/HAKR_Technical_Workgroup_Report_2_20_19_Final.pdf)).

Advanced Health monitors and works to improve performance on a number of measures related to childhood health and the health aspects of kindergarten readiness as part of the quality program aimed at achieving performance targets on the CCO quality incentive measures and other performance measures.

2018 Quality Measure	Population	2018 Target	2018 Prelim	2017 Final	2016 Final	2015 Final
Assessments for children in DHS custody	Age 0-17 in DHS custody	90.0%	86.4%	91.9%	72.3%	49.6%
CAHPS composite: Access to care – Children	Age 0-17	91.3% Child	TBD	89.3% Child	89.7% Child	92.2% Child
Child immunization status	Age 0-2	72.5%	78.0%	70.5%	68.5%	54.2%
Childhood and adolescent access to primary care providers	Age 1-19	93.5%	91.4%	92.7%	91.0%	89.7%
Dental sealants on permanent molars for children	Age 6-14	22.9%	26.1%	27.8%	22.6%	17.8%
Developmental screening	Age 0-3	74.0%	83.5%	82.0%	74.3%	61.8%
Timeliness of postpartum care	Pregnant women	TBD	62.1%	64.5%	58.8%	55.9%
Timeliness of prenatal care	Pregnant women	91.7%	92.4%	90.6%	92.1%	83.6%
Weight assessment and counseling	Age 3-17	30.4%	68.1%	33.1%	Not reported	Not reported
Well-child visits in the first 15 months	Age 0-15 months	72.5%	69.6%	65.7%	57.4%	58.9%

In 2018, Advanced Health reached out to Jackson Care Connect to learn more about their Starting Strong program. The Starting Strong program supports expectant mothers and families with young children. It also supports local providers in engaging patients in care and promotes utilization of selected preventive services by offering members vouchers for attending a variety of health care appointments and engaging in services. The vouchers can be exchanged at the Starting Strong storefront for a wide variety of items such as diapering and potty training supplies, breastfeeding supplies, baby gear, and other health and safety products.

### E. Project or program brief narrative description:

Advanced Health plans use the program development, structure, and implementation advice so generously shared by Jackson Care Connect to design a similar program in the Coos and Curry county service area. The program will promote increased utilization of preventive services and support providers in engaging their patients in timely, appropriate care. In the initial implementation of the program, Advanced Health is investigating which health services to make eligible for vouchers and what products are most needed to offer. We will work with community partners in the early childhood and social services sectors to determine the gaps that exist for expectant mothers and families with young children and evaluate whether we can provide products to meet those community needs through this program.

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### F. Activities and monitoring for performance improvement:

**Activity 1 description:** Develop the program structure and budget.

Short term or  Long term

**Monitoring activity 1 for improvement:** Determine which health services to include in the initial program launch.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not complete	Complete	4/2019	Complete	4/2019

**Monitoring activity 1 for improvement:** Evaluate current utilization of the selected health services and expected initial utilization of the program.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not complete	Complete	4/2019	Complete	4/2019

**Monitoring activity 1 for improvement:** Work with community partners, the Community Advisory Council, and the provider network to gather information and evaluate current needs that could be met through the program.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not complete	Complete	5/2019	Complete	5/2019

**Monitoring activity 1 for improvement:** Develop documented procedures and program logistics such as member and provider outreach, staffing, location, ordering, inventory tracking, issuing and redeeming vouchers.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not complete	Complete	5/2019	Complete	5/2019

**Activity 2 description:** Launch program in Coos and Curry counties.

Short term or  Long term

**Monitoring activity 2 for improvement:** Add text here

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Closed	Open	6/2019	Open	6/2019

**Activity 3 description:** Evaluate program initial launch and determine whether to adapt, continue, or discontinue the program.

Short term or  Long term

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**Monitoring activity 3 for improvement:** Review successes and lessons learned. Determine effectiveness of program in terms of improved utilization, member satisfaction, provider satisfaction, and other stakeholder input.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not complete	Evaluation complete	2/2020	Evaluation complete	2/2020

**Monitoring activity 3 for improvement:** Present results of evaluation to stakeholders for review. Present evaluation results and stakeholder recommendations to executive leadership for decision.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not presented	Presented to stakeholders	4/2020	Presented to executive leadership	6/2020

### Section 3: Required Transformation and Quality Program Attachments

- A. Attach your CCO's quality improvement committee meeting minutes from three meetings  
 Three months of meeting minutes from the Interagency Quality Committee area included as attachments A1, A2, and A3. These meeting minutes provide evidence of the collaboration and coordination between Advanced Health's leadership, delegate organizations, and community partners in monitoring the quality, accountability, and utilization review activities of the entire CCO.
- B. Attach your CCO's consumer rights policy  
 Attachment B is a copy of Advanced Health's current Member Rights policy and procedure.

Submit your final TQS by March 15 to [CCO.MCOTDeliverableReports@state.or.us](mailto:CCO.MCOTDeliverableReports@state.or.us).