

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 review:

Response:

Quality Improvement Program Structure: AllCare's Quality Improvement Program ("QI Program") establishes a formal process for the development and implementation of an effective clinical quality improvement process, promotes objective and systematic monitoring and evaluation of clinically related activities and continuously acts on opportunities for improvement. The program focuses on activities related to health care provider access and availability, customer satisfaction, patient safety, continuity and coordination of care, chronic disease prevention and management, clinical pharmacy programs, preventative health, quality of care and service, over and/or under-utilization of services, address the social determinants of health impact on an individual's health and implement specific interventions to address health care disparities.

Transitioning from volume based to value based payments and linking quality outcomes to providers, AllCare utilizes the following elements in determining the compensation strategy to providers in our service areas: APMs (Alternate Payment Methodologies) for PCPs, Pediatricians, DHOs (Dental Health Organizations), Facilities (SNFs, hospitals and ASCs), MHOs (Mental Health Organizations) and NEMT (non-emergent medical transportation). Besides the APMs, compensation for Primary Care may include participation in the PCPCH program and the Quality Incentive and State measures. The results are monitored and measured through contract-required Performance Improvement Projects, against baseline data, established goals, benchmarks or improvement targets and established program and Board goals. The QIC is made up of board appointed voting members of practicing health care providers: family practice, pediatricians, pediatric nurse practitioner, OB/GYN. Non-voting members include: the chief medical officer, COO, chief compliance and quality officer, quality manager, population health director and the SDoH team (education liaison, housing manager, oral health manager, CAC manager). Reporting occurs to the leadership team, executive team, QIC, Compliance Committee and Board of Governors.

Compliance Program: Compliance activities are integrated with the quality program; with special attention to quality of care, access, FWA auditing, monitoring and oversight, and credentialing activities. Most of these areas have a direct connection with the Compliance Program that addresses health equity, detect, correct and prevent FWA, the credentialing and re-credentialing of providers, auditing/monitoring and oversight of First Tier, Downstream and Related entities, compliance training and education of employees, providers, Board members, checking employees, Board members and providers monthly against the OIG and GSA exclusion lists. The Compliance Program's annual work plan is created as a result of a company-wide and operational areas compliance risk assessment. The Compliance Work Plan is reviewed and endorsed by the Compliance Committee with final approval by the Board chair, CEO, CMO and Chief Compliance Officer.

Grievance and Appeal System: AllCare maintains policies and procedures, in accordance with the CFRs, OARs and our contract with the OHA. AllCare's process is comprehensive, objective and is focused on eliminating any barriers present so that members are confident their complaints and grievances will remain confidential and be resolved as expeditiously as possible. AllCare submits quarterly complaint, grievance and appeals information to designated OHA staff that includes the Quality Coordinator and Quality Manager. The quarterly reports include comprehensive details regarding quarterly data compared to historical data, analysis of the individual complaints/grievances as well as an analysis of the denials (types, reasons denied, number and identified trends). The Quality Strategy Plan addresses interventions and goals for this required area of monitoring and oversight.

Utilization Review:

AllCare, as required by federal rules and Oregon statutes, the contract with OHA and AllCare's internal Quality Program description, monitors the over and under-utilization of services. These activities assist internal staff where to direct additional human resources, identifies early trends regarding access and quality of care, identifies troublesome areas and monitors compliance with FWA standards and develops interventions addressing healthcare disparities. AllCare has designated a key contact for Civil Rights complaints and developed policies and procedures that are utilized in staff training.

To ensure enrollees' rights to services, AllCare's executive and management staff regularly meet with vendors where there have been significant contract changes. For example in 2017, AllCare terminated the contract with Jackson County Mental Health for outpatient mental health services. Options of Southern Oregon transitioned as the primary contractor for outpatient mental health services for AllCare members in Jackson County. During the transition, weekly meetings were held between AllCare, Options, JCMH and OHA officials to ensure that access requirements, quality of care and quality of services were being adequately addressed at the highest standards.

- 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):

Response:

AllCare CCO sponsors three Consumer Advisory Councils (CACs) representing Curry, Josephine and Jackson Counties. The CAC chairs for each county, are designated Board members and attend every CCO Board meeting to give updates on CAC activities.

The CCO staff that attends the monthly CAC meetings includes: the Quality Manager, Dental Integration Manager, SDoH Manager, Health, Education Integration Coordinator and the CAC Manager. The CCO staff ensures that the CAC activities reflect and align with the CHA, CHIP, AllCare CCO and Board goals. Every two years, the Board approves a CAC budget of \$500,000. These monies are distributed based on CCO enrollment for each county. Each CAC has discretionary ability to spend the dollars on projects that will support Transformation activities reflected in the CHIP. Annually, there is a combined CAC retreat that focuses on inspiring CAC members to continue their commitment of Community projects and bolster enthusiasm for the CCO work in their service areas.

AllCare CCO is sponsoring Listening Sessions for quality metrics and TQS strategies. Thus far in 2018, a Listening Session for self-identified Native Americans was held regarding ED utilization. Even though AllCare CCO had one of the lowest ED rates in the State, when further analysis was conducted, it was found that there was a high ED rate for those identifying as Native Americans and members with an SPMI diagnosis. This is an example of how AllCare is looking at the delivery system through a health equity lens.

In 2017, AllCare had designated staff to sponsor company-wide mandatory training in Health Equity with 100% of AllCare's 210 employees trained. This led to the formation of a Health Equity and Inclusivity Action Team and Health Equity Champions. Topics included: Implicit Bias I and II, Health Literacy, and Cultural Agility. External organizations and companies also requested the training with 81 participants completing the training. (For more information, please see the Power Point Health Equity 2017 Review).

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

Response:

Since the advent of the CCO health care delivery model, getting 'upstream' to prevent costly, inefficient health care and improve outcomes, the CCO Board as part of the overall quality strategy, endorsed efforts to

address the SDoH (social determinants of health). This includes but is not limited to the following areas: insufficient food, inadequate or no housing, utilities, domestic violence and transportation. Public safety and education (K-12) systems are supported through innovative grants or funding of projects. The strength or absence of the SDoH have a direct impact on the 'health of individuals', 'health of the communities we serve' and can predict future health outcomes of individuals and their families. Specific areas of focus continue to reflect the 2013-2018 CHA (Community Health Assessment) and CHIP (Community Health Improvement Plan). The AllCare Board utilized the CHA and CHIP to formulate CCO Board goals for 2015-2018. Monitoring activities, specific community engagements are presented to the Quality Committee and the Board for regular updates.

Currently, a collaborative effort is under way between the CCOs (JCC, AllCare and Primary Health), hospitals (Asante Health Systems and Providence), and the County Health Departments (Josephine and Jackson) to begin a formal CHA process. The end-product will be used by all entities resulting in efficiencies and elimination of replicated efforts in this process. In addition, the end-product will be a 'guide' to reflect a consistent and formal community health improvement plan across all sectors. In Curry and Coos County, a collaborative effort has begun with the CCOs (AllCare and WOA) in the development of the CHAs and CHIPs for those counties.

Through the CACs' input, listening sessions, compilation of county and state data and surveys the results will be used to prioritize the work. Though interventions may be collaborative, the different community partners will have the flexibility in the development of their CHIPs that reflect specific demographic, quality needs and desired outcomes.

- iv. Describe how your CCO is working with community partners (for example, health systems, clinics, community-based organizations, local public health, local mental health, local government, Tribes, early learning hubs) to advance the TQS:

Response:

In response to the original legislation to 'improve the health of the community', AllCare hired dedicated **staff** to be liaisons between oral health (2013), education K-12 (2013), NEMT (2014), and housing (2016). Integrating health with entities not directly related to physical health care was a component of their job duties; this resulted in those key staff being the direct contact for the primary areas of focus as well as other Social Determinants of Health (SDoH). The goal is to support non-medical activities or projects in the communities served that directly impact an individual's current health status or long-term health outcomes.

The CCO model of care delivery system is unique in its perspective as the model encourages the CCO to take problematic data or trends and structure strategic partnerships (non-medical) with solutions in order to reduce or prevent poor health status. AllCare is in the midst of utilizing external consultants to aid in the development of ways to measure the effectiveness of AllCare investments; both short and long-term. The efforts will demonstrate if the grants, donations, sponsorships and embedded personnel have made a difference in local schools, public safety, housing, non-emergent transportation and other grass-roots efforts in tackling issues that impact the individuals and communities. AllCare has retained the services of CORE (Centers for Outcome, Research and Evaluation), Eco-Northwest and Health Management Systems to assist in this effort. CORE is developing metrics based on collected data that will demonstrate results in AllCare's direct investments and the effect those investments have had on the cost of care, health outcomes and sustainable community resources.

AllCare's Board (utilizing the CHIP and CHA) adopted three major Board goals for the CCO Initiatives: Community Engagement, Housing and Education (K-12). One of the interventions in supporting the Board goals was to establish a team (ACEIT – AllCare Community Engagement and Investment Team) to develop a

process to review requests for grants, donations and sponsorships from external stakeholders. The manager of this team works directly with external stakeholders and the consultants in the formulation of unique metrics that support the Triple Aim and support the sustainability of the varied programs.

The following are examples (not all inclusive) of the types of monetary and in-kind support AllCare CCO has provided to Community stakeholders:

Organization	Type of Support or Sponsor	Name of the project
OBC Charitable Institute	Primary	Blue Zones (community-wide wellness project) for Josephine County
KOBI-TV	Collaborative	PSA Opioid Prevention Campaign
Oasis Shelter Home	Primary	Domestic Violence Shelter – Curry County
College Dreams	Collaborative	Wrap Around Support for ‘At Risk’ Children – College and Career preparation
RV-COG	Embedded Staff	Referral Specialist and Care Coordinator at AllCare CCO for Seniors and Persons with Challenges
Roots and Wings Child Development	Collaborative	Preschool Scholarships
Rogue Retreat	Primary for AllCare members	Supportive Housing Program
PAX Good Behavior Games	Primary	Program to address children’s self-control, less classroom disruptions and long term prevention of negative behaviors.
Jackson County HHS	Primary	Needle Exchange Program
First Tooth Training	Primary	Training for Primary Care and Pediatric Offices in all three counties
211 Info line	Primary	Resource and referral service number for all three counties in southern Oregon
Suicide Prevention Campaign	Primary	United Way social media campaign
Health Services Advisory Committee	Collaborative – In Kind	Support for Head Start
Snap Match	Primary	Brookings Harbor Grower’s Market – provides matching SNAP benefits for purchase of fresh produce.
Grants Pass Sobering Center	Primary	Bricks and mortar in the original building – it is an alternative to jail for people with MH and A & D issues.

B. Review and approval of TQS

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

Response:

The COO led the TQS Development Team in the TQS process. This consisted of three meetings with the team to develop an action plan, identify Team members and a TQS element Team Lead. It was up to each Team Lead to then schedule individual meetings and coordinate with other internal personnel to develop the specific element for the TQS. Each participant was provided with the TQS samples, TQS FAQs, the OHA website link with the OHA webinars and ‘office hours’.

During the second scheduled meeting, there was a collaborative open discussion for each component to identify how other sub-components could support the primary component of the TQS element.

The third meeting was a final 'touch base' to identify problematic areas of concern to assist in meeting the March 16th submission date.

The Chief Quality Officer and COO reviewed the team leads' TQS completed documents and provided feedback. There did seem to be confusion regarding how to interpret the examples. Feedback will be provided to OHA.

The end products reflect collaboration within AllCare, alignment with Board strategies and supports the AllCare Health Equity Strategic Work Plan.

C. OPTIONAL

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

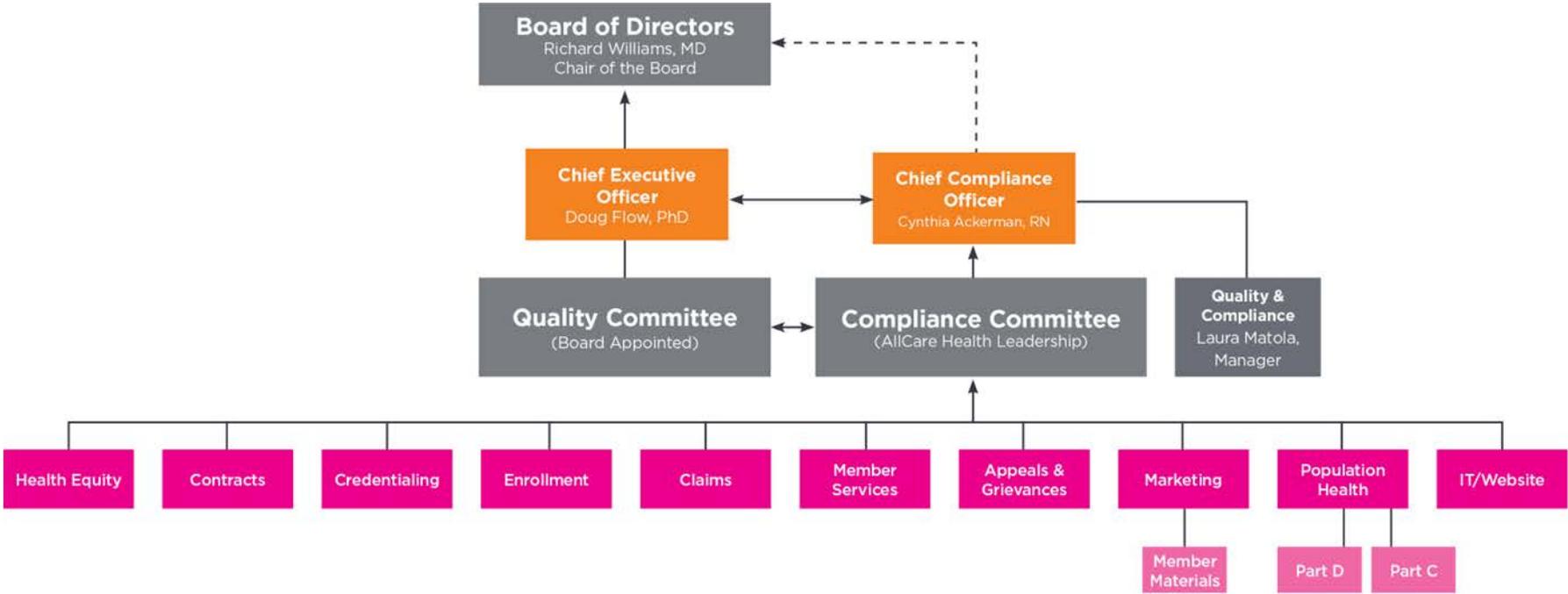
Response:

Please see the attached documents.

Section 3: Required Transformation and Quality Program Attachments

- A. Attach your CCO's quality improvement committee meeting minutes from three meetings:
- B. Attach your CCO's consumer rights policy
- C. OPTIONAL: Attach other documents relevant to the above TQS components, such as policies and procedures, driver diagrams, root-cause analysis diagrams, data to support problem statement, or organizational charts.

AllCare Compliance and Quality Oversight & Monitoring





2017 Health Equity Year
End Report
AllCare Health, Inc.

Transformation Plan

Coordinated Care Organizations (CCO) transformation plans establish the foundation for OHA's partnership with CCOs to achieve Oregon's health system goals. Plans also encourage continuous quality improvement, recognizing that transformation is a continuous process and that a CCO's transformation plan will and should evolve over time. As part of the contract process, each CCO was required to develop a transformation plan geared specifically to the needs of the community it serves. Plans demonstrate how the organization will work to improve health outcomes, increase member satisfaction and reduce overall costs.

Health Equity & Inclusivity Action Team

To meet the goals of the 2015-2017 Transformation Plan the Health Equity & Inclusivity Action Team was developed to look internally at AllCare's Policy's and Procedures along with ways to influence the provider network to better address the Cultural and Linguistic needs of our members. The key domains that the team focused on were:

Domain 6: Cultural and Health Equity

Domain 7: Workforce Diversity

Domain 8: Quality Improvement for Underserved Populations

Health Equity & Inclusivity Action Team

Team members 2017:

- Kelley Burnett, DO (Associate Medical Director)
- Alan Burgess (Alternative Payment Model Manager)
- Amy Burns, PharmD, BCPS (Director of Population Health Management)
- Andrea Franchi (Provider Network Manager)
- BreeAnn Standley (Provider Network Advocate)
- Claudia Pohling, RN (Care Coordination Manager)
- Cynthia Ackerman (Chief Quality & Compliance Officer)
- Debbie Ameen (Director of Strategic Planning)
- Greg Hilstad (Manager of AllCare Health eHealth Services)
- Josh Balloch (Vice President of Government Relations and Health Policy)
- Kari Swoboda (Wellness Programs Supervisor)
- Kathy Charles (Human Resources Manager)
- Kevin Whitley (Director of AllCare eHealth Business Services)
- Shalene Lambert (PCPCH Coordinator)
- Lana McGregor (Behavioral Health Integration Manager)
- Laura McKeane (Oral Health Integration Manager)
- Laura Matola (Quality Manager)
- Sam Engel (Coordinator Social Determinants of Health)
- Mark Bradshaw, MD (Chief Medical Officer)
- Natalie Case (Quality Analytics Specialist)
- Sheila Anders (Director of Member Services)
- Will Brake (Chief Operating Officer)
- Cheri Ferguson (Member Services Supervisor)
- Athena Goldberg, LCSW (Behavioral Health Director)
- Gita Yitta, DMD (Associate Medical Director of Oral Health)
- Cassie King (Director of Brand Strategy)

Goals Met For 2017

The following slides have the summary and results for the following met Goals from the 2017 strategic plan:

- Have all staff trained in internal Cultural Humility Training
- Offices participating in the APMs surveyed with equity(AllCare CCO only)
- Implementation of Provider Network Transformation Services (PNTS) and Population Health Work Group addressing Health Inequities (Data Driven)(AllCare CCO only)
- Training of Medically Certified Spanish Language Interpreters- Two (2)
- Preferred Language Cards added to member packets.(AllCare CCO only)
- Development of LGBTQ Health Training for Primary Care Providers

Goals Unmet For 2017

- Equity Wins/Awareness/Champions added to employee newsletter
AllCare had not developed an internal newsletter to be distributed to employees. This was moved to the 2018 strategic plan as an employee recognition program.
- Develop culturally-specific materials to assist Hepatitis-C/HIV patients and their providers.
This project was not able to be addressed for 2017 and has been moved to 2018.
- AD-Hoc: Materials sent to members developed with an alternative language version
All standard letters sent members have alternative language versions developed. For 2018 Ad-Hoc letters will be a focus.



Goal: Have all 210 staff, for all lines of business trained in our internal Cultural Humility Training by June of 2017



Background

The Health Equity & Inclusivity Action Team has put together a training developed from the CLAS standards in partnership with So Health-E. It is intended for those that participate to have the ability to:

- Understand the fundamentals of cultural competency, diversity and inclusion.
- Examine your own personal lenses and biases.
- Examine the concept of cultural humility and the link to life-long learning and service equity.
- Understand the impact of privilege and unconscious bias on health outcomes for marginalized populations.
- Examine the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.
- Identify current challenges and barriers to providing health care, educational, and social services to culturally, ethnically, linguistically and socially diverse populations in Southern Oregon.
- Learn strategies for providing culturally responsive services and strategies to improve community engagement and increase inclusion of diverse communities.

Survey

After each five hour training all participants are given a evaluation form developed by So Health-E. The evaluation is designed to find deficits in the training that the facilitator can then use to improve the training. The survey is broken into three sections. Increase of Understanding, Quality of the Presentation, and Comments.

SO Health-E Training Evaluation

Topic: Navigating Diversity Through Inclusion Trainer(s): Sisk
 Location: AllCare Downstairs Conference Room Date: 12/27/2016

Please rate your learning today:
 On the left of the chart below, please rate your knowledge BEFORE participating in staff training.
 On the right of the chart below, please rate your knowledge AFTER participating in staff training.

BEFORE Staff Training				Topic(s)	AFTER Staff Training			
None	Some	A lot	Very Much		None	Some	A lot	Very Much
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diversity and Equity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	CLAS Standards	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Cultural Humility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Privilege and Unconscious Bias	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please rate the quality of the presentation:

	Definitely	Needs Work		
The information was relevant and useful in my life or work.	5 4 3 2 1			
The pacing was appropriate and helped my learning.	5 4 3 2 1			
The presenter(s) showed respect for & interest in participant questions.	5 4 3 2 1			
The presenter(s) were knowledgeable.	5 4 3 2 1			
The presenter(s) maintained a productive learning environment.	5 4 3 2 1			
We had time for reflection, interaction, and to think about application.	5 4 3 2 1			
The content was well organized.	5 4 3 2 1			
The content and materials were accessible.	5 4 3 2 1			

What was your most important learning from this workshop?

How could the workshop be improved?

Other comments (feel free to expand on the back):

Revised: 7/13/16

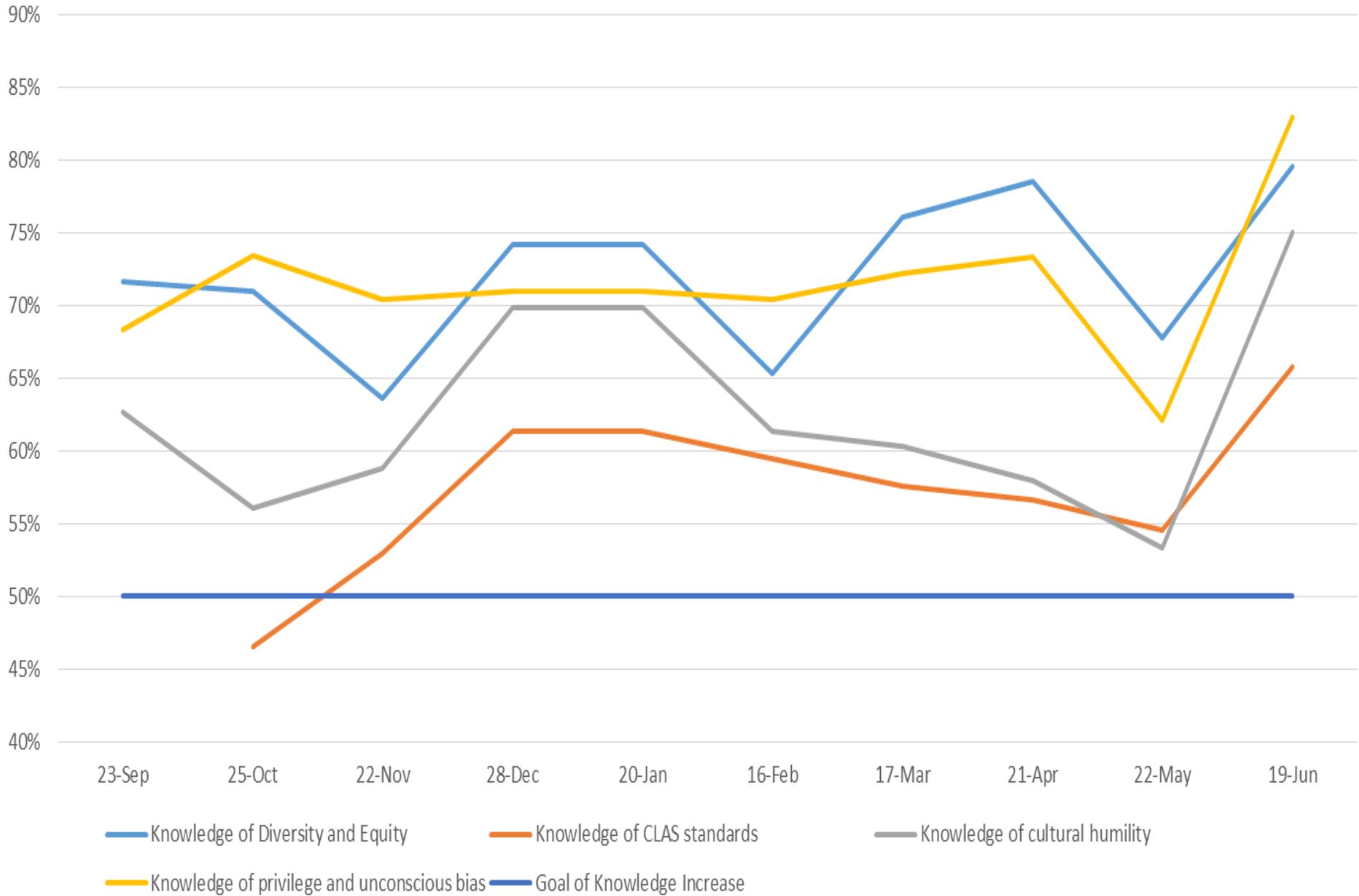
Increase of Understanding

AllCare's facilitators have a goal of a 50% increase of understanding for each of the topics in the training. Those topics are:

- Diversity and Equity
- CLAS Standards*
- Cultural Humility
- Privilege and Unconscious Bias

**CLAS Standards was added to the survey as of October 25th 2016*

Increase Of Understanding



Quality of the Presentation

AllCare's facilitators try to maintain a overall 80% satisfaction with the training. That percentage is calculated with the following questions:

The information was relevant and useful in my life or work.

The pacing was appropriate and helped my learning.

The presenter(s) showed respect for & interest in participant questions.

The presenter(s) were knowledgeable.

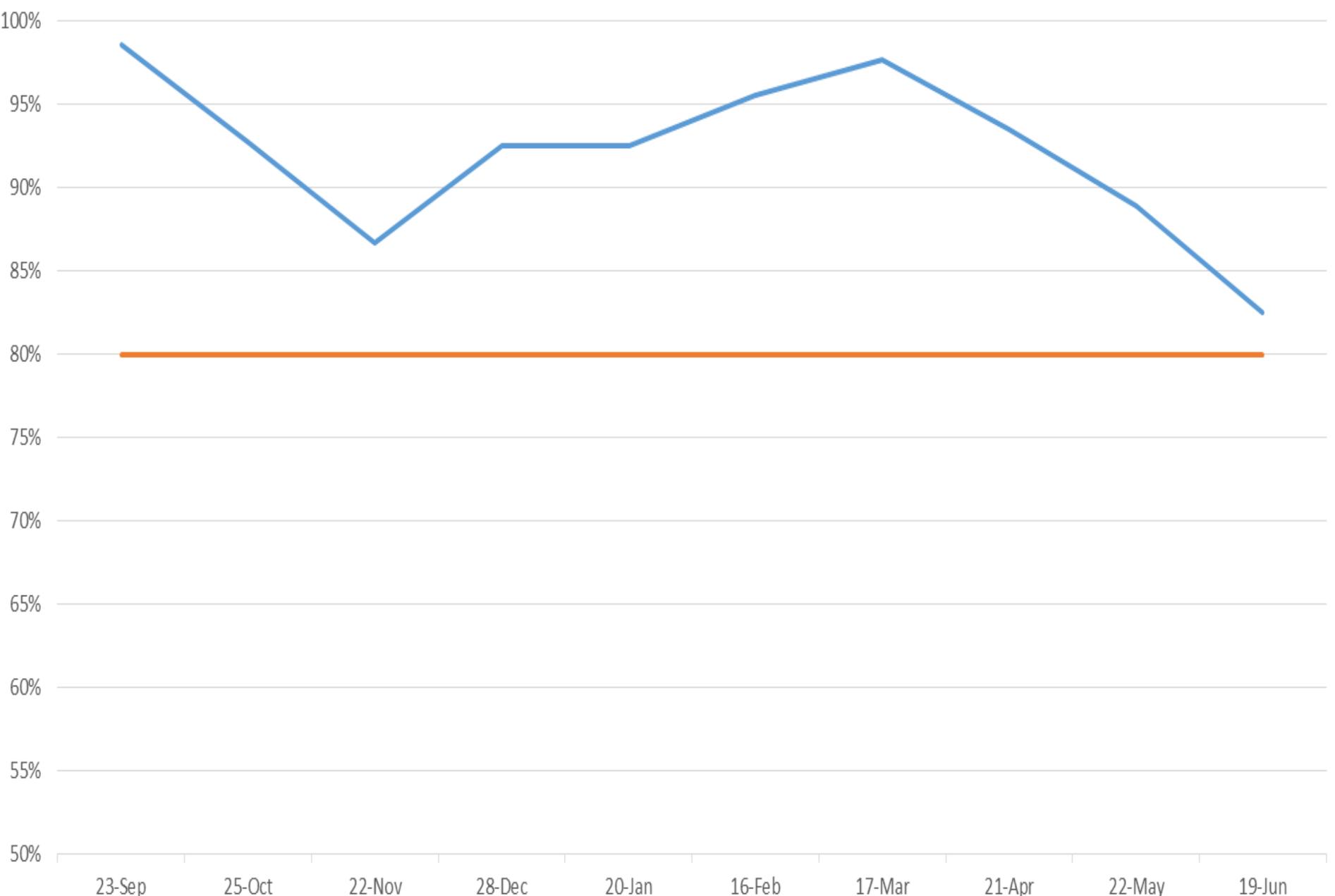
The presenter(s) maintained a productive learning environment.

We had time for reflection, interaction, and to think about application.

The content was well organized.

The content and materials were accessible.

Overall Perception Of Training



Current Internal Staff Trained as of 6.19.2017

210 Participants

100% of employees

AllCare Family of Businesses:

- AllCare CCO, Inc-(Oregon Health Plan)
- AllCare eHealth Services, LLC-(EMR, Billing Services)
- AllCare Health Plan, Inc-(Commercial Insurance Plans)
- AllCare Independent Physician Association, Inc.

Current External Staff Trained as of 6.19.2017

81 Participants from these Organizations and Programs :

- ReadyRide
- Southern Oregon Education Service District
- Grants Pass School District*
- Southern Oregon Health Equity Coalition
- Coates and Kokes
- U-Can
- Options of Southern
- Hearts With A Mission
- Future's Without Violence
- Southern Oregon Success
- Josephine County Public Health
- On Track Recovery
- La Clinica Community Health
- Mountain View Family Practice
- Rogue Valley Council of Governments

*On May 22nd Grants Pass School District sent 120 classified staff (Bus Drivers, Teachers Aides, Janitorial Staff, etc.) through a 4 hour cultural agility training facilitated by one AllCare staff and one staff member of So-Health-E. 480 staff will be trained over 18 months.



Moving forward

To meet our 2018 requirement, the Health Equity and Inclusivity Action Team put together four one-hour trainings for all of our staff. They will be one hour and offered throughout the year and at various times of the day.

Cultural Agility-This will give staff the skills for adapting to cultural differences while being agile during interactions with co-workers and members.

Health Literacy- This will define what health literacy is and why marginal health literacy can be a barrier to health care and health outcomes for our members.

Creating an affirming setting for Non-Binary (those who don't identify as man or woman) People- This training includes important terms, data, and expert-informed practices, which will offer suggestions for how any staff member can implement simple changes to improve the experiences of patients with non-binary gender identities.

Implicit Bias- This training will help staff understand what implicit bias is, its effect on health care, and overcoming implicit bias in health care.



Goal: To have contracted providers that participate in the AllCare CCO's Alternative Payment Models (APMs) surveyed with our members perception of being treated differently by 2017.



Surveys

Provider offices that participate in AllCare Health's Alternative Payment Models (APM) are surveyed annually to determine patient satisfaction with access to care and their provider. In an effort to make the program more equitable the following question was added to the survey:

Do you feel that you were treated differently from other patients because of any of the following? (Check all that apply) Insurance Type, Race, Gender, Age, LGBTQ, Disabled, Language, Other

The surveys were completed in January 2017 and used as a baseline to evaluate the provider's office before AllCare Health implemented a large education campaign around cultural humility and transgender health.

Surveys

AllCare had a total of 1,980 surveys returned from members that had a visit at the following types of provider offices:

- Primary Care (722)
- Pediatrics (277)
- Surgical Specialists (219)
- Medical Specialists (570)
- Dental(192)

Surveys

Those with written responses were put into five categories:

- Positive
- N/A
- Benefit Issue
- Provider complaint
- Support staff/office complaint.

Sample responses

Insurance Type	Other	Race	Gender	Age	LGBTQ	Language	Disability
10	2	2	2	0	1	0	6

Sample Surgical Specialty Comments:

Positive-*“This MD gave outstanding care. He was kind, considerate, professional and went over and above to assure excellent care I would HIGHLY recommend this physician”*

Benefit Issue-*“It is unfortunate that I am unable to get the back injection I need. Insurance no longer covers it and I am not financially able to do it myself and the injection was successful but now I need another.”*

Provider complaint-*“Not enough time due my speech”*

Support staff/office complaint-*“Communication with his staff is difficult call backs in 3 days, some time never. Very very frustrating. I felt he didn’t care about my pst op problems of which I am still having. Disappointed I didn’t need the additional pto...frustration and what I feel some what lack of care i am still in pain in the same area i pointed out after surgery, next appt Jan 3rd havent seen him since July.”*



Goal: To increase the availability of Certified Medical Interpreters in the region for 2016 and 2017.



Certified Medical Interpreters

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

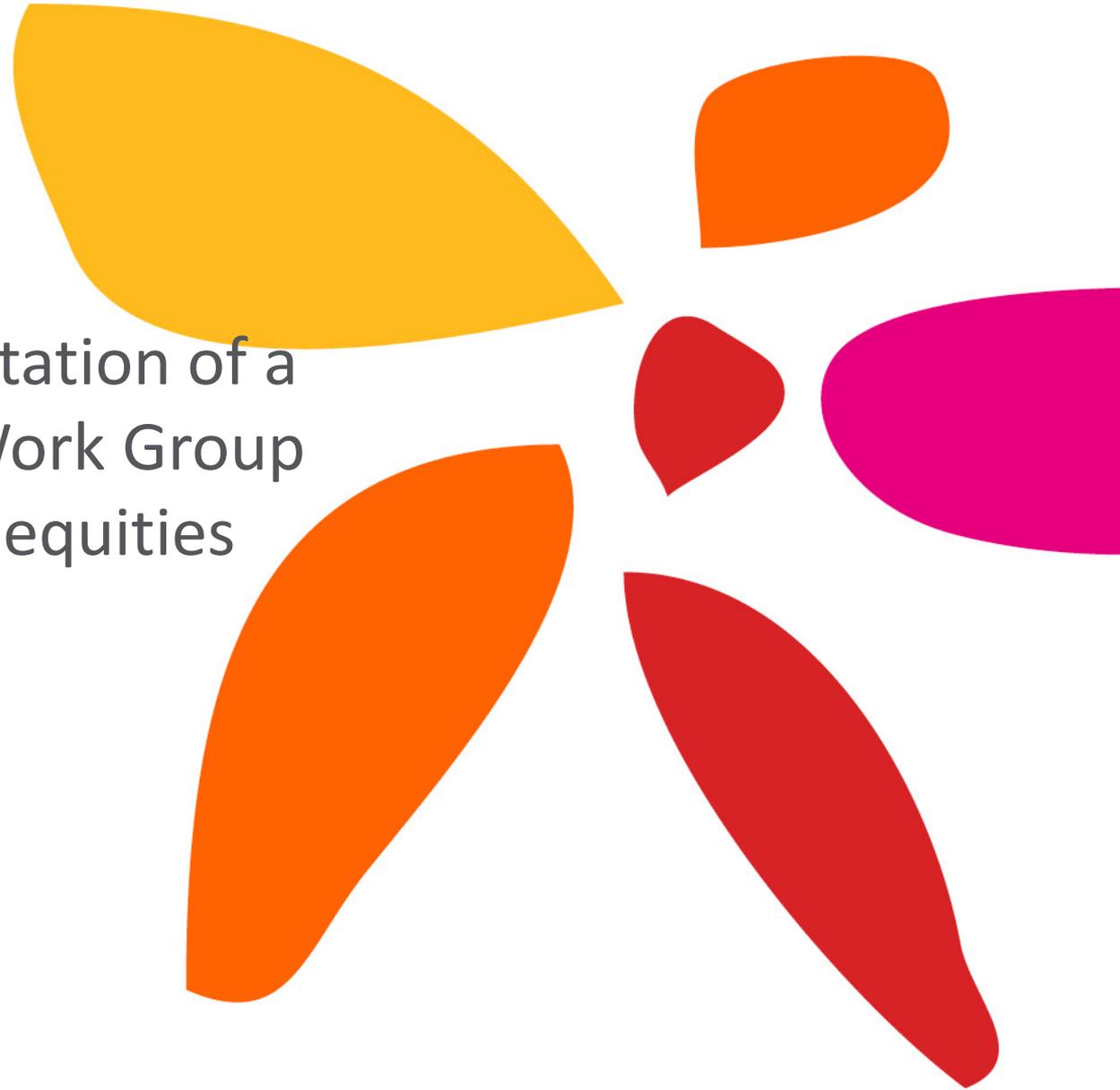
We worked internally to add a Health Equity measure to the APM's. This measure was an automatic pass for offices that had at least one Certified or Qualified Medical Interpreter on staff.

There were two trainings we were able to coordinate with OHA and So-Health-E to add 39 interpreters in our region in the last year.

AllCare is developing a internal permanent training to be available for interpreters in the region. AllCare has also now become Oregon's Third CCHI Certified Medical Interpreter Testing Site; Only Location Outside Portland to Offer Written and Oral Exam



Goal: The Implementation of a
Population Health Work Group
addressing Health Inequities
(Data Driven)



Implementation of Provider Network Transformation Services (PNTS) and Population Health Work Group addressing Health Inequities (Data Driven)

AllCare Health has seen much success through the development of the PNTS department developed with local stakeholders and providers. This new work group was developed to look at health inequities within the OHA incentive measures and identify areas of improvement. The PNTS data analysts worked with the Population Health Department to develop a dashboard to start to trend inequities for each incentive measure. The group looked at the measures by Race, Ethnicity, Age, Language, Disability, and SPMI diagnoses to identify opportunities for improvements. Disparities with a population greater than 35 were trended.

ED Utilization by Race (Lower Score is Better)



	African American	American Indian/Alaskan Native	Asian American	Hawaiian/Pacific Islander	Hispanic/Latino	White	Other	Unknown
July 2014	41.7	53.4	27.1	48.6	36.7	44.3	39.3	40.5
July 2015	48.9	43.1	24.7	39.5	39	40.3	26.7	31.4
July 2016	48.6	54.8	21.2	36.5	38.1	39.9	28	36.7
November 2016	54.6	56.4	17.4	47.0	37.7	39.3	27.4	37.6

Implementation of Provider Network Transformation Services (PNTS) and Population Health Work Group addressing Health Inequities (Data Driven)

To address health disparities that are identified within this work group AllCare will begin hosting Multicultural Health Listening Sessions. Multicultural communities often convey health information and knowledge qualitatively – through sharing stories – while professionals tend to rely more upon quantitative methods – such as data collection – to gather information. Storytelling and other qualitative methods can help professionals understand and determine the meaning behind the numbers, which is key to effective policy and program development. In addition, sharing a personal story has the added benefit of empowering the storyteller and, if applicable, can also help with his/her healing process. This is especially true when the story is heard by those in leadership positions who can influence positive changes to address elements shared within the story.



Line of Business	
AllCare CCO (Medicaid)	49,162
AllCare Advantage (H3810)	2,500
AllCare Medigap	30
Total Enrollment	51,692

*The AllCare PEBB contract termed 12/31/2017

A. TQS COMPONENT(S)			
Primary Component:	Grievance and appeal system	Secondary Component:	Access
Additional Components:			
Subcomponents:	Access: Availability of services	Additional Subcomponent(s):	Access: Second opinion Access: Timely Access
B. NARRATIVE OF THE PROJECT OR PROGRAM – AllCare Project #1			
<p>Project: AllCare will ensure a formalized structure and process that providers and their staff are educated and well-versed on health literacy, their ability to remove barriers for their patients and improve health outcomes.</p>			
C. QUALITY ASSESSMENT			
Evaluation Analysis:	<p>AllCare’s Appeals and Grievance Program reflects following the OARs and CFRs. However, as a result of the AllCare Health Literacy training program and analyzing the 2017 Complaint data, it was found that 20 of the 280 complaints (Exhibit I), reflected “...that the provider’s explanation or instruction was inadequate or incomplete”.</p> <p>Though the number is relatively small in comparison to the total number of complaints, from a health care disparity lens, the number could be larger indicating a reluctance or intimidation to complain about their provider. This could have a direct impact on the members’ compliance with their treatment plan, and having the opportunity to attain their full potential and highest level of health. The following represents potential root causes for the disparity:</p> <p>Providers-</p> <ol style="list-style-type: none"> 1) Provider office turnover; 2) Providers and their staff being unaware of using medical jargon in their interactions with patients; 3) Inadequate time or ‘rushed’ appointments; 4) The providers’ requirements to meet regulatory health screenings, surveys and quality measures; 		
D. PERFORMANCE IMPROVEMENT			
<p>Activity:</p> <ul style="list-style-type: none"> • Specific Interventions will be included in the 2018 Health Equity Plan; • Provider and office staff education – utilizing the STEPS program approach: 1) Speak slowly; 2) Teach back; 3) Encourage questions; 4) Plain language; and 5) Show examples; • Provider and office staff education on how to access and utilize certified clinical interpretive services; • Add language on the Provider Portal and Provider Manual on how to access interpretive and translate services; 		<p><input checked="" type="checkbox"/> Short-Term Activity <u>or</u></p> <p><input type="checkbox"/> Long-Term Activity</p>	

<ul style="list-style-type: none"> Utilizing existing data, analyze for avoidable ED or inpatient stays potentially related to misuse, underusing, overusing or not using medications properly or as prescribed; and Develop specific interventions based off of the data results and preventative quality specifications. 					
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Quarterly and monitored by the Quality Committee	No formalized process exists	The Work Plan will be developed and reflect the actual and potential gaps identified in the root cause analysis.	12/2018	The Work Plan will demonstrate completion dates and the number of provider offices trained.	09/2019

A. TQS COMPONENT(S)					
Primary Component:	Fraud, waste and abuse	Secondary Component:	Choose an item.		
Additional Components:	Health Care Compliance: Auditing, Monitoring and Oversight of First Tier Entities				
Subcomponents:	Choose an item.	Additional Subcomponent(s):			
B. NARRATIVE OF THE PROJECT OR PROGRAM - AllCare Project #2					
As a federal and state requirement, AllCare will create a formalized structure and process for auditing, monitoring and oversight of First Tier Entities.					
C. QUALITY ASSESSMENT					
Evaluation Analysis	<p>The following are components of the root cause analysis.</p> <ol style="list-style-type: none"> 1) Though auditing, monitoring and oversight of First Tier (FT) entities occur, there is a lack of documented processes that includes: a maintained list of FT entities, a dedicated audit team (operational area leads and subject matter experts SMEs), a special investigative unit (SIU), audit tool development and revision process, a schedule of FT audits, a team responsible for the analysis and summary of findings and defined reporting process (Compliance Committee, Risk Assessment inclusion, Quality Committee and Board of Governors). 2) This was a finding in the 2016 and 2017 EQR audits. 3) This is an area of moderate to high compliance risk. 4) During focused audits, it was discovered that from an oversight standpoint, inconsistent standards were being used by the reviewers: sample size, allowing vendors to have dedicated individuals to assist in navigating the administrative chart review, collaborating with other CCOs, and inclusion of credentialing staff to conduct credentialing audits of the FT entities. 5) No audit checklist has been developed. 6) A policy and desk procedure needs to be developed reflecting the gaps in the current audit process. 				
D. PERFORMANCE IMPROVEMENT					
Activity: <ul style="list-style-type: none"> • An AllCare CCO Compliance Risk Assessment will be generated for the OHA line of business; • Reflecting the results of the compliance risk assessment, an AllCare CCO work plan will be developed; • A final Auditing, Monitoring and Oversight of First Tier Entities policy and desk procedure will be developed. • The Board Chair, CEO and Chief Compliance Officer will approve the policy and desk procedure. • The Work Plan will be distributed to Compliance Committee for the activity of First Tier auditing, oversight and monitoring. 					<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input checked="" type="checkbox"/> Long-Term Activity
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)

<p>The Work Plan will be monitored by the Compliance Committee and reports to the Board.</p>	<p>No formalized process exists.</p>	<p>The FT oversight, monitoring and auditing policy and procedure will be developed and reflect the gaps identified in the root cause analysis.</p>	<p>09/2019</p>	<p>The Work Plan will demonstrate completion dates of the FT oversight and monitoring processes.</p>	<p>The Work Plan will include specific timeframes for completion of each activity.</p>
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A. TQS COMPONENT(S)					
Primary Component:	Health equity and data	Secondary Component:		CLAS standards and provider network	
Additional Components:					
Subcomponents:	Health Equity: Data	Additional Subcomponent(s):		Cultural Considerations	
B. NARRATIVE OF THE PROJECT OR PROGRAM - AllCare Project #3					
AllCare CCO will hold four (4) listening sessions in Josephine and Jackson County to address the Emergency Room disparity in the Native American and SPMI population.					
C. QUALITY ASSESSMENT					
Evaluation Analysis:	<p>AllCare has identified two populations that have a disparity compared to the rest of the plan for emergency department utilization. Those members that identify as Native American and members diagnosed as Severe or Persistently Mentally Ill (SPMI) in Jackson and Josephine County. Our goal is to determine the reasons these members access the Emergency Room and to assist them in engaging or re-engaging with their primary care provider.</p> <p>AllCare also has a disparity within the African American/Black population for Emergency Department utilization. When the population is broken out by county the sample size is not large enough to be statistically significant. For example for the period of 2016 the African American population in Jackson County was 153 and Josephine County was 37. Compared to the sample of the Native American population of 192 in Jackson County and 129 in Josephine County. AllCare recognizes this disparity and is tracking it through a quarterly Equity dashboard.</p>				
D. PERFORMANCE IMPROVEMENT					
Activity: AllCare will hold 4 listening sessions two (2) in each county identified for each population.				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Strategic Plan developed with input from community.	Sessions will be held to get community input	Strategic Plan developed	08/2018	Plan developed and implementation of strategic plan	01/2019
Activity: Monitoring of populations for improvement of disparity				<input type="checkbox"/> Short-Term Activity <u>or</u> <input checked="" type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)

Quarterly reporting through the OHA quality metrics.	Native American Population: 6 points above target July 2016 SPMI Population: 41 points above target July 2016 (see chart below)	Native American Population: 4 points above target July of 2019 SPMI Population: 39 points above target July of 2019 (see chart below)	07/2019	Native American Population: 2 points above target July of 2019 SPMI Population: 36 points above target July of 2019	12/2019
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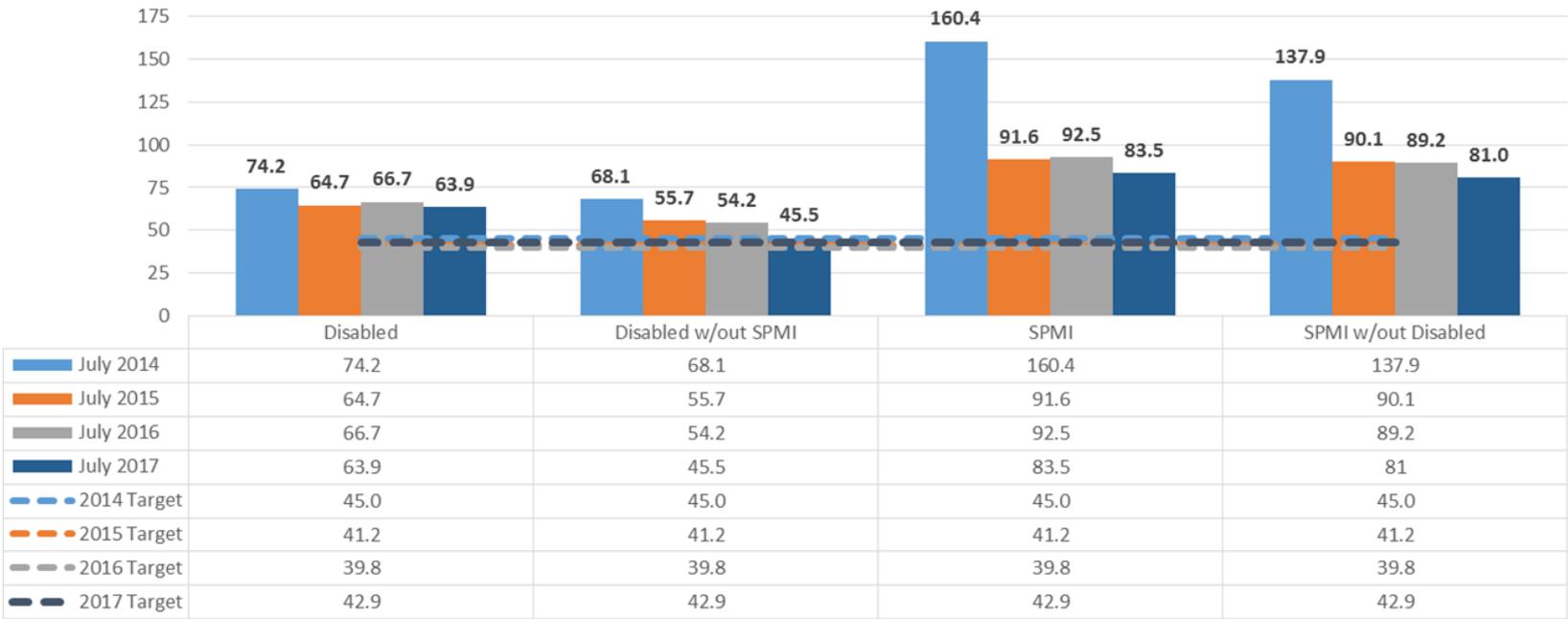
Activity: Report back to participants of what was done to improve disparity

Short-Term Activity or
 Long-Term Activity

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Participants in each session will be invited back in 2019 to present what interventions were done from their feedback	None	100 participants from all sessions	08/2018	Invite participants back to report back of what interventions were done	08/2019

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ED Utilization by SPMI & Disability
(Lower Score is Better)



Challenges in progressing toward target or benchmark:

Story telling is a new model for receiving this information from communities. Buy in from the local medical community may be difficult.

Strategies to overcome challenges:

Advocating and educating about multicultural health in the region.

A. TQS COMPONENT(S)					
Primary Component:	CLAS standards and provider network	Secondary Component:	Access		
Additional Components:					
Subcomponents:	Health Equity: Cultural competence	Additional Subcomponent(s):			
B. NARRATIVE OF THE PROJECT OR PROGRAM - AllCare Project #4					
AllCare CCO will develop and implement a training program to increase the availability of Medically Certified Interpreters.					
C. QUALITY ASSESSMENT					
Evaluation Analysis:	Currently, there is no established training program in Southern Oregon for medical interpreters. In 2015 So-Health-E, the local Regional Health Equity Coalition, completed several listening sessions with the Latino community. The response overwhelmingly was that the community needed more Certified Medical Interpreters. We believe that increasing Medical Certified Interpreters will improve the availability of services to our Limited English Proficiency (LEP) members.				
D. PERFORMANCE IMPROVEMENT					
Activity: Create a resource tool for providers to know when it is appropriate to use an in-person interpreter				<input type="checkbox"/> Short-Term Activity <u>or</u> <input checked="" type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Monitoring of interpreter use by members in region	Monitoring is currently being developed internally	Monitoring program developed	08/2018	Increase of interpreter utilization by two (2) percent	08/2019
Activity: Create and maintain interpreter training program recognized by the state of Oregon.				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)

AllCare will send an internal interpreter to the Bridging the Gap training of trainers program and maintain program licensure for two years	Internal interpreter selected will begin training in early April	Internal Interpreter trained and first training session scheduled	07/2018	Program is transitioned to a fee for service to sustain on going costs	07/2019
Activity: Train 30 and Certify 15 medical interpreters in the region				<input type="checkbox"/> Short-Term Activity <u>or</u> <input checked="" type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Participants in each training session will be tracked and assisted through OHA interpreter application process.	28 interpreters currently in the region 6 of which are Certified	30 new qualified interpreters trained	08/2018	Test 15 interpreters at AllCare	12/2019

A. TQS COMPONENT(S)					
Primary Component:	Access	Secondary Component:	Utilization review		
Additional Components:					
Subcomponents:	Access: Quality and appropriateness of care furnished to all members	Additional Subcomponent(s):			
B. NARRATIVE OF THE PROJECT OR PROGRAM - AllCare Project #5					
AllCare CCO will develop and implement polices to identify and address under and overutilization of services. We will further develop a process to regularly report these findings.					
C. QUALITY ASSESSMENT					
Evaluation Analysis:	Currently, AllCare does not formally monitor over/under utilization of services. We understand the importance of processes that enable our organization to better monitor and report on these issues. We also understand the importance of providing guidance for taking action on over/under-utilization findings. An example of an area identified for improvement related to utilization was found during a benefit meeting. Many of the population health staff expressed that they were unaware of our “meals on wheels” post hospitalization benefit. As an organization we feel this particular benefit has the ability to increase overall healing, decrease stress for the member, and reduce overall readmission rates for our members. Our department intends on educating staff as well as providers to increase the use of this benefit. A preliminary review reveals that in the 4 th quarter 967 members were hospitalized and only 2 members utilized this benefit. Reporting these findings to our Quality Improvement Committee and Pharmacy and Therapeutics Committee will enable us to develop strategies to reduce both over and underutilization.				
D. PERFORMANCE IMPROVEMENT					
Activity: <ul style="list-style-type: none"> Develop policies within Population Health department to identify under- and over-utilization of services. Identify national and state benchmarks to be used to measure under/overutilization. Identify sources of evidence based literature to incorporate to help identify populations to target. 				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input checked="" type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Population Health dept. creates policies to identify and address under- and over-utilization of services.	No current policy to address under/over utilization; current projects are adhoc	Policy(s) to be developed	06/2018	Policy(s) is created	09/2018

Activity: Identify current claims and software programs to develop reports that analyzed for gaps, as well as health inequities and disparities.				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Population Health dept. will identify current claims and software programs to develop reports that analyzed for gaps, as well as health inequities and disparities to include in policy.	No current policy to address under/over utilization; current projects are adhoc	Policy(s) is created	06/2018	Reports are developed for ongoing monitoring based upon policy	09/2018
Activity: Develop criteria for reporting findings to the QI and P & T committees				<input type="checkbox"/> Short-Term Activity <u>or</u> <input checked="" type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Population Health dept. will report over/under utilization findings to the QI and P & T committees	No reporting of under/over utilization; current projects are adhoc	Procedure for reporting is created and implemented	09/2018	Identify at least 5 services that are under and/or over utilized with strategies developed.	03/2019

A. TQS COMPONENT(S)					
Primary Component:	Health information technology	Secondary Component:	Utilization review		
Additional Components:					
Subcomponents:	HIT: Health information exchange	Additional Subcomponent(s):			
B. NARRATIVE OF THE PROJECT OR PROGRAM - AllCare Project #6					
AllCare CCO will incorporate reporting from the Premanage system to provide a more accurate and up to date census report for our inpatient members. This system incorporates all hospital systems within the state.					
C. QUALITY ASSESSMENT					
Evaluation Analysis:	AllCare CCO currently does not use any HIE for concurrent inpatient review. Our census reports are generated from our internal IT department which receive reports from local contracted hospitals. There are many gaps in this process, including a time lag (data can be >24 hours old) and incomplete coverage (not all hospitals share this information with AllCare CCO). By utilizing the Premanage program we anticipate improvement of our visibility to our inpatient census. Premanage provides real-time data on emergency department visits as well as inpatient and outpatient admissions. This timely information will assist our utilization management team to become involved in discharge and resource planning immediately upon admission with the expectation of reducing readmission rates and increasing improved transitions of care.				
D. PERFORMANCE IMPROVEMENT					
Activity: Determine current gaps in care and baselines for inpatient monitoring.				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Gaps determined (e.g., mean timeliness of notification; hospitals participating in sharing reports)	Gaps are not determined	Gaps to be identified and listed	06/2018	Gaps are identified and listed	09/2018
Metrics on TOC referrals identified and developed (e.g. # of referrals generated from current reports; time to TOC referral from admission date)	Metrics not identified	Metrics and baselines to be identified	06/2018	Metrics and baselines are identified	09/2018
Activity: Train UM staff on Premanage software				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u>	

Utilize inpatient reporting from Premanage for census reports				<input type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	How activity will be monitored for improvement	Baseline or current state	How activity will be monitored for improvement	Baseline or current state
UM Premanage team Identified and trained	No team in place	UM Pre-manage team to be Identified and formed.	06/2018	UM Premanage team trained, and implements intervention	09/2018.
UM Premanage team implements intervention	No team in place	UM Pre-manage team trained and implements intervention	09/2018	UM Premanage team implements reporting from Premanage	12/2018.
Activity: Monitor and evaluate for change in re-admission rate				<input type="checkbox"/> Short-Term Activity <u>or</u> <input checked="" type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)		
UM Premanage team evaluates any changes from baseline data of readmission rates with implementing new data of timeliness of notification of admission.	Readmission rates for 2017 were 11.8% No data established yet on readmission compared to notification of admission.	Report established that includes date of notification of inpatient hospitalization to be integrated with readmission report.	03/2019		

A. TQS COMPONENT(S)					
Primary Component:	Utilization review	Secondary Component:		Choose an item.	
Additional Components:					
Subcomponents:	Choose an item.	Additional Subcomponent(s):		Under Utilization of Medication	
B. NARRATIVE OF THE PROJECT OR PROGRAM - AllCare Project #7					
AllCare CCO Population Health Department perceives an underutilization of the prescription medication Truvada from in-house pharmacy claims reviews. This medication has evidence to support the prevention of the spread of HIV when used prophylactically. Our goal is to increase the utilization of Truvada; a medication used to prevent HIV in AllCare members.					
C. QUALITY ASSESSMENT					
Evaluation Analysis:	Currently, AllCare provides the benefits for Truvada. While there is known evidence that HIV continues to spread within Oregon, there is very little promotion of Truvada around the state. In 2016, there were 6.4 new diagnoses of HIV per 100,000 people in Oregon. Current county HIV statistics found on the Oregon.gov website reveal that in April of 2018 Jackson County had 285 confirmed cases, Josephine County had 110 cases, and Curry County had 25 confirmed cases. The evidence for Truvada shows that when taken as prescribed, the medication is very effective in reducing high risk patient's chances of contracting HIV by more than 90 percent according to the Centers for Disease Control and Prevention. AllCare's focus will be to increase awareness of the availability of this medication to our members, for example by integrating local provider offices and treatment facilities to assist in the education of Truvada's benefits and use as well as continue to not require a prior authorization for the medication to assist in timely distribution.				
Activity: Identify a baseline percentage of appropriate use of Truvada within our membership based on national and local statistics.				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Utilization of national and local data produced by the CDC and Oregon Health Authority.	We currently do not have this population identified.	Determine surrogate markers to identify the targeted population.	09/2018		
Activity: AllCare CCO will target our local organizations that specifically serve this population and our network providers with the assistance of our Marketing and Provider Transformation Services Departments to increase awareness of Truvada, statistics and opportunity for use within our service area.				<input type="checkbox"/> Short-Term Activity <u>or</u> <input checked="" type="checkbox"/> Long-Term Activity	

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Develop and distribute marketing materials to local provider offices and facilities.	There is currently no marketing material put out by AllCare to promote the awareness of Truvada.	Create posters/handouts/pamphlets that can be distributed to locations as educational materials on Truvada.	09/2018	Distribution of materials.	12/2018
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Truvada use will be monitored by in-House claims data with quarterly reporting.	Our current utilization is 0.03% utilization.	Increase clinically appropriate utilization of Truvada by at least 5 %	06/2019	Maintain increased percentage of use.	12/2019

A. TQS COMPONENT(S)					
Primary Component:	Access	Secondary Component:	Utilization review		
Additional Components:					
Subcomponents:	Access: Second opinions	Additional Subcomponent(s):			
B. NARRATIVE OF THE PROJECT OR PROGRAM - AllCare Project #8					
AllCare will formalize a process to monitor members access to second opinions					
C. QUALITY ASSESSMENT					
Evaluation Analysis:	AllCare CCO Population Health Department currently covers referrals for second opinions for diagnostic treatment and evaluations and/or recommendations for OHP covered health services. At this time AllCare CCO Appeals and Grievances is the only department tracking the quality of second options. We will monitor this benefit through the Utilization Management Department by examining quantity and need for out of state providers to address potential access issues. It is currently unknown how often members are utilizing a second opinion and how often they are required out of network or state. AllCare CCO will develop a process within Utilization Management Department by creating a report to identify members who have a service request for a second opinion and determine the frequency of need for out of network providers. We will analyze data to identify gaps of care and work with contracting and credentialing to increase access where needed. Results will be brought to Quality Improvement committee.				
D. PERFORMANCE IMPROVEMENT					
Activity: Develop reports to track second opinions and analyze gaps identified. Send to Quality Improvement Committee Quarterly.				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Authorization and Claims Data will be monitored once report is developed, all results brought to QI committee to ensure compliance	No current report within the Utilization Management Department	Report created and monitored quarterly within Utilization Management Department.	09/2018.	Report sent to QI Committee quarterly	12/2018

A. TQS COMPONENT(S)					
Primary Component:	Health information technology	Secondary Component:	Patient-centered primary care home		
Additional Components:					
Subcomponents:	HIT: Patient engagement	Additional Subcomponent(s):			
B. NARRATIVE OF THE PROJECT OR PROGRAM - AllCare Project #9					
AllCare will increase the active utilization of the AllCare Patient Portal by its members.					
C. QUALITY ASSESSMENT					
Evaluation Analysis:	<p>Patient engagement, through the use of health information technology, is a key component of a Patient-Centered Primary Care Home (PCPCH) and other federal value-based payment programs. The implementation and efficient use of a patient portal is a key component of patient engagement.</p> <p>AllCare Health has employees who travel to medical offices in three counties to help practices use their Certified Electronic Health Record Technology (CEHRT) more efficiently and meet value-based care program requirements. Of those practices, 34 use Greenway PrimeSuite CEHRT, which is hosted and supported by AllCare Health.</p> <ul style="list-style-type: none"> • 14,161 member lives are in practices who use PrimeSuite. • Greenway PrimeSuite practices either do not have a patient portal or only meet the minimum threshold requirements for the patient engagement measures of PCPCH, Meaningful Use, and Advancing Care Information. • 20 PrimeSuite practices have a patient portal and have a patient utilization rate of less than 15% (patients who have electronic access, send secure messages, and view/download/transmit their health information). • 2,100 out of 14,161 patients are actively engaged with their providers through the use of health information technology. • Throughout the next year, AllCare Health will work with PrimeSuite practices to adopt and increase the percentage of patients who have and actively use a patient portal. 				
D. PERFORMANCE IMPROVEMENT					
Activity: AllCare Health will develop and implement strategies to increase adoption rates of practices who obtain and adequately use a patient portal.				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
PrimeSuite EHR analytic dashboards data on	85% (12,000 patients) are not	5 percentage point increase in	03/2019	Active patients increase to 22%	09/2019

patient access measures.	actively engaged in the use of a patient portal.	active patient's portal engagement.			
Activity: AllCare Health will propose a measure for our 2019 Alternative Payment Models (APM) to incentivize providers to obtain a portal and actively engage patients in its use.				<input type="checkbox"/> Short-Term Activity <u>or</u> <input checked="" type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Practice attestation regarding portal usage.	TBD	Establish a baseline of all practices who participate in the APM.	01/2019	None	

A. TQS COMPONENT(S)			
Primary Component:	Integration of care (physical, behavioral and oral health)	Secondary Component:	Severe and persistent mental illness
Additional Components:			
Subcomponents:	Choose an item.	Additional Subcomponent(s):	Coordination of Care
B. NARRATIVE OF THE PROJECT OR PROGRAM - AllCare Project #10			
<p>AllCare CCO will collaborate, develop and support a formalized structured process that integrates oral health, behavioral health and physical health in one setting for individuals with a diagnosis of mental illness and residing in Josephine County.</p> <p>Oral integration currently: First Tooth – Pediatricians providing oral health assessments at well child checks. FQHCs and SBHCs are routinely performing oral health checks. Expanded Practice Dental Hygienists are providing outreach and performing oral health assessments at all local schools (K-12) as well as all Early Head Start and Head Start programs in AllCare’s three county region. WIC.</p> <p>Behavioral Health Integration currently: FQHCs and SBHCs. Multiple therapists in schools. Embedded therapists in some Primary Care clinics. WIC. Options for Southern Oregon Hillside clinic – a FNP provides primary care services at Options for Southern Oregon, a local Community Mental Health Program. Much integration has happened in terms of Oral and Physical as well as Behavioral and Physical but not many services are geared to improve oral health for our members experiencing mental health challenges. This underserved population often does not engage, seek, or follow through with dental services.</p> <p>Target population: AllCare has provided Oral Health and Chronic Disease training to the provider and staff at the Hillside Clinic, which is integrated within Options for Southern Oregon. The Hillside FNP has begun to provide oral health assessments for every patient at every visit. The FNP is completing a visual examination of the patient’s mouth/teeth, a risk assessment, provides educational materials, brief interventions (per scope) and referral to the patient’s dental home as appropriate. Focus is on incorporating dental into all appointments, educating on the importance of oral health and the impact it has on our chronic diseases and linking members to their dental homes for regular care.</p> <p>Hillside staff can also provide some coordination of care, a warm handoff to dental home for patients that may be resistant to dental services. Hillside staff also can include the patient’s behavioral health providers, which are co-located in the clinic, for additional support to ensure member gets connected to their dental home.</p>			
C. QUALITY ASSESSMENT			
Evaluation Analysis:	<p>AllCare can demonstrate integration of oral health services in Pediatric, Primary Care and school settings. Further integration efforts with physical health and behavioral health care is provided at the Hillside Clinic, a 5 star PCPCH within an outpatient mental health clinic.</p> <p>However, there is a gap for members experiencing mental health challenges and receiving or needing oral health care. The following list identifies causal factors for these gaps in care:</p> <ul style="list-style-type: none"> • This population has been underserved in receiving oral health care (preventative and for acute oral health needs); • This population does not routinely engage, seek, or follow through with dental services; • Certain medications prescribed for mental health conditions have a negative impact on the condition of teeth and oral health status; 		

	<ul style="list-style-type: none"> Understand that additional member barriers may include symptomology of illness: paranoia, delusional, anxiety, disorganized (missed appointments), not able to verbalize physical health complaints, trauma phobias
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AllCare CCO will collaborate, develop and support a **formalized** structured process that integrates oral health, behavioral health and physical health in one setting for individuals with a diagnosis of mental illness and residing in Josephine County.

D. QUALITY ASSESSMENT

Evaluation Analysis:	<p>AllCare can demonstrate integration of oral health services in Pediatric, Primary Care and school settings. Further integration efforts with physical health and mental health care is provided at the Hillside Clinic (an outpatient mental health clinic). However, there is a gap for members experiencing mental health challenges and receiving or needing oral health care. The following list identifies causal factors for these gaps in care:</p> <ul style="list-style-type: none"> This population has been underserved in receiving oral health care (preventative and for acute oral health needs); This population does not routinely engage, seek, or follow through with dental services; Certain medications prescribed for mental health conditions have a negative impact on the condition of teeth and oral health status; Understand that additional member barriers may include symptomology of illness: paranoia, delusional, anxiety, disorganized (missed appointments), not able to verbalize physical health complaints, trauma phobias:
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E. PERFORMANCE IMPROVEMENT

Activities:	<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity
<ol style="list-style-type: none"> A work plan will be developed; Identify AllCare members with a mental health diagnosis; Identify mental health medications that have a direct negative impact on oral health status; Further stratify the AllCare members with a mental diagnosis and identify which of those members are receiving medications that have a direct negative impact on oral health status; At the integrated mental health/physical health clinic, incorporate into the intake, an oral health assessment; Identify with each individual, any perceived barriers in seeking oral health care and create interventions geared to mitigate those barriers; 	

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
The Work Plan will be monitored by the Quality Committee.	No formalized coordination process currently exists.	The Work Plan will be developed and reflect interventions that address the gaps in care identified in Section C of the Quality Assessment Section.	07/2018	The Work Plan will reflect completion dates of the interventions.	07/2019

A. TQS COMPONENT(S)			
Primary Component:	Special health care needs	Secondary Component:	Social determinants of health
Additional Components:	Integration & Coordination of Care		
Subcomponents:	Choose an item.	Additional Subcomponent(s):	Dual Eligible Low Income Members
B. NARRATIVE OF THE PROJECT OR PROGRAM - AllCare Project #11			
<p>AllCare will develop a formalized process to identify Dual Eligible members with Special Health Care Needs, stratify according to risk and refer to care coordination for those with needs within the Social Determinants of Health.</p> <p>The Dual-Eligible Care Coordination team will review initial Health Risk Surveys (HRS) for a % of their caseload to develop baseline scores. The project results should document the validity of the Health Risk Survey as a screening tool to capture special needs population, social determinants of health and care coordination needs. These baseline scores can later be correlated against each other and change-over-time measures to determine effective interventions and strategies, informing SDoH needs and resources in the community, relative to member outcomes.</p>			
C. QUALITY ASSESSMENT			
Evaluation/Analysis:	<p>To improve health care outcomes and reduce gaps in care for AllCare Health’s Dually Eligible, low income senior citizen population, we have identified the members that have Dual Eligibility to focus on determining which interventions provide the greatest impact for change. This population is at high risk for poor outcomes related to Social Determinants of Health.</p> <p>Initial phase-establishing a baseline by March 2018</p> <p>The Health Risk Survey will be completed with each member in the Dual Eligible Program to obtain an overall baseline of their health risk score. It is expected to ascertain Social Determinants of Health needs and identify the complexity of Care Coordination Services. Dually eligible Members with a Health Risk Score of 10 or more will be referred to the Dual Care Coordination program. The member is contacted by the care coordination team for further assessment of specific needs and development of a personalized plan of care, which will include specific interventions and outcomes.</p> <p>Reevaluation and Analysis by September 2018</p> <p>The Health Risk Survey will be re-administered to a pre-established percentage of the program participants. A comparison will occur using the initial prior scoring of the HRS and the newly re-administered survey to identify a reduction in the overall HRS scoring. A reduction of the HRS score would be indicative of the effectiveness of care coordination, interventions and the validity of the tool being utilized.</p> <p>Additionally, member cases will be reviewed in an attempt to identify interventions that are highly effective in reducing barriers and increasing a member’s health care self-sufficiency.</p>		

D. PERFORMANCE IMPROVEMENT

Activity: Dual-Eligible (DE) program care coordinators will complete the Health Risk Survey (HRS) on a percentage of the overall Dual Eligible population to establish baseline scores in year one.

Short-Term Activity or
 Long-Term Activity

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Health Risk Survey administered	The DE program began in 2018, we are currently establishing baseline.	20% population HRS baseline (approx. 160 members)	09/2018	New cohort of 20% population HRS baseline (approx. 160 members)	03/2019

A. TQS COMPONENT(S)					
Primary Component:	Access	Secondary Component:	Value-based payment models		
Additional Components:	Health equity and data				
Subcomponents:	Access: Timely access	Additional Subcomponent(s):	PCPCH		
B. NARRATIVE OF THE PROJECT OR PROGRAM - AllCare Project #12					
<p>AllCare has been measuring provider access for our members through a survey tool as part of our Alternative Payment Model (APM). We also monitor network adequacy for our members in complying with the standards outlined in OAR 410-141-3220 - Accessibility, by using a tighter than required rule of 10 mile/10 minute geo-access standard for all members regardless of location (urban/rural). AllCare plans to increase access oversight as receiving timely care in an appropriate setting is instrumental in providing top quality care in the most cost effective manner. We have identified an access measure called Third Next Available Appointment that we will roll out in the first year to the primary care clinics. This will provide objective data-oriented feedback on access levels available to our members. We will include member demographics (age/sex/race) and geography (urban/rural) in analyzing the access data to monitor that all covered populations have adequate access.</p>					
C. QUALITY ASSESSMENT					
Evaluation Analysis:	<p>Measuring access via member surveys provides some information to the health plan; but it is somewhat limited as the surveys represent a sampling of patients seen; and don't represent the voice of patients that didn't have an office visit during the period. To improve network oversight and monitor that AllCare is meeting the Availability of Services (42 CFR 438.206) requirement, we feel that more objective quantifiable feedback is needed from our network providers. In consideration, we have researched and identified that a fairly common measure in the industry (Third Next Available Appointment) is an access measure that will objectively quantify routine appointment availability for our members. Adding this new measure to our existing survey results, along with monitoring and meeting geo-access standards, should provide extensive feedback on the access levels within our network. Review of demographic data at the provider level will provide oversight to the adequacy of access for all populations served.</p>				
D. PERFORMANCE IMPROVEMENT					
Activity: In 2018 we are adding the Third Next Available Appointment measure to the primary care APM. Success in the measure for 2018 will be determined by participating providers reporting their data into the health plan				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Quarterly data submission received from provider clinics	No reporting	Receive data from at least 75% of participating providers in 2018	12/2018	Baseline established for 2019 performance year. Compliance with the 28-day OAR	04/2019

				requirement for next available appointment will be included in target setting.	
Activity: In 2019 we will hold the providers accountable to access performance targets as established from the 2018 baseline data. Demographic data will be applied to measure results to monitor equity in access levels for all populations served.				<input type="checkbox"/> Short-Term Activity <u>or</u> <input checked="" type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Quarterly measurement in the APM program	TBD	Improvement target pending 2018 baseline and comparison to industry standard performance	04/2019	At least 50% of participating providers meet improvement target for 2019 performance	12/2019
Activity: In 2019 we intend to expand the Third Next Available Appointment to the Specialist APM.				<input type="checkbox"/> Short-Term Activity <u>or</u> <input checked="" type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Quarterly data submission received from provider clinics	No reporting	Receive data from at least 75% of participating providers	12/2019	Baseline established for 2020 performance year. Compliance with the 28-day OAR requirement for next available appointment will be included in target setting.	04/2020

A. TQS COMPONENT(S)					
Primary Component:	Health information technology	Secondary Component:		Value-based payment models	
Additional Components:	Add text here.				
Subcomponents:	HIT: Analytics	Additional Subcomponent(s):		Health equity and data	
B. NARRATIVE OF THE PROJECT OR PROGRAM - AllCare Project #13					
Develop a targeted diabetes care management program that leverages the OHA technology plan requirements to transition to QRDA I reporting (member level detail on eCQM measures). AllCare expects to realize improved A1c test scores for the program participants.					
C. QUALITY ASSESSMENT					
Evaluation Analysis:	AllCare has not met the HbA1c Poor Control target for both the 2016 and 2017 performance years in the OHA incentive program. Care management of the diabetic patients has been largely left up to the network providers. In reviewing the results for the measure there are significant variances in measure compliance at the clinic level indicating that health plan intervention is needed. AllCare can leverage the QRDA I data to identify patients and clinics that need assistance in managing their diabetic patients. Through implementing increased care management for diabetics that have been out of measure compliance we expect to see improved health outcomes for those patients. Success of the program in the near term will be measured by bringing at least 50% of the targeted patients into the diabetic program. The goals of the program will be to identify existing barriers to care, educate members, and ultimately improve the HbA1c test results and health of the patients engaged in the program.				
D. PERFORMANCE IMPROVEMENT					
Activity: Identify target patients for engagement in diabetes care management program.				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
QRDA I data will be obtained for our Prime Suite (EHR) offices from 2017 measurement year	149 non-compliant (poor control) members identified	Enroll at least 50% of targeted patients into diabetic program	12/2018	Enroll at least 50% of expanded target patient list into diabetic program (larger list resulting from additional practices reporting QRDA1 to AllCare in 2019)	12/2019
Activity: Improvement in HbA1c testing for patients enrolled in diabetic program.				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
HbA1c test results for program participants will be compared to pre-program results, or the prior measurement year moving forward	TBD based on program enrollment	20% of participants with poor control (>9%) results from prior year will have a lower test result by end of year, or be in control (<=9%). All other program participants w/o prior year testing done will have HbA1c test done in the year.	12/2018	20% of expanded # of participants with poor control (>9%) results from prior year will have a lower test result by end of year, or be in control (<=9%). All other program participants w/o prior year testing done will have HbA1c test done in the year.	12/2019
Activity:				<input type="checkbox"/> Short-Term Activity <u>or</u> <input checked="" type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Zip code analysis of identified patients done annually to determine if access issues need to be addressed	TBD	Zip code analysis done and reviewed for problem areas. Initial report will represent baseline data.	12/2018	Annual zip code analysis updated and reviewed for problem areas and compared to baseline.	12/2019

A. TQS COMPONENT(S)					
Primary Component:	Value-based payment models	Secondary Component:	Health equity and data		
Additional Components:	Add text here.				
Subcomponents:	Choose an item.	Additional Subcomponent(s):	Add text here.		
B. NARRATIVE OF THE PROJECT OR PROGRAM - AllCare Project #14					
<p>In 2018 we plan to explore the feasibility of modifying both our risk-based primary care capitation model and the primary care Alternative Payment Model (APM) to increase the value based component to both programs:</p> <ul style="list-style-type: none"> We are looking at adding a new tier to the capitation model that would be at a reduced level to the current tier 1. The new capitation tier would apply for newly enrolled members that haven't been seen yet with that provider and/or members not seen in their assigned clinic for the past 12 months. We plan to develop a downside risk model for the primary care APM in 2018 with a rollout date of 1/1/2019 if the new concept gets approved. 					
C. QUALITY ASSESSMENT					
Evaluation Analysis:	<p>Both the capitation and APM value based programs that we have already implemented have modified provider behavior in a positive manner. We have seen increased focus on the measures that our programs have emphasized with positive results on the OHA incentive measures.</p> <p>A perceived shortcoming of our program is that the combination of the capitation model and APM has resulted in an increase in overall compensation for the providers without an element of downside risk involved. We feel moving the dial towards adding some risk for the providers will produce a more powerful value based model.</p> <ul style="list-style-type: none"> The proposed capitation model will incentivize the providers to get new patients in for a new patient exam; and will equally incentivize them to get as many of their members as possible in for important routine care. The downside risk APM should increase provider focus on the incentive measures included in the program. If designed with adequate risk levels the new model could serve as a qualified Advanced APM for MIPS/MACRA and CPC Plus for those providers serving Medicare enrollees as well. 				
D. PERFORMANCE IMPROVEMENT					
Activity: Develop and then pursue internal approval for the redesign of the capitation model to add a new capitation tier that lowers payment for new members or those not seen in the past year.				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Board approval of capitation redesign to be pursued for mid-year implementation	Current risk adjusted capitation model	Get final Board decision on proposed redesign of capitation model	04/2018	Rollout of new capitation model if	07/2018

				approved by Board	
Activity: Develop and then pursue through provider feedback and AllCare Board of Director approval a new downside risk component to our primary care APM.				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Develop program and schedule meetings with providers to present and determine program feasibility	Current upside only APM	Present downside risk model to network providers and determine feasibility of the approach. Obtain Board approval if decision is to move ahead with new model.	07/2018	If accepted by providers and receives Board approval then rollout of new model	01/2019
Activity: Develop and then pursue through provider feedback and AllCare Board of Director approval a new downside risk component to our specialty care APM. Pursuit of this activity hinges on the outcome of the primary care downside risk implementation.				<input type="checkbox"/> Short-Term Activity <u>or</u> <input checked="" type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Develop program and schedule meetings with providers to present and determine program feasibility	Current upside only APM	Present downside risk model to network providers and determine feasibility of the approach. Obtain Board approval if decision is to move ahead with new model	07/2019	If accepted by providers and receives Board approval then rollout of new model	01/2020
Activity: Monitor APM measure results within our Value Based Program and apply a health equity lens at the member and provider level to assure disparities are identified and addressed.				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Detailed reporting of APM measure results with demographic, race and geographic data applied to be done with Q2 and Q4 reporting	Measure results rolled up by provider	Detailed rollup with health equity lens completed twice per year	09/2018 for initial detailed analysis of Q2 APM results	Detailed analysis produced with health equity lens applied and disparities identified and addressed twice per year	09/2018