

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 Board goals. Progress reports occur bi-monthly, gap lists are distributed to health care providers and strategies are revised if improvement goals are not being met. Reporting regularly occurs to the metrics committee, leadership and executive team, health equity task force, CACs, QIC, Compliance Committee and Board of Governors.

The QIC is made up of board appointed voting members of practicing health care providers: family practice, pediatrics, pediatric nurse practitioner, OB/GYN. All board-appointed Committees have at least one member from the Board of Governors. Non-voting members include internal staff: the chief medical officer, COO, chief compliance and quality officer, compliance and quality director, vice-president of population health and the SDoH team (education manager, integration team manager, oral health manager, CAC manager). In 2018-19, projects were viewed through a health equity lens with a commitment to infusing regional data into dashboard reporting thereby using the data to inform policy decisions and to more effectively target populations and geographies for potential interventions. Reporting regularly occurs to the leadership and executive team, health equity task force, CACs, 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 Compliance Liaison, 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 OHA Quality Coordinator and OHA Quality Manager. The quarterly reports include comprehensive details regarding 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 reports include appeals and grievances from delegated entities (DCOs, CMHPs); specifically reviewing the denial letter language against health literacy and grade-level standards.

AllCare staff are trained on how to submit internal quality of care concerns based on their observances from interacting with members in a variety of settings. The quality of care issues are directly linked to the member not achieving optimal health outcomes within their environment or other barriers identified by clinical staff. The observances can reflect care received by contracted DME providers, SNFs, home health agencies, providers from tertiary facilities. The Quality Work Plan addresses interventions and goals for this area of monitoring and oversight. Reporting regularly occurs to the leadership and executive team, health equity task force, CACs, QIC, Compliance Committee and Board of Governors.

**Intensive Care Coordination (ICC) Program** is a person centered, field based, Intensive Case Management Model. An interdisciplinary team approach is utilized to manage the diverse aspects of member care throughout the continuum. Members are engaged in a variety of community settings through the use of motivational interviewing, the teaching of self-management skills, and through the comprehensive holistic support that they receive from their designated interdisciplinary team. Supports include transitional care, multi-condition management, and assistance with navigating the healthcare delivery system, facilitation of access to community and statewide resources, and advocacy. The goals of the Intensive Care Coordination Program is to enhance the quality of life for our members and strive to achieve the highest quality of care possible and the most cost effective outcomes. The ICC staff works closely with the Quality and Compliance department in identifying opportunities to improve the quality of care, quality of service and access to the appropriate health care providers and social resources in the community.

**Utilization Review:**

As required by federal rules and Oregon statutes, the contract with OHA and AllCare's internal Quality Program description, AllCare staff monitors the over and under-utilization of services. These activities assist internal staff where to direct additional human resources, identify early trends regarding access and quality of care, identify troublesome areas, monitor compliance with FWA standards and help to develop interventions to address healthcare disparities. An example of an under-utilization focus area is reflected in one of AllCare's TQS projects. Based on pharmacy claims review, the medication Truvada has been under-utilized in AllCare members diagnosed with HIV. There is evidence that the medication if used prophylactically can prevent the spread of HIV. The goal of the project is to increase the prescribing of Truvada.

To ensure enrollees' rights to services, AllCare's executive and management staff regularly meet with First Tier entities where specific contract requirements (this can be administrative or actual healthcare services) have been delegated outside of AllCare. Decisions on when requirements are delegated may depend on the level of expertise required, the need for human resource efficiencies, and technology systems. Generally, quality oversight is not a delegated function and is retained by AllCare. Focused areas of oversight include checking the OIG exclusion list, compliance and HIPAA training, existence of their Code of Conduct and the ability to monitor downstream and related entities. AllCare has designated a key contact for Civil Rights complaints and developed policies and procedures that are utilized in staff training.

- 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:**

The Board of Governors provides oversight responsibility for the CCO by reviewing quality outcomes data and providing an endorsement and adoption of the collaborative CHA and CHIP work. The CHIP reflects transformative interventions by stakeholders, internal staff and consumers in AllCare's service area.

AllCare CCO sponsors three Consumer Advisory Councils (CACs) representing Curry, Josephine, Jackson and southern Douglas counties. The CAC chairs for each county, sit on the Board of Governors and attend every CCO Board meeting to provide updates on CAC activities and consumer feedback on topics of interest.

The CCO staff that attends the CAC meetings regularly include: the Compliance and Quality Director, Dental Integration Manager, SDoH Integration Manager, Health and Education manager and the AllCare CAC Manager. The CACs in each county endorse the priorities identified in the collaborative CHA and CHIP. This greatly aides and provides guide posts for the CACs to approve requests for funding activities that reflect and align with the collaborative CHA and CHIP and AllCare CCO Board priorities. Every two years, the Board approves a CAC budget of \$500,000. These monies are distributed with a base amount that is equal in each county and secondarily by CCO enrollment. Each CAC has discretionary ability to spend the dollars on projects that will support Transformation activities reflected in the collaborative CHIP. Annually, there is a combined CAC retreat that focuses on inspiring CAC members to continue their commitment to Community projects and bolster enthusiasm for the AllCare CCO work in their service areas.

- 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. In 2018, specific areas of focus continued to reflect the 2013-2019 CHA (Community Health Assessment) and CHIP (Community Health Improvement Plan). The AllCare CCO Board utilized the CHA and CHIP to formulate 2018-19 Board priorities with concerted efforts on developing social services contracts, data collection and validation processes while creating metrics tied to reflect changes health care costs.

Beginning in early 2018, AllCare CCO agreed to help fund and participate in a collaborative CHA in Josephine and Jackson Counties. Through a convener of health care regional community leaders Jefferson Regional Health Alliance (JRHA), hired a non-profit public health organization, Health Resources in Action (HRiA). HRiA was charged to provide strategic guidance and technical assistance for the CHA and to collect, analyze and report the data for the final CHA deliverables. It was believed that by joining efforts with other CCOs (Jackson Care Connect and Primary Health), hospitals (Providence and Asante Health Systems), FQHCs (Siskiyou Community Health Center, Rogue Community Health and La Clinica), and Public Health Departments (Josephine and Jackson County) there would be a **collective impact** on health care transformational activities that involved the SDoH, addressed the economic, cultural and system barriers to health care access while reducing the costs of health care services. In addition, relationships and resources could be leveraged through collaboration to implement best practices and ensure a sustainable health care system. Over 1,100 residents, stakeholders, health care consumers, focus groups and interviews

participated in the collaborative CHA process. Through the process of compiling, analyzing and synthesizing qualitative data, a list of fifteen key themes emerged. This list was then prioritized by key stakeholders resulting in the following six priority key themes: substance use, affordable housing, mental health and wellbeing, poverty and employment, parenting and life skills and education and workforce development. From those six key themes, the list was narrowed to three areas that community stakeholders, consumers, and partners prioritized as being the most important in improving the health of the region: **Behavioral Health (mental health and substance use), housing and parenting support and life skills.**

The 2020 CHIP is to be completed by June 2019 and will be used as a 'guide' to reflect a consistent and formal community health improvement plan across all sectors in southwest Oregon. In Curry and Coos County, an effort has begun with AllCare and Advanced Health in the development of the collaborative CHA and CHIP for those counties utilizing the same process.

Through the CACs' input, listening sessions, compilation of county and state data and surveys the CHA 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. AllCare CCO has determined that access to preventative and restorative oral health care, partnering with public safety officials and maintaining the ACES and trauma informed programs is of paramount importance. These focused areas and others will be added to the collaborative CHIP prior to submission to OHA.

- 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 Integration Team's involvement has resulted in most holding governance positions or are directly involved in systems change within the areas of oral health, housing, education K-12, and public health. 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. For example, southern Oregon has become a 'trauma informed region' based on the adoption and growth of the ACEs (Adverse Childhood Events) training and work. AllCare has been a primary sponsor of this work and to date, all school employees (principles, teachers, cafeteria staff, and bus drivers) of all school districts in Josephine and Jackson counties have been trained. AllCare continues to fund 3 public health positions in Josephine County: Registered Dietician, RN and WHNP.

AllCare has used 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 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 has developed metrics based on collected data that demonstrates results in AllCare's direct investments and the effect those investments have had on the cost of care, health outcomes and sustainable community resources.

In February 2019, AllCare's Board (aligning with the collaborative CHA and CHIP) adopted three major Board goals for the CCO Initiatives: Behavioral Health (Mental Health and Substance Use), Housing and Parenting Support and Life Skills. One growing concern is the sustainability of local projects and programs as funding of the CCOs has undergone multiple changes since the advent of the CCO model of care concept. The CHIP team (previously the ACEIT team) reviews requests for grants, donations and sponsorships from existing and emerging partners. The manager of this team works directly with external stakeholders and the consultants in the formulation of unique metrics that support the collaborative CHA and health care transformation; always looking through the lens of sustainability of the varied programs.

B. Review and approval of TQS

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

**Response:** AllCare's TQS work group meets regularly to review the status and progress of projects. As there are staff involved with projects without the experience of quality documentation work, additional training has occurred to review updated processes and coach staff on how to use the required formats. Staff members are assigned to listen to the TQS webinars sponsored by OHA.

The TQS projects have had impacts on the value based payment APMs. For example, one of the projects was to look at adjusting (lowering) capitation for primary care providers as a way to incent providers to engage and see their patients (our members). There has been a 2% increase in primary care visits for those providers.

To date, the projects reflect collaboration within AllCare, alignment with CHIP and Board strategies and support 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:**

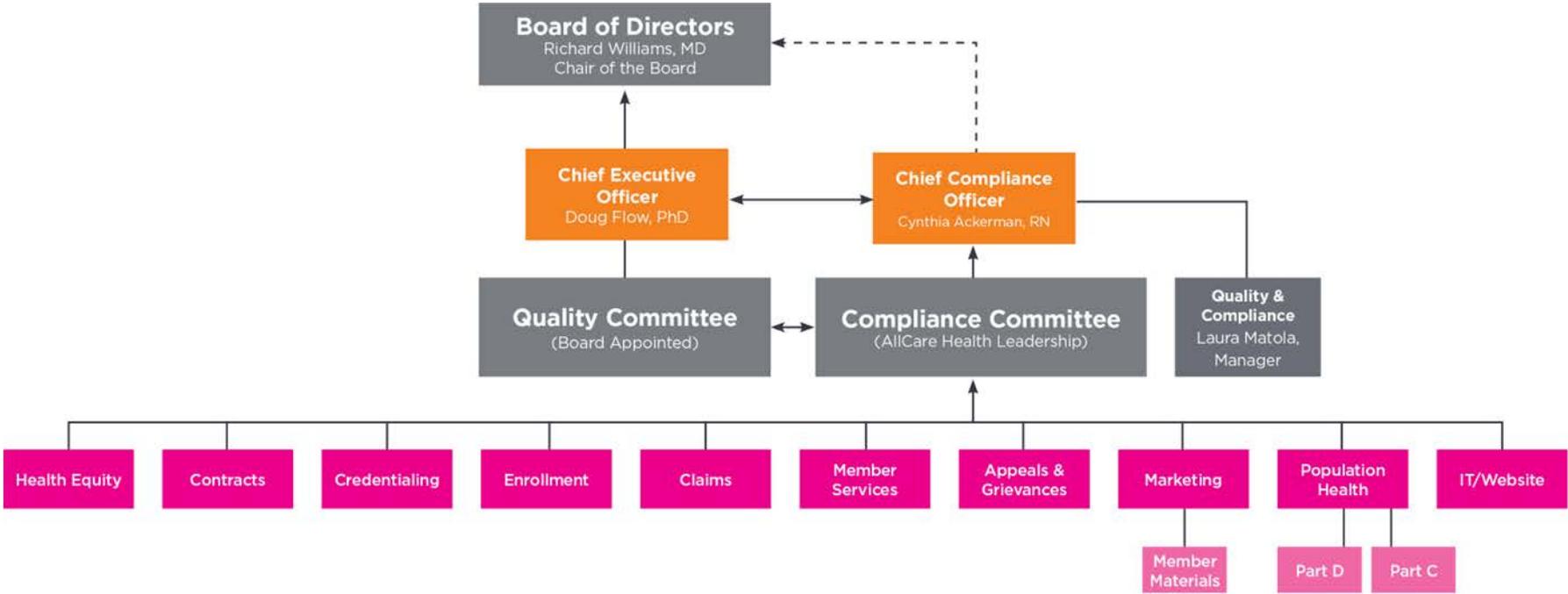
**Company Historical Overview:**

On August 1, 2012, AllCare CCO was one of the first eight CCOs to be awarded a contract with the Oregon Health Authority to become a Coordinated Care Organization. By February 2019, AllCare CCO had a total enrollment of 50,111 members. AllCare's service area is primarily rural and includes Josephine, Jackson, Curry and southern Douglas counties.

AllCare CCO embraced the 2012 legislative directives "to work under a global budget....to improve the health of the community, address and support workforce development, direct resources to the social determinants of health." Our CCO uses flexible spending dollars for items or services that are not funded OHP benefits but could result in avoidable, unnecessary health care costs. These directives were created as an adjunct to support the Health Care Transformation Triple Aim of members getting the "right care at the right place of service, members being satisfied with their care and their care provided in the most cost-effective manner". Josephine and Curry counties are the poorest in the State; having the lowest tax bases resulting in Public Safety, Public Education K-12 and the Public Health Departments all vying for the same scarce general fund dollars. AllCare CCO forged ahead in the further development of public-private partnerships in the communities we serve, supporting established entities along with grass roots efforts in addressing the social determinants of health.

AllCare improved the health care and health care satisfaction of our members by focusing efforts supporting the collaborative CHA, CHIP, Board of Directors 2015-2018 Goals, Quality Incentive and Statewide metrics, Performance Improvement Projects and the Transformation Quality Transformation (TQS) measures.

# AllCare Compliance and Quality Oversight & Monitoring





## AllCare CCO Enrollment February 12, 2019

	Curry	Douglas	Jackson	Josephine		
Physical, Mental, Dental/APLUS	3,308	470	25,459	19,283	48,520	Total APLUS
Physical and Mental/EPLUS	2	0	42	14	58	Total EPLUS
Mental and Dental/NPLUS	300	6	895	325	1,526	Total NPLUS
Mental Only/JMENT	2	0	4	1	7	Total JMENT
Total AllCare CCO enrollment by county	3,612	476	26,400	19,623	50,111	Total CCO Enrollment



## AllCare Advantage Enrollment February 12, 2019

	Curry	Douglas	Jackson	Josephine		
Gold	0	0	108	192	300	Total Gold
Gold Rx	0	0	428	804	1,232	Total Gold Rx
Preferred Rx	0	0	174	193	367	Total Preferred Rx
Preferred Rx/CCO APLUS	0	0	376	725	1,101	Total Preferred Rx w/CCO APLUS
Preferred Rx/CCO NPLUS	0	0	65	49	114	Total Preferred Rx w/CCO NPLUS
Total AllCare Advantage enrollment by county			1,151	1,963	3,114	Total Advantage enrollment



Total AllCare Enrollment  
January 8, 2019

53,225

## Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through F until all TQS components and subcomponents have been addressed)

**A. Project or program short title:** Grievance and Appeal System, Project #1: Provider and staff health literacy education.

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

**B. Primary component addressed:** Grievance and appeal system

- i. Secondary component addressed: Access
- ii. Additional component(s) addressed: Add text here
- iii. If *Integration of Care* component chosen, check all that apply:
  - Behavioral health integration
  - Oral health integration

**C. Primary subcomponent addressed:** Access: Availability of services

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

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

In 2017 there was a trend of an increased number of complaints submitted due to the provider/plan explanation, or instructions were inadequate or incomplete. AllCare chose to focus on health literacy for our provider offices, our internal staff and for our oral health and behavioral health partners with an increase in understanding of a person’s health and their treatment. This helps to remove barriers for patients and improves health outcomes.

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

Provide education to providers 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

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

AllCare monitored the number of complaints submitted regarding the provider/plan explanation or instructions were inadequate or incomplete on a quarterly basis. The number of complaints submitted regarding the provider explanation has decreased in 2018 to 5. However the number of plan explanations did increase to 11. AllCare continue to conduct internal training on health literacy and has developed a series of training sessions.

In addition, AllCare monitors the notice of action or adverse benefit letters sent out by the oral health organizations and the behavioral health organizations. AllCare is working with these entities to improve written notifications to member.

**Activity 1 description** (continue repeating until all activities included): Plan Complaints

Short term or  Long term

**Monitoring activity 1 for improvement:** Complaints Tracking

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
15 Plan Complaints	10	12/31/2018.	5	12/31/2019

## OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO

### A. Project or program short title: [Health Equity, Project 1, Listening Sessions](#)

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

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

- i. Secondary component addressed: CLAS standards and provider network
- ii. Additional component(s) addressed: [Add text here](#)
- iii. If *Integration of Care* component chosen, check all that apply:  
 Behavioral health integration  Oral health integration

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

- i. Additional subcomponent(s) addressed: [Cultural Considerations](#)

### D. Background and rationale/justification:

Through the use of demographic and claims data, AllCare Health CCO has identified that a disparity exists for two populations in regard to Emergency Room utilization for physical health reasons. The data shows that in Jackson and Josephine counties, members who identify as Native American and members diagnosed with a Severe and Persistent Mental Illness (SPMI) have a significantly higher rate of ER utilization in comparison to the rest of the AllCare Health CCO population. 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.

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

AllCare had two staff participate and graduate from Oregon Health Authority's Developing Equity Leadership through Training and Action (DELTA) program. DELTA is a health equity and inclusion leadership program that includes training, coaching, and networking to health, community, and policy leaders in Oregon. This nine-month program trains 25 members committed to advancing health equity and diversity throughout Oregon.

Through this training, the staff were exposed to and trained in Multicultural 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.

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

**Activity 1 description** (continue repeating until all activities included): Held a “Provider” Listening Session to present the community findings and encourage partnership in addressing the community need. The responses were categorized as follows:

#### **Scheduling Improvements:**

Offer same day appointments

Fill gaps (no shows, canceled appointments)

Start day with lighter schedule

Send out appointment reminders

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Offer extra office hours outside of 9:00 – 5:00, Monday - Friday

Flag high utilizers or no shows in schedule

Provide a walk in clinic

Give patients choice in days and times for appointments

Same day appointment notices posted in the office

Schedule appointments for high needs patients at the end of the day to allow for more time and less rushing

Schedule appointments for acute illness, have MA contact patient to validate

### Follow Up:

Follow up with no shows to Behavioral Health

Follow up on ER visits and remind them about extended hours and same day appointments

Follow up quickly with patient after an ER visit

### Communication:

Reduce stigmatizing language used by office staff and providers (use High Utilizer versus Frequent Flyer, High Needs Patients versus Needy Patients, etc.). The provider sets the tone for the practice.

Better communication – from hospitals or SNFs to providers

Make sure patients are aware of transportation options, educate both staff and patients

Use Community Health Worker for phone calls and to communicate options to patients

Create flyers reminding patients about same day appointments

Provide a follow up letter after appointment

Short term or  Long term

**Monitoring activity 1 for improvement:** Sessions to be accountable to the community

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Strategic Plan in development to present to community	Development of strategic priorities	04/2019	Plan developed and implementation of strategic plan with presentation back to community	07/2019

**Activity 2 description:** The most recent reports show a decrease in ED utilization by the Native American and SPMI populations compared to baseline.

Short term or  Long term

**Monitoring activity 2 for improvement:** As of October 2018, data, Native American ED utilization is at 49.0/1000, 4.8 points above the target of 44.2. SPMI population ED utilization is at 84.3/1000, 40.1 points above target.

**OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO**

<b>Baseline or current state</b>	<b>Target / future state</b>	<b>Target met by (MM/YYYY)</b>	<b>Benchmark / future state</b>	<b>Benchmark met by (MM/YYYY)</b>
Native American Population: 6 points above target July 2016 SPMI Population: 41 points above target July 2016	Native American Population: 4 points above target July of 2019 SPMI Population: 39 points above target July of 2019	07/2019	Native American Population: 2 points above target July of 2019 SPMI Population: 36 points above target July of 2019	12/2019

## OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO

### A. Project or program short title: CLAS Standards Project 1: Training program to increase the availability of Medically Certified Interpreters.

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

### B. Primary component addressed: CLAS standards and provider network

- i. Secondary component addressed: Access
- ii. Additional component(s) addressed: Add text here
- iii. If *Integration of Care* component chosen, check all that apply:
  - Behavioral health integration
  - Oral health integration

### C. Primary subcomponent addressed: Health Equity: Cultural competence

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

### D. Background and rationale/justification:

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.

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

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

AllCare CCO will develop and implement a training program to increase the availability of Medically Certified Interpreters.

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

**Activity 1 description** (continue repeating until all activities included): Develop an In-office reimbursement policy

Short term or  Long term

**Monitoring activity 1 for improvement:** An internal tracking method was also developed to understand Interpreter Utilization. It was identified that Interpreter utilization by "In-Office" employed interpreters was not able to be tracked. Developed a reimbursement policy to incentivize provider offices submitting a claim for interpreter services.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Increase in office interpretation and track through the claims system	Develop and implement policy to understand in office interpreter utilization.	12/31/2018	Review policy implementation to see if reimbursement and increased access has increased interpreter utilization by 2%	8/2019

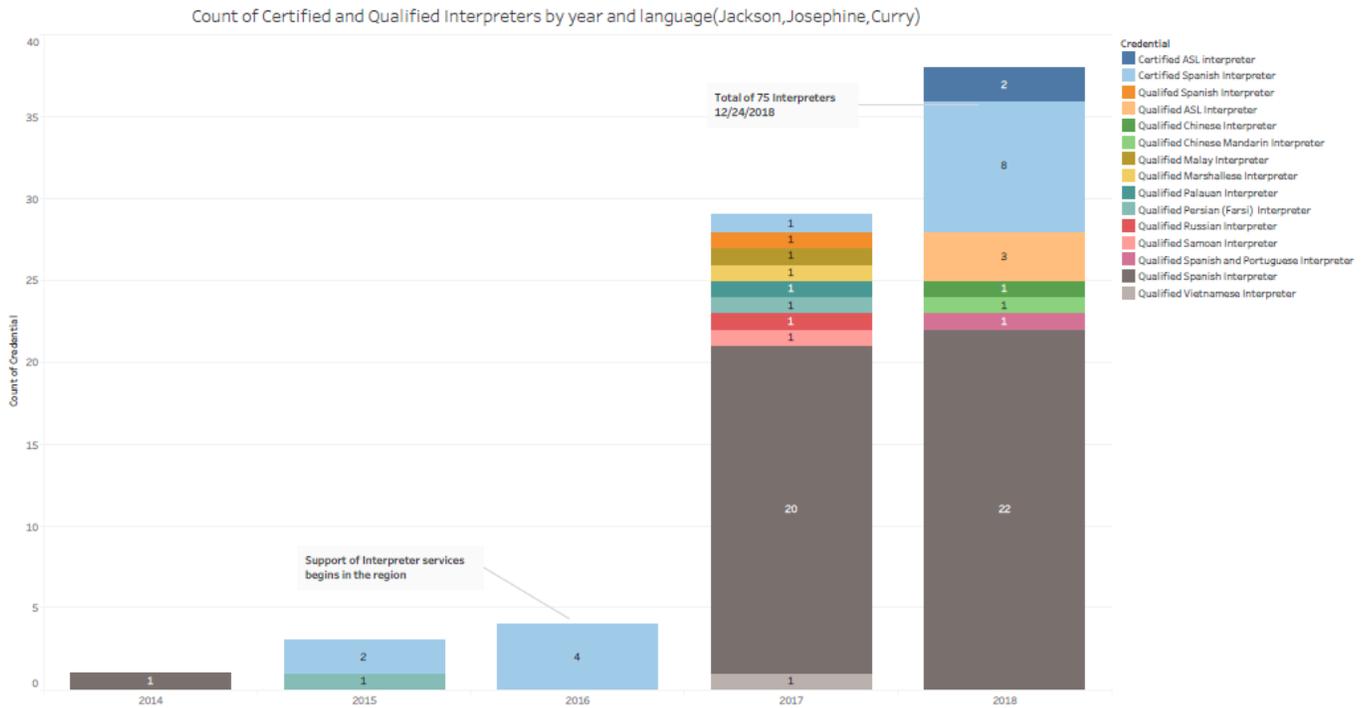
**Activity 2 description:** Interpreter Training

Short term or  Long term

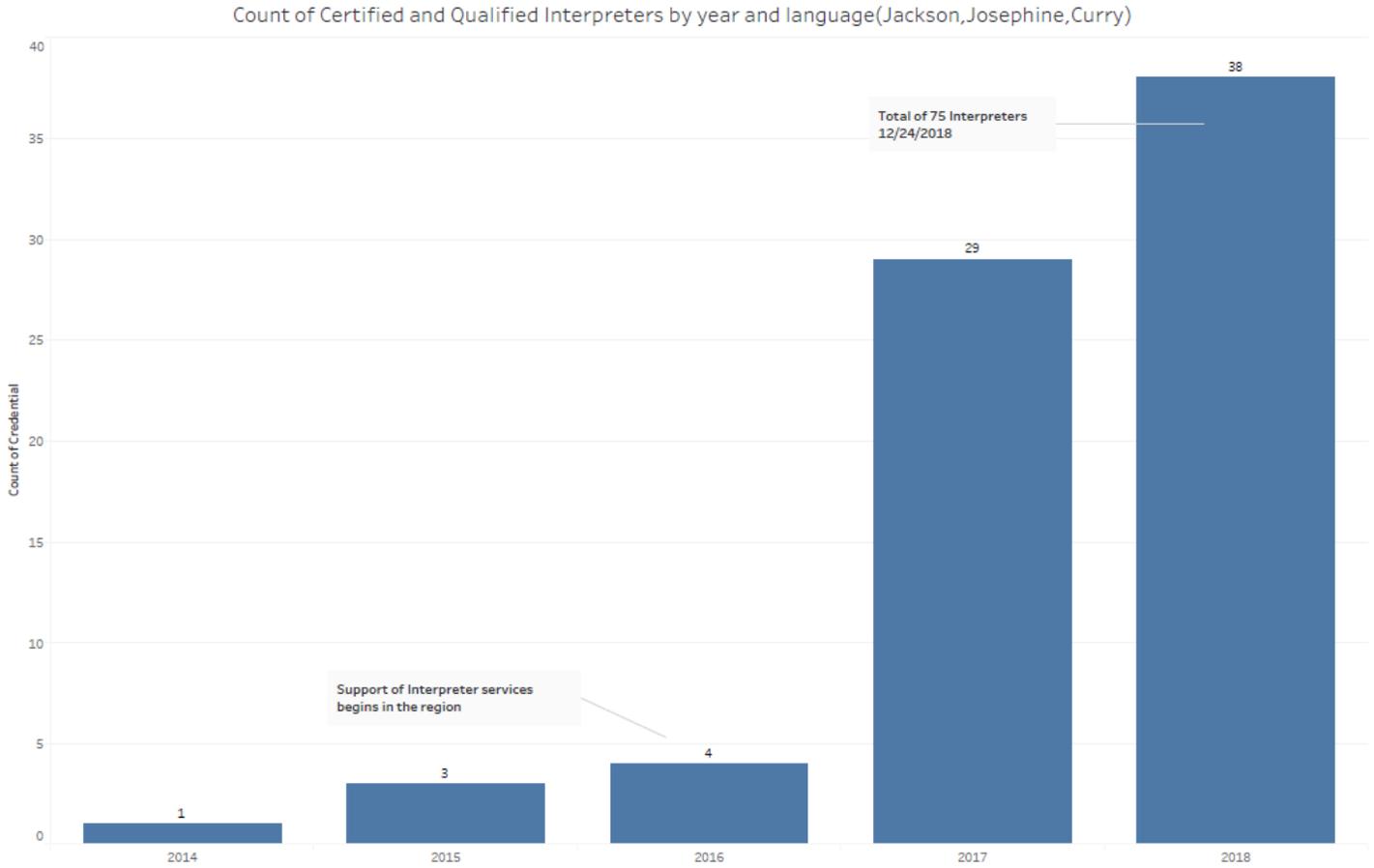
**Monitoring activity 2 for improvement:** One staff member was trained as a trainer in the 64 hour Bridging the Gap training program from Cross Cultural Solutions. Two trainings were completed in 2018. Please see Attachment below. Currently 70 interpreters are Qualified in the region and 21 are Certified.

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Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Program is transitioned to fee for service to sustain on going costs	Program has a total cost of \$950.00 and three individuals are awarded scholarships each session.	7/2018	Transition program to break out sessions so that local interpreters can participate in Continuing Education.	07/2019



# OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO





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## Become a Qualified Medical Interpreter

Meet the State of Oregon's requirements for Medical Interpreting



Picture yourself as one of the many Limited English Proficient (LEP) people across the United States. Those who struggle or are unable to speak English. Imagine the feelings you have as your knowledge of your health is in someone else's hands. This could feel scary or stressful.

This is why health care interpreters matter. They are the only bridge between health care and the LEP patient. Not only do these interpreters speak both languages, they have also been trained to explain medical terminology. Their job exists to make sure all patients get the same quality of health care as everyone else.

AllCare CCO is a licensed training site for the Bridging the Gap 24 hour interpreter training that meets the state of Oregon's requirements to become a Qualified Medical Interpreter.

The cost is \$750.00 for the 8 day training and \$100.00 for the test book. Lunch will be provided. Course requirements are on the back of this flyer.

\*Scholarships Available

For Scholarship information and to register:  
<https://www.surveymonkey.com/r/18TG8BG>



Sponsored by AllCare CCO

## Medical Interpreter Course Requirements

AllCare will facilitate the application process to Oregon Health Authority for participants completing this training to become a qualified medical interpreter with the state of Oregon.

- \*Be at least 18 years of age
- \*Must have a high school diploma or GED
- \*Are not on the Medicaid exclusion list
- \*Complete a language proficiency test in the target language. A high school diploma from a country that predominantly speaks that language will be accepted.
- \*You can schedule a language proficiency test with AllCare. The cost is \$75.00
- \*A letter on your employer's letterhead attesting to 15 hours of documented interpreting experience.
- \*A clear copy of a driver's license, state-issued ID card or passport for your background check.

The training will be held at AllCare's main headquarters 1701 NE 7th St. Grants Pass, Or. The dates for the training will be Tuesday, March 14th 2019 through Friday, March 15th 2019 and Tuesday, March 19th 2019 through Friday, March 22nd 2019. You must attend all 8 days to meet the 60 hour requirement by Oregon Health Authority. Each session will begin at 8:00 am and end at 5:00 pm

## Deaf & Hard of Hearing Forum

An event to help the medical provider overcome communication barriers which present with Deaf patients. Presenters will explain Deaf and Hard-of-Hearing needs, impacts of misdiagnosis and language deprivation, Deaf culture and communication etiquette, legal duties, pitfalls, and how to avoid the latter.

Sept. 27th - 2825 E Barnett Rd, Medford      Sept. 28th - 1701 NE 7th St., Grants Pass

Agenda (both locations)	
Registration	7:45 a.m. - 8:15 a.m.
Deaf Culture Chad/Danise	8:15 a.m. - 9:30 a.m.
Stories Panel	9:30 a.m. - 10:00
Break	10:00 a.m. - 10:15 a.m.
When to use an Interpreter Stacy/Meval	10:15 a.m. - 11:15 a.m.
Expert Panel	11:15 a.m. - 12:00 p.m.
Questions/ Wrap-up	12:00 p.m. - 12:50 p.m.

Register online at:  
[surveymonkey.com/r/Deaf\\_Forum](https://www.surveymonkey.com/r/Deaf_Forum)



**Chad A. Ludwig, MSW, AGAC, DI**  
 Chad is a Director for Regional Resource Center on Deafness (RRCC) with Western Oregon University (WOU). Chad works as a freelance Deaf and Deaf/Blind interpreter (CI) on the side in the community.



**Danise Thew Hackett, Ph.D., MSW, CRC**  
 is an Associate Professor and Program Coordinator for the Rehabilitation and Mental Health Counseling Graduate Program at Western Oregon University. Danise is the Principal Investigator of the Deaf and Hard of Hearing Oregonian Community Needs Assessment.



**Stacy Crosby, AllCare Health Network & Health Equity Mgr.**  
 Stacy is the Network & Health Equity Manager for AllCare Health. In this position he is able to look at facilities on a systems level within the provider network and find ways that we can change the system to work for everyone.



**Mavei Morales**  
 Mavei is the ADA Coordinator and Civil Rights Investigator for CIVIA service recipients. Mavei is fluent in Spanish. Mavei provides technical assistance to CIVIA staff and CIVIA contractors in the areas of nondiscrimination, Section 504 and ADA compliance.

## OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO

### A. Project or program short title: Utilization Review Project 1: Under and Over Utilization of services.

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: Access
- ii. Additional component(s) addressed: Add text here
- iii. 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

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

### D. Background and rationale/justification:

AllCare has access to multiple sets of data regarding utilization, however, this data has not been used to its analytical capacities due to under developed policies, staffing, reports, etc. We now have staff dedicated to projects within the Utilization Management Department and intend to expand on making data more usable to management to look deeper into the utilization of services.

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

AllCare's Utilization Management Department looks for ways to improve the monitoring of utilization of services to provide improved member access to services and appropriate use of services. We have continued to focus specifically on over-utilization of ED visits and under-utilization of PrEP and HCV medications for 2018. We intend to look for ways to develop a dashboard that will identify services in these categories that will allow us to be proactive instead of reactive to changes in utilization in 2019.

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

AllCare has developed a departmental policy that now addresses both under and over utilization of services. However, due to the quantity of benefits and services offered it has been a challenge to initially select a group of services to target that will prove to be of greatest benefit to the member as well as result in cost saving for the health plan. As mentioned above we had previously selected an over and an under- utilized service that we have targeted as different projects. Specific to this project we continue to work on developing accurate reports and create a dashboard that encompasses both under and overutilization of services accurately. Underutilization continues to be most difficult because it is not as apparent as overutilization.

**Activity 1 description** (continue repeating until all activities included): Population Health dept. will create policies to identify and address under- and over-utilization of services.

Short term or  Long term

**Monitoring activity 1 for improvement:** AllCare has now established a general policy regarding over and underutilization, however this activity will continue as we see a need for more in-depth procedures related to monitoring once reports have been developed.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Rough draft of policy	Baseline policy developed	12/2018	Add to policy more detailed procedure once reports are developed	07/01/2019

## OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO

**Activity 2 description:** Identify current claims and software programs to develop reports and dashboard that are analyzed for gaps, as well as health inequities and disparities.

Short term or  Long term

**Monitoring activity 2 for improvement:** AllCare has chosen to utilize an established collaborative meeting to integrate discussions around creating regular reporting that can be added to utilization management's policy as well as submitted to the Quality Department. As previously mentioned many of our processes include adhoc reporting when a suspicion or concern is raised regarding a service. Our goal is to develop two regular scheduled reports showing over-utilization and under-utilization of services. We then intend to turn these reports into a dashboard that can be presented quarterly to the Quality team. As mentioned previously we were able to complete our goal of finishing the department policy on monitoring the utilization of services however to date we have not been able establish regular reporting that can be analyzed for gaps, health inequities and disparities. This is due to time and staffing constraints and will continue to be an activity for us in 2019.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Collaborative team established	Integration of reviewing adhoc reports on staff identified utilization concerns	12/2018	Integration of established reports and dashboard within team meetings	09/2019
No regular scheduled reports	Overutilization and underutilization scheduled reports created	07/2019		
No dashboard	Create dashboard for target notifications	07/2019		

**Activity 3 description:** Develop criteria for reporting findings to the AllCare Quality Improvement Committee and the Pharmaceutical and Therapeutics Committee.

Short term or  Long term

**Monitoring activity 2 for improvement:** There is no update or advancement on this activity as reports with findings have not yet been established.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No criteria for reporting to QI and P & T Committee	Criteria for reporting to other departments developed	07/2019		

## OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO

### A. Project or program short title: Utilization Review, Project 2: Under Utilization of Truvada

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: Access
- ii. Additional component(s) addressed: Add text here
- iii. 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

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

### D. Background and rationale/justification:

AllCare identified an under-utilization of the PreP medication Truvada and developed goals around increasing utilization of this medication. We formed a collaborative that included representation from AllCare Health, HIV alliance, Jackson Co. Public Health, and Rogue Community Health. A culturally specific group met monthly to create a work plan to accomplish goals by December 2018. We identified baseline data, conducted a LBGTQIA listening session in November, and scheduled a provider dinner in February 2019 to recruit providers with assistance from AETC medical director, HIV pharmacist, and Asante behavioral health nurse practitioner as speakers. Topics will include STI testing and conversations around sexual health, use of PreP and PeP, as well as information on how to have culturally appropriate conversations with the underserved populations, and establish a post training activity scheduled in March 2019.

### E. Project or program brief narrative description: AllCare Health will continue to complete activities related to increasing the use of PreP medications to prevent the spread of HIV.

#### Activities and monitoring for performance improvement:

**Activity 1 description:** Identify a baseline percentage of appropriate use of Truvada within our membership based on national and local statistics. We were able to establish a baseline of 627 members

Short term or  Long term

#### Monitoring activity 1 for improvement:

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No established data	Baseline data	12/2018		

**Activity 2 description:** 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.

Short term or  Long term

**Monitoring activity 2 for improvement:** AllCare health has targeted our community by creating a collaborative meeting that occurs monthly and includes staff from: HIV alliance, our local health department, and local provider offices and pharmacists. Beyond meeting together to discuss concerns and goals for promotion of appropriate prophylaxis, the

## OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO

team has scheduled community provider trainings as well as preliminary marketing of culturally specific materials that will be dispersed throughout the network.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No community team	Multi-disciplinary team	12/2018	Continues to meet to develop goals	03/2019
No scheduled provider education	Scheduled provider education	12/2018	Conducted provider education	03/2019
No listening sessions	Scheduled listening sessions	11/2018	Conducted listening sessions	12/2019
Creation of marketing materials	Distribute PreP Marketing materials	03/2019	So-Healthy-E HIV Alliance Lunch & Learn Event	09/2019
Truvada use will be monitored by in-House claims data with quarterly reporting.			Increased use seen in data	10/2019

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Health Equity Training Series  
**Blood-Borne and Sexually Transmitted Infections**  
 Talking with your patients in a culturally appropriate way

**Wednesday, February 13th, 2019**  
 5:00 p.m. to 7:00 p.m.  
 Jacksonville Inn  
 Dinner will be provided.

Featuring:

- Chris Evans, MD, MPH, AANiVS**  
 AETC Presentation: Update on STD screening and treatment. This presentation qualifies as three CME or CEU.
- Jennifer Mappus, PharmD:**  
 Prescribing Pre Exposure Prophylaxis.
- Dawn Coglian, FNP:**  
 Culturally Appropriate ways to have discussions with underserved populations.

RSVP to Amy DeChenne at:  
<https://www.surveymonkey.com/HEAETC>  
 or Amy.DeChenne@AllCareHealth.com

**Earn CME & CEU Credits**

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<https://www.surveymonkey.com/HEAETC>  
 or Amy.DeChenne@AllCareHealth.com

**OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO**

**A. Project or program short title:** Health Information Technology, Project 1: Targeted Diabetes Care Management Incorporating Use of QRDA1 Data

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

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

- i. Secondary component addressed: ...
- ii. Additional component(s) addressed: Add text here
- iii. If *Integration of Care* component chosen, check all that apply:
  - Behavioral health integration
  - Oral health integration

**C. Primary subcomponent addressed:** HIT: Analytics

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

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

AllCare has not been successful in meeting the HbA1c Poor Control metric for our diabetic population. A1C test results have not been available to the health plan in an organized fashion historically. With the push by OHA to expand EHR metric reporting to incorporate QRDA1 member level data we saw the opportunity to leverage that new information to improve the focus on which members we need to target for inclusion in our Diabetes Care Management program. In addition to the use of this newly available A1C test data, our Care Coordination team revamped the diabetes program criteria to include additional data points for identifying those members that could benefit the most from inclusion in the program.

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

AllCare revamped our diabetes care program in 2018. A key aspect of the revamped program was to incorporate additional health information data into the selection criteria for those members that are deemed to benefit the most from inclusion in the program. Key data points that were decided upon included A1C test results (QRDA1 type data), MARA predictive risk scores, and inpatient and emergency department utilization with diabetes as the primary diagnosis. Another feature of the new program is Chronic Case Managers are able to increase member health literacy by providing health education that supports the medical treatment plan that members have developed with their PCP and/or Specialist. In addition, an increase in collaboration is to also take place with the health plan and medical providers. Dental assessments for program enrollees will also be a focus.

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

**Activity 1 description** (continue repeating until all activities included): Diabetes Care Management Program Update and Targeted Member Engagement. Care Coordination updated the Diabetes Chronic Care Management program to include additional member outreach as well as the inclusion of more data points in member selection criteria for the program. The updated program criteria is implemented into the Health Risk Survey and other EHR assessments used within Care Coordination.

Short term or  Long term

**Monitoring activity 1 for improvement:** Diabetes Care Management Program Update and Targeted Member Engagement

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
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**OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO**

<p>Diabetes Care Program exists but no awareness of A1C test status for members targeted for inclusion in the program.</p>	<p>Revamp program to include a more advanced data-driven process in targeting potential program enrollees. Enroll at least 50% of expanded target patient list into diabetic program.</p>	<p>12/2018 revised program has been developed. Enhancements to our Case Management platform (Essette) to support the program took longer than anticipated and slowed down progress in rolling out the program. Results of the member enrollment into the program came in at 29% enrolled of those targeted.</p>	<p>Expand the program roster to include members from other clinics when they begin to report QRDA1 data. Enroll at least 50% of expanded target patient list into diabetic program.</p>	<p>12/2019</p>
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**Activity 2 description:** Care Coordination Staff Training. Conduct training to Care Coordination staff on the revamped diabetes program. Provide an increased awareness to staff of the metrics so that they can help drive a measurable improvement in results.

Short term or  Long term

**Monitoring activity 2 for improvement:** Care Coordination Staff Training

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
<p>New Care Coordination staff lacked knowledge of HbA1c metric standards and results.</p>	<p>Train at least 80% of all Care Coordination staff.</p>	<p>12/2018 all current staff trained.</p>	<p>New hire staff into the department will receive training as part of their orientation.</p>	<p>Ongoing.</p>

**Activity 3 description:** Improvement in HbA1c Testing for Patients Enrolled in Diabetic Program. Meeting the OHA incentive improvement target/benchmark is a critical goal for the program. A key focus is to get the patients and their providers more engaged in the management of their diabetes with improved results showing up in the form of better HbA1c test results relative to the 9% Poor Control threshold.

Short term or  Long term

**Monitoring activity 3 for improvement:** Improvement in HbA1c Testing for Patients Enrolled in Diabetic Program

**OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO**

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
29.9% Poor Control rate for 2017	2018 improvement target of 27.9%	12/2018 – preliminary results for 2018 performance coming in at 27.4%	TBD – new OHA target for 2019 measurement year.	12/2019

**Activity 4 description:** Care Coordination Staff Monitoring of Dental Assessments. A new feature of our program to keep in alignment with the new OHA incentive measure is an emphasis on program participants getting an annual dental assessment. Staff will have gap list information to keep abreast of assessment status throughout the year.

Short term or  Long term

**Monitoring activity 4 for improvement:** Care Coordination Staff Monitoring of Dental Assessments

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
TBD – pending	Meet state benchmark or CCO improvement target for the measure.	12/2019	TBD	12/2020

## OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO

### A. Project or program short title: Health Information Technology, Project 2: Utilization of the PreManage system.

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

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

- i. Secondary component addressed: Utilization review
- ii. Additional component(s) addressed: Add text here
- iii. If *Integration of Care* component chosen, check all that apply:  
 Behavioral health integration  Oral health integration

### C. Primary subcomponent addressed: HIT: Health information exchange

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

### D. Background and rationale/justification:

AllCare Health currently runs daily reports from its claims system that are used by the utilization management (UM) nurses to know who is in the hospital and assist in managing their cases. The data in this report is based on only those hospitals who notify AllCare that a member has been admitted. There are times when a hospital does not notify us that a member has admitted and we are unaware, so the member does not receive the benefit of a UM nurse assisting with their case. This can happen when a member is unable to tell the hospital what coverage they have, do not have their card, or provide misinformation to the hospital. The integration of PreManage will assist us in having a more accurate census of our inpatient members that is real-time anywhere in the state of Oregon.

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

AllCare intends to utilize the PreManage system to incorporate the most accurate inpatient admission data available to better serve our members. In 2018 we were able to achieve training and add user access to PreManage, as well as get our Chief Information Officer engaged in the collaboration with PreManage to review its capabilities and develop goals for future use. AllCare is still working with the PreManage staff to develop specialized cohorts and reports to assist in narrowing the following gaps: admit notification greater than 48 hours, errors resulting in no notification of admission, delayed transferring of records via fax, and incorrect demographic information of members.

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

Activities remaining for this project include: Development of reports and cohorts within the PreManage system that can be utilized by AllCare staff to monitor inpatient admissions and staff utilizing available reports within PreManage to compare with current reports. A previous activity identified that we found to be unsuccessful and will remove at this time was metrics related to transitions of care with improved admit notification timeframes. Preliminary data does not show a difference since transition care plans are performed at time of discharge, however, as a health plan, we will continue to look at ways to improve our readmission rates with one of the angles being transitions of care outside of this project.

**Activity 1 description** (continue repeating until all activities included): Utilization management RN team to be trained on use of available reports within PreManage and to begin integrating into daily workflow as a “double check” that admissions have been requested to the health plan. This will also assist in opening care coordination cases as appropriate in a more timely fashion.

Short term or  Long term

## OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO

**Monitoring activity 1 for improvement:** AllCare was able to complete this activity by December 2018. UM RN team had been developed, all training provided, and use of standard available reports are now utilized in their daily workflow to monitor for missing admit notifications.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No team in place	Team created	12/2018		
Training of nurses with access to PreManage	Training completed	12/2018		

**Activity 2 description:** AllCare to utilize our IT department to create more useful cohorts and reports that meet the needs of AllCare CCO so that the UM RN team can work straight from these reports instead of our current ones that pull from AllCare's claims system.

Short term or  Long term

**Monitoring activity 2 for improvement:** New activity for 2019.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No specialized reports developed	Reports developed by PreManage with AllCare's specifications	07/2019	Use of new reports implemented in daily workflow for UM RN staff	09/2019.

## OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO

A. **Project or program short title:** Health Information Technology, Project 3: Increase active patient portal utilization.

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

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

- i. Secondary component addressed: Patient-centered primary care home
- ii. Additional component(s) addressed: none
- iii. If *Integration of Care* component chosen, check all that apply:  
 Behavioral health integration  Oral health integration

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

- i. Additional subcomponent(s) addressed: none

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

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.

AllCare Health has employees who travel to medical offices in three counties to help practices use their Certified Electronic Record Technology (CEHRT) more efficiently and meet value-based care program requirements. Of those practices, 34 use Greenway Prime Suite CEHRT, which is hosted and supported by AllCare Health.

- i. 14,161 member lives are in practices who use Prime Suite.
- ii. Greenway Prime Suite 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 Promoting Interoperability.
- iii. 20 Prime Suite 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).
- iv. 2,100 out of 14,161 patients are actively engaged with their providers through the use of health information technology.
- v. Throughout the next year, AllCare Health will work with Prime Suite practices to adopt and increase the percentage of patients who have and actively use a patient portal.

E. **Activities and monitoring for performance improvement:**

**Activity 1 description** (continue repeating until all activities included): AllCare Health will develop and implement strategies to increase adoption rates of practices who obtain and adequately use a patient portal.

Short term or  Long term

**Monitoring activity 1 for improvement:** AllCare Health's PCPCH Coordinator encouraged and educated provider offices on the use of the patient portal in order to increase their PCPCH point total and potentially their tier level. AllCare Health ran reports and determined that there was an increase in members using the AllCare Patient Portal from 2,100 to 3,051 users. This is an increase of 7 percentage points.

**OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO**

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
85% (12,000 patients) are not actively engaged in the use of a patient portal.	5 percentage point increase in active patient's portal engagement.	9/2018	Active patients increase to 25%	9/2019

**Activity 2 description:** AllCare Health will implement a measure for the 2019 Primary Care Alternative Payment Model to incentivize providers to offer access to patients (or patient-authorized representatives) the ability to view online, download, and transmit their health information via a fully integrated patient portal.

Short term or  Long term

**Monitoring activity 2 for improvement:** This measure was rolled out in our 2019 Alternative Payment Model. AllCare Health's Provider Services department will support and encourage provider offices to adopt or increase patient portal utilization on an ongoing basis.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Baseline undetermined at this time.	We will obtain a baseline via year-end attestation by providers participating in the 2019 APM.	3/2020	5% increase in offices that attest to utilizing a fully integrated patient portal.	3/2021

## OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO

### A. Project or program short title: Access, Project 1: Second Opinions

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

### B. Primary component addressed: Access

- i. Secondary component addressed: Utilization review
- ii. Additional component(s) addressed: Add text here
- iii. If *Integration of Care* component chosen, check all that apply:
  - Behavioral health integration
  - Oral health integration

### C. Primary subcomponent addressed: Access: Second opinions

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

### D. Background and rationale/justification:

AllCare Health allows second opinions to all members for diagnostic and treatment evaluations/recommendations for OHP covered services. Coverage extends to out of network providers as appropriate. Our current reporting was identified to have gaps as it required the ordering provider to select that the service is related to a second opinion, and this was found to not always be accurate.

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

AllCare intends to look for ways to more accurately report on second opinions specific to utilization and gap identification. Reports developed will be shared with the QI committee as well as the Provider Services Department to assist in provider access and contracting needs.

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

We have continued to run into challenges due to: providers identifying requests as second opinions incorrectly, identifying ways our system best tracks these service requests, and staff time needed for analyzation of the reports developed to determine accuracy. Since our last update we have integrated an analyst on staff to assist in the thorough reviewing and improved development of the report. Prior to 2019 we were also able to add more clear language in our member handbook for 2019 related to second opinions and anticipate increased provider education through the provider portal.

**Activity 1 description** AllCare continues to work on developing an effective report that accurately identifies requested second opinions.

Short term or  Long term

**Monitoring activity 1 for improvement:** AllCare's population health workgroup has been able to run preliminary data on second opinions based on data input on each authorization requested. We were able to identify two specialties that appear to utilize second opinions the most, obstetrics/gynecologic and orthopedics. When looking deeper at the report it was clear that services requested as a second opinion by the provider should not have been called second opinions. Population Health's data analyst will continue to manipulate the criteria for reporting with a goal to increase efficacy on reporting and look for outliers that may benefit on office outreach and education.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
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**OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO**

Preliminary Report available with gaps	Preliminary data to analyze	12/2018	Improved accuracy of reporting	07/2019
Member handbook does not mention cost in relation to second opinion	Clarification of “no cost” for second opinions in the member handbook	12/2018		
Gaps identified to provide provider outreach/education	List of provider offices that identify second opinion on an authorization incorrectly	07/2019	Providers have a clear understanding of what constitutes as a second opinion	09/2019

## OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO

### A. Project or program short title: [Access, Project 2: Days to 3<sup>rd</sup> Next Available Appointment-Primary and Specialty Care](#)

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

### B. Primary component addressed: [Access](#)

- i. Secondary component addressed: Value-based payment models
- ii. Additional component(s) addressed:
- iii. If *Integration of Care* component chosen, check all that apply:
  - Behavioral health integration
  - Oral health integration

### C. Primary subcomponent addressed: [Access: Timely access](#)

- i. Additional subcomponent(s) addressed:

### D. Background and rationale/justification:

In 2018, AllCare identified a need for an objective access measure to improve network oversight and help assure that availability of appointments for our members is in compliance with the standards outlined in 42CFR 438.206. Our research determined that Days to Third Next Available Appointment was an industry accepted access measurement that could be added to our Value Based Payment Model. The measure contains the structure and data gathering framework to drive improvement in access standards within the network. The 2018 plan was to roll the new measure out for primary care providers, gather data as reported to the health plan by the participating providers, and then establish a benchmark and baseline for performance targets going forward into 2019.

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

AllCare included the new access measure for the 2018 measurement year in our Value Based Payment Model for primary care physicians. Rollout of the measure included a communication plan outlining the measure criteria for the provider community, distribution of a reporting template with instructions, and ongoing technical support to offices by staff. Data was reported by 93% of the primary care providers that participate in our Value Based Payment Model. Analysis of the data received indicated that measurement was not done consistently and setting performance targets from it was not deemed equitable. In light of the data credibility issues, we retooled the measure for 2019 reporting to establish a more defined and consistent standard of measurement based on time for new patient visit to establish care. With the re-set of the measure criteria the performance management aspect of this project has been pushed back one year. In effect, 2019 will serve as the data gathering year to determine baseline performance, establish an overall benchmark target, and set individual performance targets for the following year.

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

Activity 1 description: Revamp of Primary Care 3rd Next Rollout: AllCare found and now recognizes that appointment scheduling varies significantly between practices and EHR platforms. This variability caused discrepancies in the data received in 2018 that compromised the ability to set fair targets. After reviewing the options, we decided that visits for establishing new patient care is an appointment type that is universal in definition and is a critical access standard to monitor. Thus, we set the measurement criteria based on this type of visit. With this modification agreed upon we rolled out to the primary care network the revised criteria for reporting in 2019.

Short term or  Long term

## OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO

**Monitoring activity 1 for improvement:** Gather Baseline Data for Primary Care

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
AllCare obtained data in 2018 but found credibility issues in the data, thus requiring 2019 be set as the new baseline data gathering year.	Baseline data gathered from at least 90% of participating clinics and performance targets set for 2020.	1/2020	Set a benchmark based on consideration of the network data received along with national standards to be researched. Set improvement targets as a performance target for those providers well off the established benchmark.	1/2020

**Activity 2 description:** Performance Target Accountability - Moving into 2020 primary care providers will be held accountable for either meeting the benchmark or an improvement target on this new access measure. AllCare will collect the data and report out progress relative to each provider's target as part of our quarterly reporting on the Value Based Payment Model.

Short term or  Long term

**Monitoring activity 2 for improvement:** Quarterly Reporting on Metric Status to Providers

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
AllCare to provide quarterly reporting to participating providers of their performance against target.	TBD	12/31/2020	At least 50% of participating providers meet their established target for 2020 performance.	12/31/2020

**Activity 3 description:** Rollout of 3<sup>rd</sup> Next to Specialty Care Providers – Consistent with our original plan the new access measure was to be expanded into the Specialty Care Value Based Payment model in 2019. The plan was to start with Primary Care to get the project started, and then with lessons learned, expand in the following year to Specialty Care.

Short term or  Long term

**Monitoring activity 3 for improvement:** Gather Baseline Data for Specialty Care Providers

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Gather baseline data from	Baseline data gathered from at	1/2020	Set a benchmark based on	1/2020

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participating providers during 2019 performance year.	least 75% of participating clinics and performance targets set for 2020.		consideration of the network data received along with national standards to be researched. Set improvement targets as a performance target for those providers well off the established benchmark.	
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**Activity 4 description:** Performance Target Accountability - Moving into 2020 providers will be held accountable for either meeting benchmark or an improvement target on this new access measure. AllCare will collect the data and report out progress relative to each provider’s target as part of our quarterly status reporting on the Value Based Payment Model.

Short term or  Long term

**Monitoring activity 4 for improvement:** Quarterly Reporting on Metric Status for Specialty Care Providers

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
AllCare to provide quarterly reporting to participating providers of performance against target.	TBD	12/31/2020	At least 50% of participating providers meet their improvement target for 2019 performance.	12/31/2020

## OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO

### A. Project or program short title: *Integration of Care, Project 1: Integration of Care of SPMI and SUD members.*

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)*

- i. Secondary component addressed: Severe and persistent mental illness
- ii. Additional component(s) addressed: Special Health Care Needs
- iii. If *Integration of Care* component chosen, check all that apply:  
 Behavioral health integration  Oral health integration

### C. Primary subcomponent addressed: *Access: Availability of services*

- i. Additional subcomponent(s) addressed: Access: Quality and appropriateness of care furnished to all members

### D. Background and rationale/justification:

Poor oral health outcomes for persons with Serious & Persistent Mental Illnesses (SPMI) and for individuals with Substance Use Disorders (SUD).

There are many known factors that contribute to the SPMI populations receiving less oral health care and having poorer oral health outcomes. These factors include: less access to dental providers, poor oral hygiene, poor diet, socio-economic issues, mental health diagnosis/severity/stage, side effects of medications, lack of perception of oral health self needs, lack of knowledge of oral health problems, fear and anxiety about dental visits or procedures and fear of judgement by dental professionals. Most of these same factors are true for SUD populations as well.

Furthermore, studies have shown these populations have much higher rates of poor oral health outcomes such as dental caries, extracted teeth, periodontal disease, edentulous and oral cancer and are also at greater risk for poor health outcomes such as infections, heart attack, stroke, poorly controlled diabetes and preterm labor.

Increasing access to oral health education, preventative and early interventions and treatment services in Behavioral Health settings where people who have SPMI and/or SUD are accessing services can greatly improve health outcomes for these folks that would not otherwise access these services regularly.

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

AllCare will continue to monitor our 2018 project of providing dental screenings, prevention services and coordination of ongoing oral health care services in an integrated primary care clinic located within a Certified Community Behavioral Health Center (CCBHC). Additionally, our goal for 2019 includes an expansion of the assessment done by the integrated primary care provider to include a warm handoff to dental services being provided onsite by one of our contracted Dental Care Organizations.

AllCare is also taking integration of physical, behavioral and oral health in 2019 to a new level by working with stakeholders to provide dental services embedded in a Substance Use Disorders (SUD) treatment agency in Jackson County. This treatment agency will have full continuum of SUD services that can reach members at many different stages of their alcohol and/or drug use. This program will also include members who are in residential treatment and are pregnant or parenting while to have educational and preventative services with their children to give them skills to encourage good oral hygiene in their children.

## OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO

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

#### Activity 1 description (continue repeating until all activities included):

Informal needs assessment to determine if the oral health assessment completed by the PCP was meeting the intention of the pilot project. Assessment showed need for more oral healthcare services on site. Surveyed patients and found they would see a dental provider if one was located at the CCBHC.

Discussion with stakeholders to determine capacity and resources for a dental provider within CCBHC.

Planning sessions with stakeholders to develop the implementation plan.

Short term or  Long term

**Monitoring activity 1 for improvement:** ongoing monitoring of claims and care coordination being provided

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Oral health assessments being completed in an integrated primary care clinic at a CCBHC	Plan for increase oral health services within CCBHC by 5%	4/2019	Dental Provider embedded in CCBHC	06/2019

#### Activity 2 description: Expanding embedded model to be used in a substance use disorders treatment agency.

Evaluate, refine and formalize the embedded dental provider program to share with other behavioral health treatment settings.

Discussion with stakeholders about the needs and plan. Determine capacity and resources for a dental provider within a SUD treatment agency.

Adapt model to meet the needs and resources of the SUD setting.

Planning sessions with stakeholders to develop the implementation plan.

Short term or  Long term

**Monitoring activity 2 for improvement:** ongoing monitoring of claims and care coordination being provided

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No oral health services within SUD settings	Oral health education, prevention, early intervention and treatment services embedded in a SUD agency	6/2019	Develop an integrated model of oral health care that can expand to other behavioral health treatment sites.	12/2019

## OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO

### A. Project or program short title: [Special Health Care Needs, Project 1: Intervening on Social Determinants of Health of the Special Needs Population](#)

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

### B. Primary component addressed: [Special health care needs](#)

- i. Secondary component addressed: Social determinants of health
- ii. Additional component(s) addressed: [Add text here](#)
- 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:

Care Coordination has decreased member's Health Risk Score by an average of 30%.

A chart audit was performed on all members who had a risk score increase of 10 or more points or a decrease of 20 or more points.

For those with a substantial decrease (20 or more) in score, two or more of the following was found to be true:

1. Member joined a gym
2. Member had Intensive Care Coordination Program Team staff attend MD visits with them.
3. Member had help from Intensive Care Coordination Program Team to get needed medication or DME in place.
4. Member has assistance from Intensive Care Coordination Program Team to get paid caregiving in place.
5. Member had assistance from the Intensive Care Coordination Program Team with connecting with community resources for food, housing, or heating assistance.

For those with a substantial increase (10 or more points) in score, one or more of the following was true:

1. Member had communication or other difficulties with their medical provider.
2. Member had unmet housing needs.
3. Member was not honest with or did not understand the questions due to low health literacy on first Health Risk Screening, leading to a falsely lower initial score.
4. Member had an overall global health decline, often related to advanced age or advanced disease.

The current Health Risk Survey (HRS) did not capture communication/member's perceived difficulties with providers. The HRS was updated to capture this as well as the location where the member seeks their care most often. The reasons listed on the HRS for a member's PCP-communication needs not being met were modeled after information gained from listening sessions. It was thought that even if a member feels their needs are met with their PCP, if they are seeking care most at urgent care or one specialty office, the member may also benefit from Care Coordination services.

To address SDOH that were shown to correlate with increased health risks, the dedicated manager participated on local, state and regional policy and advocacy action committees. AllCare participated in the annual Point in Time count of homeless individuals.

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Rogue Retreat and Hope Village: AllCare pioneered a social service contract to help stabilize funding and build capacity for transitional and supportive housing.

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

By April 2019, will have re-administered the new HRS to target population, which at this time includes approx. 1200 members who are old aged with state paid care services or have developmental or physical disability (receiving SSI and services).

To address members with declining health despite care coordination intervention, AllCare Health has created a new partnership with Rebuilding Together Rogue Valley to develop a Fall Prevention Program. The hope is to reduce preventable injuries for these members and to increase member safety and independence levels.

Members are identified via several mechanisms.

1. Emergency Department reports are reviewed and all members that present for a fall or injury secondary to a fall are contacted to attempt to engage them in the fall prevention program.
2. Provider offices will be receiving packets with information about the fall risk program, including a short fall risk assessment for the PCP to perform during MD visits.
3. Members already involved in Care Coordination are assessed using the fall risk assessment, and if they have a qualifying score, the PCP office is contacted to enroll member into the Fall Prevention Program.

To address member's Social Determinants of Health, specifically community resources for food, housing, utilities assistance:

1. To address health literacy, AllCare is continuing with Health Literacy projects as part of our Health Literacy program, which is both internally and externally driven. (See Project 1 and 3)
2. AllCare Health approached SDoH in a variety of ways and in close partnership with community service agencies.
  - a. Identify gaps in service and resources – these may be identified by members through care coordination or our Community Advisory Councils (CACs), data publications, community services agencies, research, or a combination.
  - b. Expand capacity in existing programs to meet the needs identified in (a. above). This may be through technical assistance, in-kind contributions of staff time and support, or financial support.
  - c. Developing new programs and contracts. This is typically done by working with existing community partners to develop new programs to fill an identified community need.
    1. The SDoH manager facilitates the exchange of best practices throughout our service area; which includes the following: Grants Pass Housing Committee, Collaborative Economic Development Committee, Southwest Oregon Collaborative, CCO Oregon SDoH workgroup, and the Housing and Transportation Committee (Jackson County), CACs and regional networks.
    2. Rogue Retreat data- target report 9-2019, benchmark- review data/determine which project of expansion is most supported, determine which plan for expansion to support.

## OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO

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

**Activity 1 description** (continue repeating until all activities included): Fall Risk Program

Short term or  Long term

**Monitoring activity 1 for improvement:** Fall Prevention Program participants will be assessed before in-home modifications are done and at three- and six-month's post-program with follow-up telephone calls. The following questions will be administered to capture measurable impact of the program:

- How many times has a member fallen since Rebuilding Together Rogue Valley did their fall risk assessment and provided in-the-home modifications?
- If they fell, did the fall require a call for emergency assistance since the initial assessment?
- If "Yes" has member been hospitalized or re-hospitalized because of a fall since the fall-risk assessment and the in-home modifications?
- Does the member feel more independent in activities of daily living since the initial assessment e.g. toileting, bathing etc.?

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Fall Prevention Program initiated in January of 2019	Analyze results of 3 and 6 month follow up calls to determine measurable success. For members with no improvement, determine if additional factors correlate with falls.	August 2019	Analyze results for the entire year of 2019. This will include review of all participant assessments and follow up calls and additional claims comparisons for 2019 vs 2018 for hospitalizations and ED visits. Based on this data, should the program continue or expand?	June 2020

**Activity 2 description:** AllCare is currently partnering with Rogue Retreat and the Center for Outcomes Research and Education (CORE) to understand how obtaining stable, affordable housing and case management services affects AllCare members' health care costs, utilization, and quality outcomes.

Short term or  Long term

**Monitoring activity 2 for improvement:** Collecting and evaluating data

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
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**OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO**

<p>Rogue Retreat in the initial stages of expansions into Josephine County.</p>	<p>Evaluate Rogue Retreat’s programming in Jackson County to better understand our population, care utilizations, healthcare costs, and member self-sufficiency (Rogue Retreat data).</p>	<p>09/2019</p>	<p>Evaluate program data and results to guide development of model. The goal will be: 75% of participants improve their “Self Sufficiency” scores from entry in program to current date (&gt;3 months)</p>	<p>09/2020</p>
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**OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO**

**A. Project or program short title:** Value Based Payment Project 1: Risk Based Primary Care Capitation

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

**B. Primary component addressed:** Value-based payment models

- i. Secondary component addressed: ...
- ii. Additional component(s) addressed:
- iii. If *Integration of Care* component chosen, check all that apply:
  - Behavioral health integration
  - Oral health integration

**C. Primary subcomponent addressed:** Access: Timely access

- i. Additional subcomponent(s) addressed:

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

AllCare has a risk-based capitation for primary care providers in our Josephine County service area. Research of encounter data underneath the capitation indicated that about 39% of assigned patients were not being seen during a 12-month period. We feel that an annual primary care visit, at a minimum, is an important aspect in maintaining, or improving, the health of our members.

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

To improve the percentage of patients seen we determined that a reduced cap payment for those members not seen in the past 12 months was a change that could provide appropriate incentives for the primary care providers to bring more patients into their office. The revised capitation model received approval by AllCare CCO’s Board of Directors. Effective with the July 2018 capitation payment the new payment model commenced.

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

**Activity 1 description:** Capitation Model Redesign Rollout in 2018

Short term or  Long term

**Monitoring activity 1 for improvement:** Successful Rollout of New Capitation Payment (Y/N)

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Current risk adjusted capitation model w/o lower tier of payment for members not seen in prior 12 months	Risk adjusted capitation model with additional tier at reduced payment for members not seen in prior 12 months	7/1/2018 rollout. Data shows through the end of 2018 the percentage of patients not seen has decreased from 39% to 37%.	Same as Target	7/1/2018 – achieved.

## OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO

### A. Project or program short title: Value Based Payment, Project 2: Value Based Payment with Downside Risk

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

### B. Primary component addressed: Value-based payment models

- i. Secondary component addressed: Health equity
- ii. Additional component(s) addressed:
- 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:

### D. Background and rationale/justification:

AllCare initially looked into developing a downside risk approach to our primary care Value Based Payment model as an Advanced APM option for our network providers that could be packaged with their Medicare business as an option to MIPS/MACRA requirements. The downside risk element is also seen as a next step in increasing the effectiveness of our VBP incentive program.

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

We developed the framework in 2018 for a downside risk model that we feel can gain traction with our network providers. The program allows for an option of upside only, with smaller potential payment; and an upside/downside option, with significantly more upside potential than the upside only track would offer. The dual track option allows for providers to opt into the track that aligns with their risk tolerance. Research during 2018 indicated the Medicaid downside risk model can't be part of the Advanced APM alternative to MIPS/MACRA requirements in our service area as the providers would need to package it with a Medicare downside risk program to qualify under the Advanced APM approach with CMS. The main issue being there is not a Medicare downside risk program in the local marketplace. The model was presented to our Physician Compensation Committee in the fall, and despite the lack of being able to qualify the program with CMS, the committee was interested in the approach and voted to move forward on an exploratory basis. The committee felt it was too significant a change to rush through for a 1/1/2019 implementation. They decided to get Board approval to pursue the concept and then get broader feedback from the network providers before making a final decision on whether or not to move forward. Expansion of downside risk to other Value Based Payment Models (e.g. Specialty Care) is an option that will be pursued based on the outcome in 2019 regarding the primary care model.

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

#### Activity 1 description: Final Board/Physician Committee Decision on Downside Risk Adoption

Short term or  Long term

#### Monitoring activity 1 for improvement:

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Downside risk model designed	Get Board approval to pursue further	7/1/2019	Contingent upon final	1/1/2020

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and has interest from Physician Committee to pursue broader network interest prior to a final vote.	interest in downside model, communicate concept to broader network and get feedback, then Physician Committee to make final recommendation to AllCare Board of Directors.		recommendation from Physician Committee and our Board, either pursue rollout of downside model for 2020, or consider other options if not approved.	
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**Activity 2 description: Monitor Value Based Payment Results with Health Equity Lens**

Short term or  Long term

**Monitoring activity 2 for improvement:**

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Quarterly provider level quality reporting done prior to Q2 reporting in 2018.	Reporting at measure and provider level for APM/VBP results with demographic, race and geographic data applied to be done with Q2 and Q4 reporting annually.	7/1/2018 – achieved.	Semi-annual report produced, disparities identified, corrective action plans developed where appropriate.	7/1/2019 for final 2018 report.

## OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO

### A. Project or program short title: Value Based Payment, Project 3: Annual VBP Program Enhancements

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

### B. Primary component addressed: Value-based payment models

- i. Secondary component addressed: ...
- ii. Additional component(s) addressed:
- 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:

### D. Background and rationale/justification:

AllCare has a Value Based Payment program for Primary Care, Specialty Care, Behavioral Health, Dental, Facilities, and Non-Emergent Medical Transportation. These VBP programs are modeled after the OHA incentive program with as much overlap in measures as feasible. We also include additional measures to address specific areas of concern (e.g. Health Equity, Patient Portal Development and Utilization, Use of Lower Cost Settings, etc.). The programs need annual refinement to keep abreast of new OHA measures and to address other identified issues/measures that have been brought to the forefront. We also look to replace measures where performance has topped out.

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

Staff in our Provider Services take the lead on VBP development and program administration. Throughout the year we collect feedback, observe the success/failure of specific measures, and develop recommended changes to the VBP programs for the following year. In the fall we convene meetings with provider committees to review the program performance, and to propose and ratify changes to the respective programs for the next year. For example, measure additions that were implemented for 2019 include: Primary Care (SBIRT, Patient Portal); Specialty Care (Severe Adverse Events within 30 Days of Surgery, Opioid Use, 3<sup>rd</sup> Next Available Appointment, Documentation of Current Medications, Tobacco screening/cessation); Behavioral Health (Mental Assessments on Foster Kids); Dental (Oral Evaluations for Diabetic Patients, Health Equity); Facility (Severe Adverse Events), Non-Emergent Medical Transportation (No changes in 2019). This same activity needs to occur annually to keep the VBP programs refreshed with the most current and relevant set of measures.

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

**Activity 1 description:** Value Based Payment annual measure set review, VBP provider committee meetings and measure set adoption for following year, vetting of measure recommendations to assure measurability, and rollout of measure changes to broader network.

Short term or  Long term

**OHA Transformation and Quality Strategy (TQS) CCO: AllCare CCO**

**Monitoring activity 1 for improvement:**

<b>Baseline or current state</b>	<b>Target / future state</b>	<b>Target met by (MM/YYYY)</b>	<b>Benchmark / future state</b>	<b>Benchmark met by (MM/YYYY)</b>
Existing measure set for 2019 performance year for VBP programs.	Measure set modifications proposed and voted upon for addition to 2020 VBP year. New measure criteria vetted to assure measurability. Changes rolled out to participating providers.	12/31/2019	Same.	12/31/2019