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 projects 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, addresses the social determinants of health and subsequent impacts on an individual's health and implements 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. The TQS projects reflect adapting to CCO 2.0 more stringent requirements with several projects reflecting other required quality work so as to achieve the greatest impact on defined areas needing focused work. Reporting regularly occurs to the metrics committee, leadership and executive team, health equity task force, CACs, Quality Improvement Committee (QIC), Compliance Committee and Board of Governors.

Ultimately, the Board of Governors is responsible for the Quality Program and the Quality Improvement Committee. 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 lead Medical Director, COO, Chief Quality and Compliance Officer, Quality and Compliance Director, VP of Utilization Management and Pharmacy Services, Director of Population Health and the SDoH Team (K-12 Education / Health Manager, Integration Team Manager, Oral Health Manager, Community Outreach Manager). Throughout the Contract Year 2020, projects will continue to be viewed through a health equity lens with a commitment to infusing regional data into dashboard reporting thereby using the data to inform and influence 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.

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. The Quality and Compliance Director provides trainings to the departments that are member and provider facing so that there are internal educational refreshers and a clear understanding of what constitutes a complaint or grievance and appeal. The Director also provides initial training to new employees within 90 days of hire.

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 for the denial, number and identified trends). The reports include appeals and grievances from delegated entities (DCOs, CMHPs, NEMT); specifically reviewing the denial letter language against health literacy, grade-level standards and to ensure that appropriate rights to appeal language was included in the denial letter. To ensure enrollees' rights to services, AllCare's executive and management staff regularly meet with subcontractors where specific contract requirements (this can be administrative or actual healthcare services) have been delegated outside of AllCare.

AllCare staff are trained on how to submit **internal quality of care concerns (ICCs)** 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. **Note:** Decisions on when requirements are delegated may depend on the level of expertise required, the need for human resource efficiencies, and use of specific technology or program systems. Generally, quality oversight is not a delegated function and is retained by AllCare CCO. Appeals are never delegated to any subcontractors; AllCare CCO is ultimately responsible for all contract required work.

Compliance Program: Compliance activities are integrated with the quality program; with special attention to quality of care, access to care, individual civil rights, FWA auditing, monitoring and oversight, Privacy and Security 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 Subcontractors, compliance training and education of employees, providers, Board members, checking employees, Board members, subcontractors, consultants and providers monthly against the OIG and GSA exclusion lists. Any allowed delegation of contracted work to subcontractors is held to the same standards that AllCare CCO is held accountable. Focused areas of Subcontractors' 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. Annual auditing of the subcontractors occur with results being shared with the BOG, Quality and Compliance Committee, Leadership. AllCare has designated a key contact for Civil Rights complaints and developed policies and procedures that are utilized in staff training.

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.

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 the TQS project for 2020 under-utilization monitoring was reviewing Type II Diabetics with a continuous glucose monitoring machine (CGM) to determine if there was a correlation between the number and acuity of hospitalizations with complications from Type II diabetes. Preliminarily, the results indicated a decrease in costs with those utilizing a CGM. Dedicated staff utilize Reliance (a regional electronic communication tool) to review ED and inpatient admissions which facilitates discharge planning and post-discharge planning that ideally begins at the time of admission.

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

Response:

AllCare CCO's Quality structure starts with the Board of Governors (BOG) and flows through the organization carrying with it AllCare's values, philosophy and business standards. The BOG relies on the CEO, Officers, VPs, Directors, and Managers of the Company to carry out activities and interventions in order to meet the Boards' overarching objectives and transformational activities. The BOG is ultimately responsible for the company and provides oversight responsibility for the CCO by reviewing quality and compliance outcomes data and providing an endorsement and adoption of the collaborative CHA, CHP and CACs' work.

The CHPs reflect transformative interventions by stakeholders, community partners, internal staff and consumers in AllCare's service area. AllCare CCO sponsors three Consumer Advisory Councils (CACs) representing Curry, Josephine/southern Douglas and Jackson counties. The CAC chairs for each county, actively participate on the Board of Governors (with one of the CAC chairs being a consumer) that attend every CCO Board meeting to provide updates on CAC approved funding requests (see below), activities and consumer feedback on topics of interest or concern.

Since 2015, the Board approves a CAC budget to be dispensed every two years; these monies are distributed with a base amount that is equal in each county and secondarily funded based on CCO enrollment. Each CAC has discretionary ability to spend the dollars on projects that support Transformation activities and CHA priorities reflected in the collaborative CHP. 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.

The CCO staff that attend the CAC meetings regularly includes: the Chief Compliance and Quality Officer, Compliance and Quality Director, Oral Health 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 CHP. This greatly aides and provides guide posts for the CACs to approve requests for funding activities that reflect and align with the collaborative CHA, CHP, SHIP (Statewide Health Improvement Plan) and AllCare CCO's additional priorities. For 2020, because the collaborative CHA and CHP (in Josephine/Jackson counties), did not reflect identified consumer areas of concern, AllCare CCO developed a stand-alone CHP that includes two additional priorities: oral health and health equity.

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. Utilizing evidence-based data, 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.
Because the collaborative CHA and CHP (in Josephine/Jackson counties), did not reflect identified specific consumer areas of concern, AllCare CCO developed a stand-alone CHP (in addition to the collaborative CHP) that included two additional priorities: oral health and health equity. The AllCare CCO Board approved the collaborative CHA and CHP to formulate priorities with concerted efforts on developing social services contracts, develop a common loop referral system between community benefit organizations, data collection and validation processes while creating metrics tied to reflect potential changes in health care costs.

Historical Summary: AllCare CCO agreed to help fund and participated 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). JRHA 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 collaborative CHP 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 CHP and CHP workgroups for those counties utilizing the same process.

Though interventions may be collaborative, the different community partners will have the flexibility in the development of their CHPs 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, building on the Health Equity plan and maintaining the ACES and trauma informed programs is of paramount importance.

As stated above, the CACs in each county endorse the priorities identified in the collaborative CHA and CHP. This greatly aides and provides guide posts for the CACs to approve requests for funding activities and

projects that reflect and align with the collaborative CHA, CHP, SHIP (Statewide Health Improvement Plan), State and Federal requirements and AllCare CCO's additional priorities.

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 **managers** to be liaisons between oral health (2013), education K-12 (2013), NEMT (2014), Health Equity and housing (2016). Integrating health with stakeholders not directly related to physical, behavioral or oral 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 original rationale still holds true in order to continue the upward trajectory of improving health outcomes for AllCare members and individuals residing in the communities we serve.

The Integration Team and Health Equity Team's involvement in addressing these areas resulted in most holding governance positions or are directly involved in systems change within the areas of oral health, housing, education K-12, health equity 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 which has allowed the WIC (Women, Infants and Children) program to stay open to all eligible Josephine County pregnant women and children.

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.

AllCare's Board (aligning with the collaborative CHA and CHP) continued with the 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. 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.

As part of the ongoing recruitment of our CACs to better reflect the history/diversity of our region and to better address community needs, we are working more closely with tribes and tribal liaisons. The most notable gain has been in Curry County with an individual representing the Tolowa Dee-ni' Nation joining the AllCare Curry County CAC.

B. Review and approval of TQS

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

Response: During the summer 2019, AllCare's Leadership and Executive Team experienced extraordinary change of focus during the CCO 2.0 RFA/Remediation/Readiness Review Stage I and II process that concluded in early December with AllCare successfully attaining a 5-year contract with the OHA. However, TQS work continued with 6 projects continuing or being slightly revised and 5 projects continuing through to 2020. AllCare's TQS work groups meet to review the status and progress of projects.
To date, the projects reflect collaboration within AllCare, alignment with the collaborative CHP, AllCare CCO's additional priorities, Board strategies and support the 2020 AllCare Health Equity Strategic Work Plan. Where it makes sense, the TQS projects may align with the QI PIPs (Performance Improvement Projects).

For example, in 2020, a new Health Equity project resulted from the Health Equity and Inclusivity Action Team reviewing data and concluded that African-American AllCare CCO members have the lowest Primary Care encounter rates. The further development of a dashboard, beginning Community Engagement efforts to identify short and long terms goals to increase PCP engagement for African American AllCare CCO members.

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. Current AllCare CCO enrollment is 48,955 members. The slight variance from years' past, is a result of Primary Health not receiving a contract with OHA, and AllCare receiving their total enrollment. Contract changes in Jackson County with PrimeCare IPA resulted in AllCare losing approximately 45%. AllCare's service area is primarily rural and includes Josephine, Jackson, Curry and southern Douglas counties.
AllCare CCO continues to embrace 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." However, changes evolving from the CCO 2.0, AllCare is building on previous successes but also adhering to the 2020 contract and rule changes. AllCare 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, CHP, Board of Directors 2020 Goals, Quality Incentive and Statewide metrics, Performance Improvement Projects and the Transformation Quality Transformation (TQS) measures.

Section 2: Transformation and Quality Program Details

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

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

B. **Components addressed**

i. Component 1: Access: Quality and adequacy of services
ii. Component 2 (if applicable): Social determinants of health & equity
iii. Component 3 (if applicable): Special health care needs
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

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

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

Pregnant women are a priority population and often have special needs. Identifying at-risk expecting mothers can be challenging. AllCare traditionally has used data reporting to assist in identifying expecting mothers who may be at risk. The data may only give a partial picture of this population. This is especially true for expecting mothers who face challenges associated with social determinates of health.

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

To give us a more comprehensive identification of expecting mothers who face challenges or are at high risk the AllCare Maternal Child Health team (MCH) will develop a collaborative relationship with the Grants Pass Women's Health Center (WHC).

Preliminary meetings to this aim have already begun. It was determined the WHC performs a comprehensive physical as well as psychosocial screening on all new patients. This screening identifies women at risk. This is also true for continual assessments done at the WHC. Thus, a woman who was not identified as at risk or facing challenges during the initial assessment, may be identified later with these continual assessments. The WHC has offered to share the initial assessments with our MCH and help develop a process to communicate ongoing assessments.

Phase 1,

Develop formal process(es) to share information.

Establish communication processes with the aim of expanded communication ability and eliminate barriers.

Establish Baseline data.

Phase 2

Implement information sharing processes.

Develop process(es) to analyze and prioritize data which has been shared.

Implement enhanced communication processes.

Phase 3

Analysis of information sharing using baseline data to determine if this is providing greater identification of at risk or challenged individuals.

Analysis of enhanced communication process(es) to ensure it is satisfying the needs of both parties. Identification of any new or existing challenges.

Analysis of outcome data to determine if we are able to make a greater impact on at-risk individuals and improving outcomes.

E. **Activities and monitoring for performance improvement**: Develop formal process to share information

Activity 1 description Meeting between WHC and AllCare MCH team. Develop formal process for sharing WHC data with MCH.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Functional data sharing

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Incomplete and inconsistent sharing of risk assessment data.	Expectations set of data shared, timeliness, and consistency.	06/2020	Data consistently shared.	09/2020

Activity 2 description: Enhanced Communication Processes

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Established functional and structured communication process

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Informal communication.	Formal scheduled communication.	06/2020	Seamless and regularly scheduled communication	09/2020

Activity 2 description: Enhanced Communication Processes

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Add text here

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Incomplete and inconsistent use of data to identify at-risk or challenged expecting mothers	Consistent comprehensive use of WHC data to identify at-risk or challenged expecting mothers	09/2020	Consistent use of data to drive interventions to help at risk or challenged expecting mothers	01/2021

Section 2: Transformation and Quality Program Details

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. **Components addressed**

i. Component 1: Special health care needs
ii. Component 2 (if applicable): Social determinants of health & equity
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

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

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

By April 2020, AllCare will have re-administered the new HRS to target population, which at this time includes approx. 1300 members who are old aged with state paid care services or have developmental or physical disability (receiving SSI and services).

AllCare has also been cooperating with OHSU on a study of SDoH within our member population. Preliminary results of both sources have indicated housing and issues associated with safe housing to be the second and third most frequently reported Social Determinate challenge behind food insecurity.

Last year AllCare developed a partnership with Rebuilding Together Rogue Valley to administer a Fall Prevention program. This program has a safe housing assessment component as well as providing assistance to fix or upgrade homes to make them safer.

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

1. All members contacted reported greater independence in activities of daily living
2. All reported no visits to the Emergency Room due to falls
3. No re-hospitalizations after discharge due to falling.

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

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

Members are identified via several mechanisms.

1. Health Risk Assessment data.

2. 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.

2. AllCare Health is approaching 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, OHSU research project, 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.

3. Partnership with United Community Action Network (UCAN) to develop expanded Rent Well program. A course for members aimed at building a plan and skills to maximize their ability to rent. The program goals are member involvement in developing an individual plan and action steps working towards their goal of obtaining housing.

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

Activity 1 description Monitor impact of program and effects upon members.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: **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 2020	Analysis of results for year of 202020. Continue program and monitoring. Plan for future expansion.	06/2021

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: Monitor and evaluate program data for "self Sufficiency"

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Rogue Retreat in the initial stages of expansion into Josephine County	Evaluate Rogue Retreat's programming in Jackson County to better understand our population, care utilization, healthcare costs, and member self-sufficiency (Rogue Retreat data).	01/2021	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 (>3 months)	01/2021

Section 2: Transformation and Quality Program Details

A. **Project or program short title**: Special Healthcare needs, Improving transitions of care

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

B. **Components addressed**

vi. Component 1: Special health care needs
vii. Component 2 (if applicable): Choose an item.
viii. Component 3 (if applicable): Choose an item.
ix. Does this include aspects of health information technology? ☐ Yes ☒ No
x. If this component addresses social determinants of health & equity, which domain(s) does it address?

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

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

Hospital discharge is often a stressful and hazardous for individuals with special healthcare needs. Discontinuity and fragmentation of care yields tangible risks of harm. Research suggests up to 49% of patients experience at least one medical error (Moore, Wisnivesky et al. 2003), and 1 in 5 patients discharged from the hospital suffer an adverse event (Forster, Murff et al. 2003; Forster, Clark et al. 2004). Importantly, more than half of these adverse events are preventable. Inadequate communication was identified as a major etiology for such adverse events.

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

Collaborative project with Asante Three Rivers Medical Center (ATRMC) discharge planning and transitional care team. AllCare Transitional Care Team (TOC) will interface with hospital teams in a proactive approach to identify, plan, and collaborate prior to discharge. Members with Special needs will be identified using z codes and/or high risk check list. Additional identification could be generated by staff or referral by any source, i.e. member, PCP, family member.

Once identified, AllCare TOC will collaborate with ATRMC discharge planners and transitional care team to develop a comprehensive discharge plan in collaboration with the member and/or member's family.

Program Outline

1. Pre-discharge coordination with ATRMC staff
    a. Weekly check in
    b. Ad hoc check in
    c. AllCare staff follow members while inpatient via EHR
    d. Call by ATRMC when members are going home
2. Telephonic outreach to members discharging from Hospital
    a. Discharge checklist
    b. PCP follow up appointment
3. Accompany certain members home upon discharge
    a. Members Identified via ATRMC or AllCare staff pre-discharge as high risk, socially challenged, or in need.
    b. Make sure prescriptions are picked up
    c. Safety inspection of home
        a. Adequacy of dwelling, i.e. heat/cool source, power, water, sewer
    d. Food
        a. Assess dietary needs
        b. Assess members access to food
        c. Assess members ability to prepare food
        d. Assess all of the above going forward
        e. Make arrangements to overcome any identified challenges with food needs.
            a. Delivered meals
            b. Delivered food boxes from food bank if qualify
            c. Educate member on food resources
    e. Coordinate with any Home Health Agencies
4. Follow member for 30 days

a. Check in every 72 hours telephonically
b. Bi-weekly home visits
c. Coordinate with ATRMC staff
d. Coordinate with Home Health or other agencies

5. After 30 days if member needs continued Care Coordination
   a. Hand off to appropriate long term Care Coordination Staff
   b. Collaborate with new Care Coordinator
   c. Notify member and introduce new Care Coordinator.

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

Activity 1 description Improved Communication and collaboration

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: The two teams will set up and carry out regular communication and collaboration.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Little to no communication between ATRMC staff and AllCare Staff	Regular productive communication and collaboration	06/2020	Refined consistent and productive communication and collaboration	01/2022

Activity 1 description Improved Transitional Outcomes

☒ Short term or ☒ Long term

Monitoring activity 1 for improvement: TOC team will track all members participating in this program. Members will be assessed at 30 days, 3 months, and 6 months for readmission to hospital, satisfaction with discharge process, continued needs, and overall opinion of the program.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
9.1 % overall readmission rate for entire member population.	8.5% Readmission rate.	01/2021	8% overall readmission rate	01/2022

Section 2: Transformation and Quality Program Details

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

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

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

B. **Components addressed**

xi. Component 1: Utilization review
xii. Component 2 (if applicable): Choose an item.
xiii. Component 3 (if applicable): Choose an item.
xiv. Does this include aspects of health information technology? ☒ Yes ☐ No

xv. If this component addresses social determinants of health & equity, which domain(s) does it address?

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

C. **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 a committee dedicated to reviewing data to look closely at the utilization of services and make recommendations to improve benefit administration.

D. **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 and 2019. We intend to look for ways to develop a dashboard or program that will identify services in these categories that will allow us to be proactive instead of reactive to changes in utilization in 2020. A previous TQS project included creating an appropriate report to monitor and analyze second opinions. This report has been established and therefore the previous project was closed, however second opinions will now be monitored under this new utilization committee.

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

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

Activity 1 description (continue repeating until all activities included): We have successfully implemented a way to track second opinion requests coming through our provider portal. We will now look for trends in requests to identify gaps and areas that need improvement on a biannual basis.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Second opinion monitoring will continue through the UMCPGURC committee.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Data pulled for years 2018 and 2019.	Analysis of 2018-2019 second opinion data.	06/2020	Data pull for first and second quarters 2020	09/2020

Activity 2 description: Improve access to PrEP by increasing education to members and provider offices. AllCare has implemented and completed several community outreach events to increase awareness of the availability of PrEP. These have been targeted to both members and providers.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Increasing use of PrEP will continue to be monitored through the UMCPGURC committee on a monthly basis.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Training and education event planned in Illinois Valley	Training and education event completed in Illinois Valley	01/2020	Training and Education event in Grants Pass	04/2020
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Monthly CEU webinars for AIDS education training center (AETC) for providers and their staff	Continue ongoing trainings	06/2020	Continue ongoing trainings	12/2020

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components 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. **Components addressed**

xvi. Component 1: Grievance and appeal system

xvii. Component 2 (if applicable): Choose an item.

xviii. Component 3 (if applicable): Choose an item.

xix. Does this include aspects of health information technology? ☐ Yes ☒ No

xx. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education

☐ Neighborhood and build environment ☐ Social and community health

C. **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.

D. **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

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

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

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: In 2019 there were zero complaint from member regarding the written material from the Health Plan or the provider. In 2019 AllCare CCO launched the Health Literacy 2.0 training. This was the second layer to the Health Literacy 1.0 that was offered in 2018. The focus on Health Literacy 1.0 was to provider staff, providers and vendors with an introduction to what Health Literacy is. In Health Literacy 2.0 AllCare CCO went on to educate staff, providers and vendors on how to write communications to members with a focus on meeting the member at their level of understanding. AllCare provided training in 2019 to 60 number of staff and to two sub-contractors (NEMT and Behavioral Health). Since the training, the improvement in letters from these two entities have improved in the readability and understanding of the written communication. Furthermore, AllCare monitors on a quarterly basis the sub-contractors Notice of Adverse Benefits letters.

However, with the monitoring of complaints, it was noted that there were 10 complaints about providers and the plan having inadequate or incomplete explanation or instructions. In review of the 10 complaints, the communication to the member was all verbal communication.

Baseline or current state	Target/future state		Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
15 Plan Complaint	10		12/31/2019	5	12/31/2020

Activity 2 description: Plan Verbal Communication

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Based on the number of complaints regarding providers and the plan having inadequate or incomplete explanation or instructions, AllCare CCO will begin to develop educational material for the staff and our providers on how to communicate verbally with a member and implement the STEP process and chunk and check methods.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
10 plan complaints	5	12/31/2020	5	12/31/2021

Section 2: Transformation and Quality Program Details

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

A. **Project or program short title**: Warm handoff from acute psychiatric hospitalization

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

B. **Components addressed**

xxi. Component 1: Behavioral health integration

xxii. Component 2 (if applicable): Serious and persistent mental illness

xxiii. Component 3 (if applicable): Choose an item.

xxiv. Does this include aspects of health information technology? ☒ Yes ☐ No

xxv. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education

☐ Neighborhood and build environment ☐ Social and community health

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

AllCare CCO would like to build on the work and gains that have been made with the Oregon Performance Plan (OPP), particularly focusing on the Warm Handoff measure. OHA's Warm Handoff goal for end of year three (June 30, 2019) was that 85% of individuals discharged from an acute care psychiatric facility will receive a warm handoff to a community case manager, peer bridger or other community provider prior to discharging. The OHA's most recent data shows that the statewide percentage for this measure is about 40%. AllCare CCO will engage with our regional psychiatric hospitals and community providers to continue this goal and meet or exceed 85% for our membership meeting the OPP specifications.

AllCare CCO would like to build on the work and gains that have been made with the Oregon Performance Plan (OPP), particularly focusing on the Warm Handoff measure. OHA's Warm Handoff goal for end of year three (June 30, 2019) was that 85% of individuals discharged from an acute care psychiatric facility will receive a warm handoff to a community case manager, peer bridger or other community provider prior to discharging. The OHA's most recent data shows that the statewide percentage for this measure is about 40%. AllCare CCO will engage with our regional psychiatric hospitals and community providers to continue this goal and meet or exceed 85% for our membership meeting the OPP specifications.

AllCare CCO believes in coordination between agencies for improved member care and we also value community integration at all levels for our members experiencing serious mental illness. Members who have been hospitalized for psychiatric reasons especially need this coordination and integration. AllCare has spent a significant amount of time and coordination for our members that have been hospitalized for psychiatric reasons over the past several years. We have kept similar measures in our Behavioral Health VBPs since the conclusion of the CCO Incentive Measure. In 2018, 91% of our AllCare CCO members received follow-up after hospitalization for mental Illness within 7 days. Additionally, 68% of those members received further follow up within 30 days after their discharge from acute psychiatric care. We view the inclusion of the warm handoff as a meaningful addition to the discharge plan. Although we have a high rate of follow ups, we have experienced difficulty in making meaningful contact with some members after they have already discharged from the hospital. Most often this initial follow up is a call from a mental health clinician, which may not be the most effective approach for some members. Warm handoffs might help to engage a population we aren't reaching now through the follow up measure. Ideally, it also improves the success of those already participating in follow up visits since the handoffs happen prior to discharge, are face to face and are with a coordinator or peer. Ideally, our assessment and engagement in the warm handoff process will help to build connections between the member and their care team before they are discharged in hopes of improved engagement in initial and ongoing treatment.

Project or program brief narrative description:

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

"Warm Handoff" means the process of transferring a patient from an acute care psychiatric hospital to a community provider at discharge, that involves face-to-face meetings with the patient, either in person or through the use of

telehealth, and coordinates the transfer of responsibility for the patient's ongoing care and continuing treatment and services.

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

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

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

☒ Short term or ☐ Long term

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

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Informal warm handoff prior to discharge for members in acute psychiatric hospitals.	Approved Policy and Procedure for Warm Handoff and Discharge Planning from acute psychiatric hospitals.	03/2020	Warm handoff policy and procedure in place that is updated regularly to reflect improvements to the program.	03/2020

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

☒ Short term or ☐ Long term

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

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No formal process, workflow or documentation exists for warm handoffs.	Internal processes and assignments are in place. Workflows are in place.	03/2020	Workflows are in place. Staff are assigned for each task. Tracking of warm handoffs has been developed.	03/2020

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

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Community partners participate in the warm handoff program.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No formal process, workflow or documentation exists for warm handoffs and are not disseminated to treatment partners.	AllCare's processes, workflows and responsible staff shared with our local acute psychiatric hospitals and community partners.	06/2020	A community warm handoff process is agreed upon and documented. There is an avenue in place for the group to provide ongoing assessment and evaluation of the warm handoff program and adjust when needed.	06/2020

Activity 4 description: Create a monitoring and tracking process

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: AllCare CCO tracks and reports out on all warm handoffs offered, declined and completed

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No baseline data for percentage of members offered a warm handoff from acute psychiatric care. Only have data on hospital follow up services in our claims system.	Track data for first year to get a baseline.	1/2021	A baseline is established for members offered, declining and receiving warm handoffs.	01/2021

Activity 5 description: Execute reporting process

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Test reporting to ensure it is working.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No baseline data for percentage of members that received a warm handoff from acute psychiatric care. Only have data on hospital	Have a year of data to develop a benchmark and improvement target.	1/2022	AllCare has procedure, data and improvement targets established and is able to build upon these annually.	01/2022

follow up services in our claims system.				

Section 2: Transformation and Quality Program Details

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

A. **Project or program short title**: CLAS Standards Project 1: Provider training program to increase the use of Medically Certified Interpreters.

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

B. **Components addressed**

i. Component 1: Access: Timely
ii. Component 2 (if applicable): CLAS standards
iii. Component 3 (if applicable): Access: Cultural considerations
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

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

C. **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.

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

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

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

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

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

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: As part of AllCare's organizational and Provider Network Cultural Responsiveness and Implicit Bias Training and Education Plan. CURRICULUM FIVE – INTERPRETER SERVICES trains providers and staff on how to work with, and access Interpreter Services.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Training has been created and all internal employees	Train ten (10) provider	12/2020	Two (2) organizations trained each quarter.	04/2021

are being offered the training.	organizations in the training			

Activity 2 description: OHA Contractual Language Services Reporting Template

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Quarterly AllCare will submit a Language Services Report to OHA. AllCare participated in the pilot study for this program. AllCare was able to identify all individuals identified by OHA that needed Interpreter Services, in addition to eight (8) individuals not identified. 29% of individuals in the pilot period had an Interpreter that was OHA Certified or Qualified.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
29% of Limited English Proficient Individuals had an Interpreter that was OHA Certified or Qualified at the encounter.	Increase the individuals that had an Interpreter that was OHA Certified or Qualified at the encounter each quarter by 10%	4/1/2021	52%	4/1/2024

Section 2: Transformation and Quality Program Details

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

A. **Project or program short title**: Patient-Centered Primary Care Home (PCPCH)

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

B. **Components addressed**

a. Component 1: Patient-centered primary care home
b. Component 2 (if applicable): Choose an item.
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☒ Yes ☐ No
e. If this component addresses social determinants of health & equity, which domain(s) does it address?

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

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

AllCare CCO recognizes and believes that by rewarding high quality, efficient care we can support our providers and most importantly, our members, in achieving better health outcomes. This is the basis for our PCPCH strategy.

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

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

AllCare CCO incentives provider offices for PCPCH recognition based on tier level, panel size, and geographical location. PCPCH payments are made using a per-member-per-month (pmpm) model and are issued on a quarterly basis.

Because clinics recognized at higher tier levels: 1) demonstrate an increased level of quality, patient engagement and care coordination; 2) have an increased focus on whole-person care and care for members with special healthcare needs and; 3) align with a greater number of measures (as outlined in the PCPCH Core Attributes), pmpm rates increase for these clinics.

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

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

☐ Short term or ☒ Long term

- **Monitoring activity 1 for improvement**: AllCare CCO will monitor member assignment among both PCPCH, and non-PCPCH provider offices by:
    - As with recognized clinics, member assignment will be prioritized by those performing at higher levels.
    - We will explore setting thresholds for providers who fall below specific quality benchmarks. Those providers will not be permitted to receive member assignment until they have improved quality and/or engaged in the PCPCH program.
    - We will utilize internal quality data and compare it with the 'PCPCHLockedList' to identify unrecognized clinics.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
80.16%	3% increase from Baseline	12/2020	85%	12/2021

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

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: AllCare CCO will monitor those clinics that are currently not recognized as well as those who have an opportunity to increase their tier level.

- AllCare CCO will continue to pursue non-PCPCH clinics for recognition by:
    - Sending letters/emails and making phone calls to explain the role of the PPC and the impact of participation in PCPCH on patient and clinic outcomes.
    - Offer technical assistance in the following ways:
        - Providing education on the PCPCH program and provide an example their potential incentive amount should they become recognized at the various tier levels.
        - Utilizing the PCPCH Technical Assistance Guidebook to assess clinic needs, barriers, and areas of improvement needed to help practices successfully implement PCPCH standards.
        - Make work-flow recommendations to better align practices with measure intent and purpose.
- AllCare CCO will assess whether or not the clinic score/tier level accurately reflects quality performance.

- AllCare CCO will encourage clinics to adopt a team-based approach to care and embrace new processes such as care coordination, while also using EHR and claims data to drive actions, resulting in better health outcomes.
- AllCare CCO will focus on increased understanding of organizational conditions and workflow improvement activities of high performing clinics.
- AllCare CCO will provide on-site support and technical assistance to offices.
- AllCare CCO will stay informed of changes to PCPCH program (quality measures, standards for tier level recognition).

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
PCPCH Clinics Not recognized: 6 Tier 1: 0 Tier 2: 0 Tier 3: 3 Tier 4: 32 5 STAR: 2	3 clinics to increase recognition tier level.	12/2020	TBD – will update when new PCPCH TA guide is released.	TBD

Section 2: Transformation and Quality Program Details

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

A. **Project or program short title**: Identify and support increased access to oral health services and integration with behavioral and physical health services.

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

B. **Components addressed**

a. Component 1: Oral health integration
b. Component 2 (if applicable): Access: Quality and adequacy of services
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☒ Yes ☐ No
e. If this component addresses social determinants of health & equity, which domain(s) does it address?

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

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

Oral Health is an essential component of comprehensive primary care. The integration of oral, behavioral, and physical health care is central to our goals of providing whole-person, coordinated care and promoting health equity. A growing body of evidence shows that oral health is critical to overall health. Research suggests that gum disease and other oral health conditions are associated with heart disease, diabetes, low birth weight and certain types of cancers. Poor oral health also contributes to missed school and work days, and can have a negative impact on overall well-being. In short, the mouth is connected to the body and an important part of whole body health.

Access to oral health services is an important issue for all. Low-income individuals are disproportionally likely to experience poor oral health which can lead to poor overall health and lost income and productivity. Populations of color, who are disproportionately represented on Medicaid, face even worse health outcomes. A recent study found that 1 in 12 (8%) low-income Oregon adults reported missed work days due to the condition of their mouth and teeth. In the

same study, four times as many low-income adults reported reducing participation in social activities due to the condition of their mouths compared with middle and high-income adults.

Project or program brief narrative description:

AllCare CCO plans to assess and address oral health integration into our physical health and behavioral health clinics. AllCare CCO's Oral Health Integration Manager will work with our oral health partners and internal staff/teams responsible for the care coordination between the oral health providers in the physical and behavioral health clinics and our staff. AllCare CCO staff will coordinate with the oral health providers to coordinate and work with these partners to build professional relationships and will continuously evaluate and adjust procedures as needed so we all remain efficiently working together for the member's benefit. AllCare CCO will collect data on the number of members seen at the clinics and the referrals made to the dental homes on an ongoing basis to establish a baseline, develop benchmarks and improvement targets and to continue to monitor this Transformation and Quality program for outcomes.

AllCare CCO plans to address access and quality and adequacy of services in the areas we serve. AllCare CCO's Oral Health Integration Manager will work with our clinics to integrate and provide services to areas that experience a high Health Provider Shortage Area, or HPSA score. Currently, this includes Josephine and Curry Counties. AllCare CCO will work with the staff at the physical health and behavior health clinics, as well as the School Based Health Centers to increase oral health access to these areas. These efforts will promote continued coordination between our community partners and will help build the professional relationships necessary to provide the best care for the members.

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

Activity 1 description (continue repeating until all activities included): AllCare CCO will increase oral health integration activities in physical and behavioral health clinics.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Work with current and future oral health integration staff and physical and behavioral health clinic sites.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Currently oral health services being done at Options (Behavioral Health in Grants Pass) and Grants Pass Clinic (Primary Care Clinic).	Identify future opportunities for oral health integration	03/2020	Identify 2 approved sites for oral health providers, will monitor for future need.	03/2020

Activity 2 description: AllCare CCO will develop internal and external workflows. AllCare will work with our oral health partners to ensure the workflows are in place including referrals to dental homes.

☒ Short term or ☒ Long term

Monitoring activity 2 for improvement: Documented processes and workflows written and completed for clinic staff and oral health providers.

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

No formal process, workflow or documentation exists for oral health integration in clinics.	Internal and external processes and workflows are in developed and rolled out.	06/2020	Oral Health providers will follow processes as designed. AllCare will monitor quarterly.	09/2020

Activity 3 description: AllCare CCO will work with external partners to identify clinics for implementation of tele-dentistry at some rural and remote locations.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Confirmation of oral health services at targeted clinics.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Lack of oral health providers at most rural primary care clinics.	AllCare will work with clinics to identify opportunities to place an oral health provider utilizing tele dentistry.	06/2020	An oral health provider is identified, equipment ordered and placed in clinic for tele dentistry.	09/2020

Activity 4 description: AllCare will monitor utilization of members seen at integrated clinics

☐ Short term or ☒ Long term

Monitoring activity 4 for improvement: AllCare CCO will monitor member utilization by quarterly utilization reports.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Develop reports around utilization and develop a baseline.	Track data for first year to get a baseline.	1/2021	Baseline results are established for members utilizing services at integrated clinics, as well as referrals to dental homes, and targets of 5% annual increases will be set for both measures increase in the number of members receiving oral health services in identified clinics.	01/2022

Section 2: Transformation and Quality Program Details

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

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

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

B. Components addressed

a. Component 1: Health equity: Data
b. Component 2 (if applicable): Health equity: Cultural responsiveness
c. Component 3 (if applicable): Access: Cultural considerations
d. Does this include aspects of health information technology? ☒ Yes ☐ No
e. If this component addresses social determinants of health & equity, which domain(s) does it address?

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

C. Background and rationale/justification:

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

D. Project or program brief narrative description:

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

The Oregon Health Authority has identified institutional bias as one of the strategic priorities for 2020-2025. https://www.oregon.gov/oha/PH/ABOUT/Pages/institutional-bias.aspx

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

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

E. Activities and monitoring for performance improvement:

Activity 1 description Establish Dashboard

☒ Short term or ☐ Long term

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

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Inequity identified and approved as project.	Dashboard established and reported to Allcare and Stakeholders	04/01/2020	Clear expectations on Dashboard and establishing a quarterly vs annual review	6/1/2020

PCP Visits by Race

		Mbrs w/ a Visit	Members			
African American/Black		**1016**	**1699**	**59.8%**	**OVERALL**	**Difference**
	2016	243	398	61.1%	66%	-4.5%
	2017	235	420	56.0%	67%	-10.8%
	2018	263	427	61.6%	70%	-8.8%
	2019	275	454	60.6%	70%	-9.1%
American Indian/Alaskan Native		**1967**	**2850**	**69.0%**		
	2016	505	751	67.2%	66%	1.7%
	2017	498	730	68.2%	67%	1.5%
	2018	489	675	72.4%	70%	2.1%
	2019	475	694	68.4%	70%	-1.2%
Asian American		**873**	**1385**	**63.0%**		
	2016	222	380	58.4%	66%	-7.1%
	2017	210	341	61.6%	67%	-5.1%
	2018	221	330	67.0%	70%	-3.4%
	2019	220	334	65.9%	70%	-3.8%
Hawaiian/Pacific Islander		**434**	**697**	**62.3%**		
	2016	108	181	59.7%	66%	-5.9%
	2017	106	181	58.6%	67%	-8.2%
	2018	101	159	63.5%	70%	-6.8%
	2019	119	176	67.6%	70%	-2.0%
Hispanic/Latino		**8862**	**13207**	**67.1%**		
	2016	2605	4082	63.8%	66%	-1.7%
	2017	2064	3115	66.3%	67%	-0.5%
	2018	2074	2984	69.5%	70%	-0.8%
	2019	2119	3026	70.0%	70%	0.4%
White		**86610**	**126991**	**68.2%**		
	2016	23464	35811	65.5%	66%	0.0%
	2017	21388	32111	66.6%	67%	-0.1%
	2018	20783	29260	71.0%	70%	0.7%
	2019	20975	29809	70.4%	70%	0.7%
Other Race		**1525**	**2481**	**61.5%**		
	2016	536	946	56.7%	66%	-8.9%
	2017	359	599	59.9%	67%	-6.8%
	2018	317	464	68.3%	70%	-2.0%
	2019	313	472	66.3%	70%	-3.3%
Unknown		**70754**	**103572**	**68.3%**		
	2016	14457	21765	66.4%	66%	0.9%
	2017	18030	26784	67.3%	67%	0.6%
	2018	19245	27518	69.9%	70%	-0.4%
	2019	19022	27505	69.2%	70%	-0.5%

Activity 2 description: Community Engagement

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Work with OHA, Regional Health Equity Coalition, and local community to establish project goals.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Approved to add to Health Equity Strategic Plan	Three clear interventions established with community	12/2020	Increase African American PCP visits to within 5% of the overall average.	12/2021

Section 2: Transformation and Quality Program Details

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

F. Project or program short title: Increased availability of Chiropractic Services in Jackson County

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

G. Components addressed

i. Component 1: Access: Timely
ii. Component 2 (if applicable): Access: Quality and adequacy of services
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

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

H. Background and rationale/justification:

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

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

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

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

I. Project or program brief narrative description:

AllCare CCO will engage in dialogue with the Jackson County Chiropractors to gain a better understanding of what drives longer wait times in the county. We will begin Provider engagement within the county to educate Chiropractors on our expectation of timely access. AllCare will determine network adequacy in Jackson County without those providers deemed to have unacceptable wait times. Consideration will be given to reducing the size of the panel by eliminating those providers that are unwilling to take corrective action to bring wait times down. Monitoring of wait times will be done monthly to assess progress toward targeted improvement levels.

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

Activity 1 description (continue repeating until all activities included): Determine the provider offices that have wait times greater than two weeks, and complete a network analysis to see if the network is sufficient without these providers.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Monthly Network Adequacy Analysis

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

Activity 2 description: Primary Care Engagement

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Chiropractor Claims Analysis

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No baseline utilization data established	Establish a baseline report of Chiropractors that are being utilized within Jackson County.	07/2020	For Chiropractors that are not being utilized, begin outreach for increased capacity. For those that can accept increased Capacity, develop a notification for Jackson County Primary Care Providers	12/2020