Section 1: Transformation and Quality Program Information

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

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

Columbia Pacific CCO (also called Columbia Pacific or CPCCO) is a wholly owned subsidiary of CareOregon, and has two contracts with CareOregon: one to provide administrative and health plan services to the CCO and the other to manage the insurance risk for physical health services and, in mid-2019, behavioral health services. In the context of the Transformation and Quality Strategy (TQS), CPCCO is ultimately accountable for the submission of the TQS as a CCO contractual requirement, but responsibility for each of the twelve TQS components is determined by the administrative agreements between CareOregon and the CCO. CareOregon administers the following health plan services to CPCCO for physical and behavioral health : utilization monitoring (TQS 1d, 11), quality of care outcomes (TQS1c), member services including translation and interpreter services (TQS 2), grievance system inclusive of complaints, notices of actions, appeals and hearings (TQS 3), provider relations and quality monitoring (TQS 1c), monitoring and enforcement of consumer rights and protections, and assessment of the effectiveness of the fraud, waste and abuse program. CareOregon also supports and administers the CPCCO IT infrastructure (TQS 5a, 5b, 5c), assures and monitors network adequacy (TQS 1a, 1e), administers value-based payment models (TQS 12), and supports the Equity and Diversity Department (TQS 4a, 4b). CareOregon is responsible for ensuring that delegates of all CCOs and lines of business are provided appropriate oversight and are operating in full compliance with state and federal regulations. The CPCCO Board receives reports from CareOregon at least semi-annually that include but are not limited to: Appeals and Grievance analysis, Utilization Management Monitoring, Delegation Oversight status and any relevant Corrective Action Plans, outcomes of the state External Quality Review and the progress of the TQS. The CPCCO Medical Director sits on the CareOregon Quality Management Committee (described below) to provide alignment between CPCCO and CareOregon.

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):

The CPCCO Board of Directors oversees the development and implementation of the strategic plan for CPCCO and is accountable for setting performance expectations for the CCO, which include metrics for quality and transformation. The Clinical Advisory Panel (CAP), at the direction of the Board, provides the strategic leadership and direction for clinical transformation. The CAP ensures CPCCO's clinical transformation efforts and quality priorities are strategically aligned with those of its constituent organizations, the CPCCO community advisory council as well as the CPCCO board, and that these efforts have the active support of clinical and executive champions at the highest organizational and community levels. The CAP has developed a strategic approach to quality that combines the CPCCO Board's strategic plan, the state mandated TQS components, clinical priority initiatives, and Performance Improvement Projects (PIPs) into a defined set of well-articulated goals to improve and transform the health and wellness of the CPCCO population. The TQS is reviewed and executed by the CPCCO CAP and, for relevant work, CPCCO's local Community Advisory Councils (CACs). The 2019 TQS will focus on the following clinical strategic priorities: achievement of CCO Incentive Measures; continued advancement of regional improvements in opioid prescribing, development of additional services to address SUDs and alcohol abuse, focus on tobacco cessation, continued training and programs to reduce health disparities especially through improvements in interpretation services, and implementation of strategies addressing high risk patients and high cost practices. Columbia Pacific CCO has three local and one regional Community Advisory Council (CAC). These CACs develop and decide the health improvement priorities of the regional Community Health Improvement Plan (CHIP), decide funding of community initiatives to address those priorities and decide and oversee community work to help achieve quality metrics and PIPs. See more, below.

All three CPCCO governance entities – the Board of Directors, CAP and CACs – have developed their respective Equity Plans and trainings for 2019. These activities are described elsewhere in the TQS.

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

CPCCO has four community-focused governance committees: three local CACs and one regional CAC. All of the four CACs have met the requirement of 51% OHP consumer participation. As such, these councils play a critical role in communicating member needs, preferences and health improvement priorities to the CPCCO Board and staff. The Regional CAC meets annually with the full Board, and there is monthly bi-directional communication between these governance bodies. All CACs play a role in developing and advancing the Community Health Needs Assessment (CHA) and Community Health Improvement Plan (CHIP). In addition, the local CACs play a role in quality improvement through several specific accountabilities: 1) reviewing and approving funds from the CCO to support health improvement initiatives spelled out in the CPCCO CHIP; 2) selecting and implementing county specific projects to help the CCO achieve its Incentive Metric targets or PIP goals; and 3) developing community education campaigns and/or coordinating with other local health and wellness campaigns in each county.

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

In addition to the community connections mentioned above, through the CAP for clinic and health system transformation, and through the CACs for community-based interventions, CPCCO has developed direct partnerships with all major clinics and safety net organization in each county. The CCO is working with the three local Public Health departments, the state and other community agencies on improving rates of childhood immunizations and harm reduction programs, leveraging opportunities for risk assessment through home visiting programs (medical and housing), prevention of chronic disease and addictions, and integrating behavioral, medical and oral health services through co-location, alternative payment models and shared care plans. Finally, the executive director of CPCCO is also the Co-Chair of the NW Regional Early Learning Hub, allowing a stronger connection between early childhood health and kindergarten readiness. Several initiatives have been enabled through this partnership including strengthening the assessment and treatment of developmental delays, parenting supports, and integration of ACEs interventions and training in local schools.

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

The annual CPCCO TQS process leverages the CareOregon quality governance structure and staffing to ensure the CCO consistently meets its contractually required OHA deliverables. Senior CO staff partner with CCO Leadership teams and CareOregon department leaders to interpret the TQS requirements, establish timelines for completion, and ensure that TQS projects, programs, and performance improvement activities are aligned with the applicable OHA guidance and CCO contractual language. The CPCCO Transformation Specialist is responsible for creating content and overseeing deliverables for programs included in the TQS. The TQS is reviewed and executed by the Columbia Pacific CCO Clinical Advisory Panel (CAP) and, for relevant work, CPCCO's local Community Advisory Councils (CACs).

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:

As described above in Section 1A, CPCCO is wholly owned by CareOregon. Founded in 1993, CareOregon is a nonprofit, community benefit company serving almost 300,000 Oregon Health Plan and Medicare members and their communities with integrated managed care services. CareOregon owns Jackson Care Connect

(JCC) and Columbia Pacific CCO (CPCCO), and partners as a risk-accepting entity with HealthShare CCO (HSO). In addition to a Medicare D-SNP plan, CareOregon Dental, and HouseCall Providers (HCP), CareOregon maintains collaborative relationships with all nine Sovereign Tribal Nations and NARA, and also provides care coordination services for and in conjunction the nine Sovereign Tribal Nations across the state providing services to approximately 18,000 tribal members. CareOregon partners with the Tribes to offer culturally appropriate services. Together, the collective organizations and programs that comprise CareOregon focus on the total health of members, over and above traditional health care. CareOregon connects with members, their families, providers and communities to help Oregonians prevent illness, respond effectively to health issues and live better lives.

CareOregon's Quality Management Program is operationalized through the Medical Management department at the direction of the Chief Medical Officer, who is delegated by the Board to be the accountable executive of the quality program. This accountability occurs through CareOregon's Quality Management Committee (QMC) as well as through integrating responsibility for quality in key positions throughout the organization, including (but not limited to):

- CMO
- Senior Medical Director, Health Services Operations
- Regional Medical Directors, Dental Director
- Executive Director, Pharmacy
- Director, Behavioral Health and Integration
- Manager, Quality Assurance Operations
- Director, Clinical Operations

The CPCCO Board receives reports from CareOregon at least semi-annually that include but are not limited to: Appeals and Grievance analysis, Delegation Oversight status and any relevant Corrective Action Plans, outcomes of the state External Quality Review and the progress of the TQS. The CPCCO Medical Director sits on the CareOregon QMC to provide alignment between CPCCO and CareOregon.

In mid-2019, CPCCO will integrate management of both the physical health and behavioral health benefits at CareOregon. By removing delegation of the Behavioral Health benefit from GOBHI, CPCCO will be best positioned to meet the new OHA requirements in CCO 2.0, RFA Attachment 11, and more meaningfully braid funding and programmatic interventions for provision of mental health and addictions services for CPCCO members. See CPCCO's RFA submission materials for details regarding the improvements expected going into 2020.

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**: Access Project 1a: Mobile Dental Home

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: Integration of care (physical, behavioral and oral health)
ii. Additional component(s) addressed: Access 1e: Timely
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: 1e. Access Timely

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

Oral health is important component of overall healthcare; and we believe people are healthier when their physical, mental, and oral health works together. We do this by focusing on coordinating care, encouraging innovation, improving community health and promoting healthy choices, and these choices allow our members to smile brightly.

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

We open a mobile dental home in November 2017 and began providing restorative and urgent services on Fridays. Located in the parking lot of the Legacy Medical Group clinics St. Helens (500 North Columbia Highway, St. Helens) this mobile home has been a well-received and innovative program to co-located dental and medical services, in a central, convenient location. CPCCO has worked to ensure the mobile dental home is available and open for business each week. DCOs have sent letters to members informing them of the mobile dental home, its location, hours of operation and available services.

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

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

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Quarterly Utilization Reviewed by DCOs

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Create quarterly utilization reports	Quarterly report created and reviewed	12/2019	10% increase in number of mobile dental visits	12/2019

A. **Project or program short title**: Heath Equity Project 4b: Improved Interpreter Access

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

B. **Primary component addressed**: Health equity

iv. Secondary component addressed: Access

v. Additional component(s) addressed: Health Equity Data, CLAS Standards and Provider Network

vi. If *Integration of Care* component chosen, check all that apply:

☐ Behavioral health integration ☐ Oral health integration

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

ii. Additional subcomponent(s) addressed: Health Access: Cultural Considerations

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

Language can be a major barrier to accessing health services for many. There is a well-documented body of evidence that shows a patient inability to communication meaningfully with their health care team leads to poor outcomes, and increased spending.

The CCO has heard through Limited English Proficiency (LEP) members and that interpretation has been a struggle in the region. To improve Columbia Pacific has taken an approach that includes:

- Education for members and healthcare facilities
- Improved access by increasing the number of interpreters in the region

- Spread of Clinical Best Practices for how to work with an interpreter

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

Upon hearing of interpretation issues the CCO began outlining steps that will bring more quality comprehensive, standardized, and well-publicized services to LEP members.

First, we reviewed current state to see that utilization and capacity for our vendor needed improvement. To improve we brought in one new vendor and created an at-risk contract with performance metrics for no-shows, complaints, and achieving 80% in person interpreter service rate. To implement and monitor for 2019 Columbia Pacific has bi-weekly recurring meeting with vendors to review utilization and quality reports.

In quarters 1 and 2 of 2019, vendors will go on a roadshow with all clinics; primary care, community mental health providers, and dental. The roadshow will work to educate providers about the service and how to access, member rights in regards meaningful language access, and best practices for how to work with an interpreter.

In quarters 3 and 4, Columbia Pacific CCO will distribute OHA Language access cards to LEP patients and clinics. We will work to educate the LEP community about language rights through mailings and working with cultural specific organizations that have been active in working to support the LEP community.

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

Activity 1 description (continue repeating until all activities included): Vendor meetings for quality and utilization review

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Bi-Weekly Meetings

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Set for one vendor, in process for second	Bi-weekly meetings	04/30/2019	Monitoring plan for vendor management	12/31/2019

Activity 2 description: Reporting

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Utilization and Capacity reports

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Monthly Utilization and Capacity reports shared by vendors	Reports that show utilization and capacity by; A. Language B. County C. Clinic	06/30/2019	Ensure capacity for 80% in person interpretation target.	12/31/2019

A. **Project or program short title**: Access Project 1c: Low Value Care

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

B. **Primary component addressed**: Access

vii. Secondary component addressed: Value-based payment models
viii. Additional component(s) addressed: Add text here
ix. 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

iii. Additional subcomponent(s) addressed: Add text here

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

Unnecessary healthcare utilization and wasteful care delivery represent a significant portion of healthcare spending. This is spending that could be decreased while improving health outcomes. A recently published JAMA article detailed data in Washington state and health care waste, estimating that 44% ($258 million) of health care services are wasteful. This is furthering the analysis previously detailed in a 2012 article in JAMA by Don Berwick and others who cited 6 areas of medical waste accounting for a conservative estimate of over 20% the total cost of health care expenditures:

- Overtreatment
- Failures of care coordination
- Failures in execution of care processes
- Administrative complexity
- Pricing failures
- Fraud and abuse.

Data from Washington state notes that most of the wasteful expenditures are driven by 11 of the 47 low-value care practices identified, such as: frequent cervical cancer screening, preoperative lab testing, EKG, CXR, PFT for low risk patients, antibiotics for URI, cardiac stress testing, imaging for uncomplicated headache etc.

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

CPCCO has discussed the concept of low value care as a cost containment strategy as well as a quality improvement strategy. The Clinical Advisory Panel and Medical Leadership group has started discussions to develop areas of focus and develop a strategy to address low value care. To assess the appropriate area of focus, Columbia Pacific analysts created a specialty referral dashboard to explore specialty utilization patterns and provide patient list for chart review and learning. Dashboard can be reviewed by specialty, PMPM, and primary care clinic assignment. In addition, we developed data regarding imaging rates within the region and between organizations.

Upon clinical review of data our regional medical directors advised on a focus of Orthopedic referrals, spine MRIs, knee and shoulder scopes, and knee arthroscopy. In 2019, we will continue to expand our ability to analyze utilization data in the context of low-value care, and continue to move this strategy into implementation phase. We will confirm with our CAP that the goals and areas of foci are clinically actionable. Our goal will be to develop continual dashboards regarding specialty referrals and imaging, and work with primary care and specialty organizations to move towards developing systems and processes to address low value care.

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

Activity 1 description (continue repeating until all activities included): Risk Agreements with Quality Monitors

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Pay for performance

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
2 counties in risk share agreements	3 counties in risk share agreement Or Individual organizations in each county obtain risk share agreement	01/01/2020	Spine/knee/shoulder – 15% reduction New face to face specialty referrals – 10% reduction Knew arthroscopy reduction <1% Partner with network to implement at least 1 choosing wisely recommendation in 2 organizations	01/01/2020

A. **Project or program short title**: Special Health Care Needs Project 10: ASQ Follow Up

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

B. **Primary component addressed**: Special health care needs

x. Secondary component addressed: Health information technology

xi. Additional component(s) addressed: Integration

xii. If *Integration of Care* component chosen, check all that apply:

☐ Behavioral health integration ☐ Oral health integration

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

iv. Additional subcomponent(s) addressed: Add text here

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

With the inclusion of ASQ screening measure we have seen screening rates increase quickly however we have not seen a proportional increase in referral to EI services. To investigate further we have funded a 24-month proposal to improve the receipt of services for young children identified at-risk for developmental and behavioral delays.

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

The work is being done in two phases. First a cross-sector stakeholder meeting with representation from Community Mental Health Providers and PCPs in each county occurred to get baseline data collection about current process and where children are lost to follow up. Second, taking the learnings from the stakeholder meeting, a new process will be developed for referral to and coordination of processes meant to ensure early receipt of services that help at-risk young children be ready for kindergarten.

At the end of the project tools will be developed to support the spread of innovation more fully across all three counties in the region so all practices can use the tools and will receive support from practice coaches to implement. The following tools will be developed by the end of 2019;

- A toolkit for Primary care
- EI referral and care coordination methods
- Family Resources for early learning providers

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Pilot sites screen rates

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Developmental Screening Completed

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
85.75%	90%	12/2019	95%	06/2020

Activity 2 description: Pilot sites children at risk and referred for follow up

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Follow up for at risk ASQ – 2 or more in black

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
4.5%	80%	12/2019	100%	06/2020

A. Project or program short title: Access: Second Opinions Project 1d: Rubicon

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

B. Primary component addressed: Access

xiii. Secondary component addressed: Patient-centered primary care home

xiv. Additional component(s) addressed:

xv. If *Integration of Care* component chosen, check all that apply:

☐ Behavioral health integration ☐ Oral health integration

C. Primary subcomponent addressed: Access: Second opinions

v. Additional subcomponent(s) addressed: Access: Timely

D. Background and rationale/justification:

It is challenging to provide access to growing demand for specialty referrals, especially in rural areas. Simply put the supply of specialists has not kept pace with demand. Many patients are left with a choice to travel to metro areas to complete a specialist appointment, which adds an additional challenge. In addition, wait times for certain specialties are beyond 30 days. Primary Care Medical Homes take the burden of coordinating travel and appointment times for patient specialty appointments. However, there is not an easy automated means of information sharing to assist with care coordination between PCP and specialists to help manage the increasing demand and workload. It's not surprising that patients, PCPCHs, and specialist are dissatisfied with the process. To provider the right care, in the right place, at the right time, timely and accurate information must be available to support patient assessment, diagnosis and treatment planning.

To address the challenge Rubicon an e-consult platform, is being implemented. Columbia Pacific has negotiated licenses for providers in addition all insurances and self-pay are able to submit under this contract without charge. We hope this allows every patient to get the care they deserve regardless of payer.

In addition, Rubicon now provides up to 20 hours of CME for completed consults, 0.5 hours of CME per consult. We view this as an upskilling tool for our providers to effectively manage patient needs.

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

Columbia Pacific CCO recruited Columbia Medical Services for the pilot of Rubicon. Columbia Medical Services has trained 2 providers to use the platform for consults, and has one superuser to trouble shoot. Providers began the consult process on February 1st 2019, and will be monitored for utilization, diversions from specialists, and satisfaction.

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

Activity 1 description (continue repeating until all activities included): Add text here

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: CPCCO patients submitted in e-consult per month per provider license

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
1	3	06/2019	5	12/2019

A. **Project or program short title**: CLAS Standards and Provider Network Project 2: Clinical Equity Plan

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

xvi. Secondary component addressed: Health equity

xvii. Additional component(s) addressed: Add text here

xviii. If *Integration of Care* component chosen, check all that apply:

☐ Behavioral health integration ☐ Oral health integration

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

vi. Additional subcomponent(s) addressed: Add text here

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

Columbia Pacific has a goal to, "help reduce health disparities and support culturally responsive services in our region." This goal was informed by the community and improved by the Clinical Advisory Panel (CAP). The first step in this plan is to provide education to our provider network on cultural competence so that our network can provide effective, equitable, respectful quality care and services that are responsive to diverse cultural health beliefs, practices, preferred languages, health literacy and other communication needs.

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

We are contracting with a vendor to provide online cultural competence training with Continuing Medical Education (CME) credits. These courses will be available to providers and the administrative staff for completion by the end of year. The vendor will provide reports at the organization and provider level to help determine if there are continued areas to focus our equity efforts. After an organization completes training we will meet with them to review reports and determine if we can continue to focus on areas of concern highlighted in the report.

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

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

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Providers that complete Cultural Competence Training

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0	100	12/2019	250	12/2020

A. **Project or program short title**: Health Equity Data Project 4a: Equity Focused Metric

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

B. **Primary component addressed**: Health equity

xix. Secondary component addressed: Access

xx. Additional component(s) addressed:

xxi. If *Integration of Care* component chosen, check all that apply:

☐ Behavioral health integration ☐ Oral health integration

C. **Primary subcomponent addressed**: Health Equity: Data

vii. Additional subcomponent(s) addressed: Access: Cultural Considerations

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

As Columbia Pacific works towards achieving equitable care for all patients, accurate and useful measurement of efforts are critical. A measurement framework which focuses on equity will help us to understand what changes are reducing inequities and whether any of our interventions might be increasing disparities. It will also serve to help guide our decisions about creating, resourcing, and implementing interventions with an equity lens.

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

Columbia Pacific quality metrics team has spent time reviewing CCO Incentive Metrics data stratified by race, ethnicity, age, sex, and health complexity to identify where disparity exists to determine an area of focus. We are narrowing this down to choose one disparity to focus on improving in Q2 2019. For the remainder of the year, we will socialize this measure with our network and create collective strategies to address the disparity.

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

Activity 1 description (continue repeating until all activities included): Add text here

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Equity focused measure in CPCCO

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0	1	06/2019	1	06/2019

A. **Project or program short title**: Health Information Technology: Health Information Exchange Project 5a: Dental PreManage

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

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

xxii. Secondary component addressed: Utilization review

xxiii. Additional component(s) addressed: Add text here

xxiv. If *Integration of Care* component chosen, check all that apply:

☐ Behavioral health integration ☒ Oral health integration

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

viii. Additional subcomponent(s) addressed: Add text here

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

Columbia Pacific delegated dental plan partners have all implemented PreManage and receive notifications for their members going to the ED for non-traumatic dental issues. They have also implemented a care coordination process whereby each member who goes to ED for dental issues receive outreach, care coordination and support in scheduling a visit.

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

Columbia Pacific would like to work with dental care partners to increase the percentage of members completing a dental visit within 30 days of an ED visit for non-traumatic dental issues.

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

Activity 1 description (continue repeating until all activities included): Dental visits completed within 30 days of an ED visit for non-traumatic dental issue

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Members completing a dental visit within 30 days of an ED visit for non-traumatic dental issues

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
40.5%	3% increase from baseline	12/2019	3% increase from baseline	12/2019

A. **Project or program short title**: Health Information Technology: Health Information Exchange Project 5a: PreManage and Regional Care Teams

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

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

xxv. Secondary component addressed: Severe and persistent mental illness

xxvi. Additional component(s) addressed: Add text here

xxvii. If *Integration of Care* component chosen, check all that apply:

☒ Behavioral health integration ☐ Oral health integration

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

ix. Additional subcomponent(s) addressed: Add text here

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

As Columbia Pacific rolled out PreManage we found the need for community collaboration to identify how to use PreManage tools better, coordinate care across organization. Case conferences and Regional Care Teams (RCT) were created to reduce duplication of effort, get better insight into who is involved with the patient, and discuss cases and assist each other. Case conferences include PCPs, Community Mental Health, and Columbia Pacific staff.

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

Every week two of our counties hold RCT meetings to do brief case conferences. In these case conferences, a multidisciplinary team reviews several member cases, create or review an existing care plan, determine priority areas of need, and identifies a lead person to conduct the follow up and outreach.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Have each county participate in a weekly multidisciplinary RCT meeting.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Counties involved in RCT case conferences

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
2 counties	3 counties	12/2019	3 counties	12/2019

Activity 2 description: Create Operations Workgroup to remove systemic barriers identified in RCT

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: 1 operation group in each county

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
2 counties	3 counties	12/2019	3 counties	12/2019

A. Project or program short title: Health Information Technology: Analytics Project 5b: Risk Segmentation

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

B. Primary component addressed: Health information technology

xxviii. Secondary component addressed: Utilization review

xxix. Additional component(s) addressed: Add text here

xxx. If *Integration of Care* component chosen, check all that apply:

☐ Behavioral health integration ☐ Oral health integration

C. Primary subcomponent addressed: HIT: Analytics

x. Additional subcomponent(s) addressed: Add text here

D. Background and rationale/justification:

Health care costs have grown steadily over the years, and a large percentage of these costs can be attributed to patients with multiple, complex health care needs. Population segmentation seeks to efficiently allocate resources to the right patients to improve quality of life and maximize efficient use of health care resources.

E. Project or program brief narrative description:

The population segmentation tool was manually re-run January 1st, 2019. The IS department continues to build out the infrastructure for automatic updating and list management, and will go live in 2019. In the meantime, a work group in Columbia Pacific has formed to begin the process of developing workflows that will leverage the information in the population segmentation tool. We will continue to do validation via our network partners and our own internal chart review. Flags have been developed that indicate the segment into which a member falls, and is uploaded into Premanage to allow for beta testing workflows and additional validation of the data set. Training materials are currently being developed for all internal staff and external stakeholders. In addition, we plan to work on developing a data feed with our provider partners to support organizational level risk stratification and care coordination to improve quality of care delivery, decrease costs, and ensure members are receiving the right care at the right time and in the right place.

Columbia Pacific's Population Health Portfolio Manager is the internal expert regarding population segmentation, and is working to develop additional internal use cases for the population segmentation data such as using the segments to inform the focus of the regional care teams, and assessing the dataset to identify gaps in care and opportunities for program improvement or development (i.e., development of a community-based palliative care program).

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

Activity 1 description (continue repeating until all activities included): Implement an automated monthly report for population segmentation

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Completion of segmentation analytics tool – auto reporting

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
None – report is manually run	Monthly automated report – Internal only	12/2019	Monthly automated report with the ability to export a clinic facing report	12/2020

A. **Project or program short title**: Health Information Technology: Patient Engagement Project 5d: Dental Request for Services Portal/ List Sharing

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

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

xxxi. Secondary component addressed: Integration of care (physical, behavioral and oral health)
xxxii. Additional component(s) addressed:
xxxiii. If *Integration of Care* component chosen, check all that apply:
☐ Behavioral health integration ☒ Oral health integration

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

xi. Additional subcomponent(s) addressed: Add text here

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

Navigating dental care has been a struggle for primary care providers and patients. Chief among the struggle is knowing what clinics accept what dental plan. To mitigate this struggle, a dental portal was created that allows primary care providers to submit a request for dental navigation and coordination by dental plan coordinators.

The member portal was originally planned for launch for release in summer 2018; however, during the testing period, several items were identified for improvement and launch was delayed to end of 2018. We used the 4th quarter of 2018 for more member portal discovery and are targeting the 2nd quarter of 2019 for "Full "member portal launch.

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

On the CareOregon provider portal, primary care clinics have access to an online form where they can input basic patient information (name, member ID, DOB, phone, clinic referring, provider name, phone number of clinic) and the dental care team will send the information to each respective dental plan for outreach and care coordination.

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

Activity 1 description (continue repeating until all activities included): # of patients sent through portal

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: # of patient sent through portal

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
28 patient requests sent in 2018	100 patient requests sent through portal	12/2019	150 patient requests sent through portal	12/2020

Activity 2 description: % of patients that receive services after portal request

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Patients who receive services post outreach.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
n/a – no data yet to identify	Create data report to capture patients who got outreach and received services	12/2019	30% receive services	12/2020

A. **Project or program short title**: Integration of Care Project 6: Prenatal Oral Health

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

B. **Primary component addressed**: Access

xxxiv. Secondary component addressed: Integration of care (physical, behavioral and oral health)

xxxv. Additional component(s) addressed: Add text here

xxxvi. If *Integration of Care* component chosen, check all that apply:

☐ Behavioral health integration ☒ Oral health integration

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

xii. Additional subcomponent(s) addressed: Add text here

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

Preventive dental cleanings and annual exams during pregnancy are not only safe, but are recommended. The rise in hormone levels during pregnancy may cause the gums to swell, bleed, and trap food casing increased irritation to gums. Preventive dental work while pregnant is essential to avoid oral infections such as gum disease, which has been linked to preterm birth. Given this recommendation, the increased dental benefits for pregnant women, and the change in life to motivate healthy behaviors, this was an ideal population to focus on accessing dental care.

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

Columbia Pacific has a prenatal incentive program, called First Steps, that provides Amazon gift cards for healthy pregnancy behaviors. In 2018, we added 2 dental incentives for completed appoints for a total of $30 dollars available per individual. We found implementation of the incentive difficult for providers managing pregnant patients to discuss. To facilitate dental care for pregnant women a list is shared of patients enrolled in First Steps monthly and the dental team separates by dental plan partner, and shares the list for outreach. Dental Plan partners use their Care Coordinators to complete 2-3 outreach calls and a letter to attempt to get the member to engage.

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

Activity 1 description (continue repeating until all activities included): % of patients that receive dental services before their delivery.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Patients who receive services post outreach, and list share.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
n/a – no data yet to identify	Create data report to capture patients who got outreach and received services	12/2019	40% receive services	12/2020

A. **Project or program short title**: Access Quality and Appropriateness of Care Project 1c: Quality Pilot Funding

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

B. **Primary component addressed**: Access

xxxvii. Secondary component addressed: Value-based payment models

xxxviii. Additional component(s) addressed:

xxxix. 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

xiii. Additional subcomponent(s) addressed: Add text here

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

The purpose of the Quality Pilot Funding is to incentivize and ensure resources for clinic partners to lead improvement projects that specifically address CCO Incentive measures that need additional efforts or resources allocated, those that are, for example, historically challenging, a CCO priority, or new measures.

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

The 2019 quality pilot funding will be available for clinics proposing improvement projects related to the following topics:

- Chronic diseases (must include Diabetes Poor Control or Controlling High Blood Pressure)
- Tobacco Cessation
- Maternal Child Health (Developmental Screening and follow-up, Childhood Immunization Status, Timeliness of Prenatal/Postpartum Care, Adolescent Well Care, or Effective Contraceptive Use)

A Request for Proposal will be released on April 1st with the goal that improvement projects would be completed by December 31, 2019.

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

Activity 1 description (continue repeating until all activities included): # of clinics who request funding

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: # of clinics that request funding

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
n/a – no data available yet	2	12/2019	4	12/2020

A. **Project or program short title**: Value-Based Payment Model Project 12: Behavioral Health Integration

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

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

xl. Secondary component addressed: Utilization review

xli. Additional component(s) addressed: Add text here

xlii. If *Integration of Care* component chosen, check all that apply:

☐ Behavioral health integration ☐ Oral health integration

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

xiv. Additional subcomponent(s) addressed: Add text here

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

To support clinics with behavioral health integration model a PMPM payment has been implemented, along with support through technical assistance provided by practice coaches that visit clinics. The Behavioral Health Integration payment model is intended to facilitate the delivery of same-day access to integrated, population-based, preventive behavioral health services.

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

We have continued to grow the behavioral health payment program by increasing the number of participating clinics to 10 as of 01/01/2019 from the previous 8, as well as funding 2 additional new FTE at Columbia Memorial Hospital (CMH) and Tillamook County Community Health Center. (TCCHC) The program has developed over the last year in this region from just reporting on unique members served with 5-12% targets, to implementing payment impacts when targets for population reach of unique members are not met. We anticipate that payment implications for population reach of unique members will incentivize clinics to take a more primary care population based approach rather than specialty mental health service approach that features small caseloads and limited access to care.

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

Activity 1 description (continue repeating until all activities included): # of clinics participating in BHI APM

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: # of clinics participating in BHI APM

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
10 clinics	11	12/2020	12	12/2021

Activity 2 description (continue repeating until all activities included): Population Reach

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: % of BHCs patient population reach

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
n/a baseline measurement in process	3 clinics with 12% or greater	12/2019	5 clinics with 12% or greater	12/2020

A. **Project or program short title**: Utilization Review Project 11: Total Cost of Care Metric

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

B. **Primary component addressed**: Utilization review

xliii. Secondary component addressed: Value-based payment models

xliv. Additional component(s) addressed: Add text here

xlv. If *Integration of Care* component chosen, check all that apply:

☐ Behavioral health integration ☐ Oral health integration

C. **Primary subcomponent addressed**: Choose an item.

xv. Additional subcomponent(s) addressed: Add text here

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

In 2018 Columbia Pacific added a Cost of Care Incentive Payment to the primary care APM program. The Cost of Care components measures emergency department and inpatient visits for Ambulatory Care Sensitive Conditions (ACSC). The measure is adapted from the Agency for Healthcare Research and Quality (AHRQ)'s PQI 90. PQI 90 is one of the measures that OHA monitors as part of the CCO waiver. ACSCs are conditions in which an acute event (ED or inpatient) could have been prevented with timely, high quality intervention in primary care. As such, they focus specifically on domains that are impactable by primary care clinics. In addition, the measure is aligned with work we have been doing with network partners by reinforcing concepts of population health management, care coordination and use of PreManage.

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

The Cost of Care Incentive Payment was added to the primary care APM program on July 1, 2018. The program has two reporting events per contract, one every six months. Baseline data for Cost of Care has been provided to each participation organization. At the first reporting event, data on the measurement period will be provided to the participating clinic, but achievement of the payment is not contingent on the achievement of a target or benchmark. Starting on August 31st, 2019, participating clinics will be required to demonstrate a 1.5% reduction in their ACSC rate in order to receive the payment. The CCO has coordinated with CMT to produce PreManage cohorts around the ACSC grouping and the cohorts are now available to clinic partners. In addition, technical assistance has been offered to clinics around panel management, team-based care, self-management support and primary care access in support of this work.

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

Activity 1 description (continue repeating until all activities included): Implement and Hold Clinics accountable for Cost of Care Ambulatory Sensitive Conditions

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Implement Cost of Care metric

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

n/a	2 clinics being measured on Cost of Care	8/31/2019	All clinics being measured on Cost of Care	7/1/2020

A. **Project or program short title**: Access: Quality and Appropriateness of Care Furnished to All Members Project 1c: Member Incentives

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

B. **Primary component addressed**: Access

xlvi. Secondary component addressed: Choose an item.

xlvii. Additional component(s) addressed: Add text here

xlviii. 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

xvi. Additional subcomponent(s) addressed: Add text here

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

Columbia Pacific recognizes that providing health education and addressing barriers is a key component in influencing health behavior. To achieve this, we couple health education with incentives to members to promote activities designed to engage them in appropriate, quality care. We believe the best way to address rising health care cost in the long term is help motivate individuals get and stay healthy. To support this work, we offer incentives to help our members prioritize preventive care.

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

In 2019 the incentives that will be offered are:

- Adolescent Well Care
- Diabetes Care
- 15 month Well Child Check
- Dental Sealants
- Colorectal Cancer Screening
- New Member Wellness Exam
- Tobacco Cessation

New Member Wellness Exam and Tobacco Cessation are new incentives in 2019 while the rest have existed in the past. Letters will be mailed to cohorts of members from March through November inviting them to participate in the program by the end of 2019.

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

Activity 1 description (continue repeating until all activities included): Incentive Engagement Rate % - Tobacco Cessation

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Hit estimated Engagement rate for Tobacco Cessation

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
n/a – Incentives not sent	5%	12/2019	8%	12/2020

Activity 2 description: Incentive Engagement Rate % - Dental Sealant

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Hit estimated Engagement rate for Dental Sealant

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
1%	5%	12/2019	8%	12/2020

G. **Project or program short title**: Value Based Payment Modes Project 12: Community Risk Share

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

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

xlix. Secondary component addressed: Access

l. Additional component(s) addressed: Add text here

li. If *Integration of Care* component chosen, check all that apply:

☐ Behavioral health integration ☐ Oral health integration

I. **Primary subcomponent addressed**: Access: Quality and appropriateness of care furnished to all members

xvii. Additional subcomponent(s) addressed: Add text here

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

In 2015 Columbia Pacific CCO entered into multiyear county-specific, county-wide gain/risk sharing agreements with the primary care providers, hospitals, mental health providers and public health agencies in Clatsop, Columbia and Tillamook counties. The intent of these arrangements is to build shared ownership and accountability for CPCCO's member health at the community level and to incentivize providers to work together to improve quality care and reduce avoidable costs and utilization. The model triggers a payout when CPCCO achieves a combined member benefit ratio (MBR) of 91% for our Behavioral Health and Physical Health benefits and when each county achieves a specific per member per month (PMPM) total cost of care. Each county has a Steering Committee of participants in the model that meets monthly to review their county-specific cost targets and monitor progress of the strategies they have implemented. In 2016, the three counties received just under $1.3 million to invest in county-specific strategies to improve quality and cost of care.

In 2017 Tillamook County decided to discontinue their involvement in the model, but Clatsop and Columbia counties moved to invest more deeply in their collaboration efforts by creating operational workgroups that are comprised of clinic, emergency department, and community mental health clinic managers. These groups work towards quality improvement with a focus on integration efforts across their systems. They run PDSA cycles to improve upon system barriers to access and integration. Also in 2017, the Clatsop County partners decided to fund a Complex Care Hub in Seaside that featured a Triage Coordinator, a social worker, and a registered nurse to provide care coordination for CPCCO members throughout the county. This team evolved to establish weekly huddles around a centralized triage process. At the huddles, representatives from each of the providers round on CPCCO members to develop aligned care plans and coordinate care.

In 2018 Columbia County replicated this model and the partners funded a Community Paramedicine program. The Community Paramedic has been incorporated into an integrated care team along with the local primary care clinics and community mental health providers of that county. Tillamook county also decided to replicate the weekly huddles in 2018 despite not having a formal agreement of the local providers to participate in the model.

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

In 2019, the Clatsop and Columbia county Steering Committees and Operations Workgroups decided to focus on Substance Use Disorder (SUD) and resolve barriers to accessing treatment within their communities. The following are key elements of their work throughout 2019:

- CPCCO's Clinical Advisory Panel combined with the county-level Operations Workgroups to create a county vision statement for SUD treatment and recovery to guide alignment and integration across clinic systems and modalities within each county
- County Operations Workgroups create charters that outline their goals and objectives to improve access to SUD treatment and submit them to the county Steering Committees for approval
- County Operations Workgroups develop and conduct PDSA cycles to test improvements in integrating care across clinic systems and improve access to SUD treatment
- County Steering Committees monitor progress and learnings from PDSA cycles and make collaborative funding decisions based on learnings from the PDSA cycles to sustain improvements to access to treatment for SUD

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

- County Risk Steering Committees monitor:
  - CPCCO total MBR
  - County PMPM
  - Operational Workgroup PDSA cycle process metrics
- Operational Workgroups monitor:
  - Utilization trends specific to PDSA focus
  - Organizational outputs related to PDSA cycles

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

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Add text here

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
90% MBR	91% or lower	12/2019	91% or lower	12/2020

Activity 2 description: PDSA Cycle

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: County Improvement Cycles

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
n/a not started	1 PDSA completed per county	12/2019	1 PDSA Implemented and Spread	12/2020

A. **Project or program short title**: Integration of Care Project 6: Integration of BH Benefit

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)

lii. Secondary component addressed: Severe and persistent mental illness

liii. Additional component(s) addressed: Add text here

liv. If *Integration of Care* component chosen, check all that apply:

☒ Behavioral health integration ☐ Oral health integration

C. **Primary subcomponent addressed**: Choose an item.

xviii. Additional subcomponent(s) addressed: Add text here

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

In preparation for the next five-year CCO contract with OHA, Columbia Pacific CCO is transitioning the management of the mental health and addictions benefits from Greater Oregon Behavioral Healthcare, Inc (GOBHI) to CareOregon. CareOregon currently manages the physical health benefit for CPCCO, and also manages both the physical health and behavioral health benefits for JCC (a sister CCO to CPCCO). Integration of the benefit at the CPCCO level, managed by the single entity, CareOregon, allows easier and more robust integration of care plans and care management for CPCCO members, seamless quality outcomes reporting, integrated funding and APMs to improve access to needed services, and more efficient assistance to primary care and behavioral health clinics to transform and integrate care.

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

The integration of the behavioral health benefit will be driven by an overall transition plan that outlines accountable individuals/departments, metrics and milestones for several bodies of work, with the ultimate goals of ensuring no disruption in care to our members or continuity of payment to providers. It is also a primary goal to ensure that this transition not only does not disrupt the crisis and safety net systems in each county, but actually enhances them.

This project has two phases. Phase one, described here, is the initial transition of the benefit, such that any disruption to services is avoided. Phase two is post transition, to capitalize on the opportunities of an integrated benefit by leveraging integrated and value based payments to providers, quality improvement activities with the network, etc.

The transition plan to integrate the behavioral health benefit is developed and tracked by two project managers under the direction of the CareOregon VP of Behavioral Health, who is also hiring new staff to manage the benefits and operational improvements expected from the transition.

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

Activity 1 description (continue repeating until all activities included): Add text here

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Add text here

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Contracts with and payment to treatment providers is delegated to GOBHI.	CPCCO/CareOregon has direct contracts with provider network for BH Services and pays claims directly.	6/1/19	CPCCO/CareOregon has simplified contracting for integrated services, reducing admin burden on provides and improving care for members.	12/31/19

Activity 2 description: Add text here

☒ 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)
Care Coordination is sub-delegated to the CMHPs in each county.	Care Coordination is done at the health plan level, and integrated into the regional care team, a multi-disciplinary care team working from a single care plan.	6/1/19	Care Coordination is targeted at specific sub-populations such as (but not limited to) members with 2 or more ED visits in a six-month period, and members with SPMI transitioning out of adult residential services.	1/1/2020

A. **Project or program short title**: Appeals Overturn Process Improvement

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

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

lv. Secondary component addressed: Choose an item.

lvi. Additional component(s) addressed: Add text here

lvii. If *Integration of Care* component chosen, check all that apply:

☐ Behavioral health integration ☐ Oral health integration

C. **Primary subcomponent addressed**: Choose an item.

xix. Additional subcomponent(s) addressed: Add text here

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

On behalf of Columbia Pacific, CareOregon initiated a project to reduce overturned appeals during 2018. During that process, we found that overturned appeals occur for one of two reasons: 1) either inadequate information is submitted at the time of the request or 2) appeals staff find existing clinical information in the record upon review that supports the overturn. In a very small portion of cases, the requesting provider has sent appropriate documentation but it was missed by the prior authorization staff (this has since been remedied with a revised training process). These findings suggest that we can reduce our rate of overturned appeals by improving the quality of documentation received at the time of the pre-service request, which would reduce the need for appeal and resulting overturn rate. In order to improve the quality of information received with appeals, CareOregon must accomplish two things: 1) better educate its provider network on the information required at the time of the pre-service request, and 2) ensure its internal processes for prior authorization are optimized. The Medical Management department convenes a monthly workgroup to identify trends related to prior authorizations, appeals, overturns and adequacy of clinical documentation.

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

Prior Authorization Documentation Requirement Education

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

Activity 1 description (continue repeating until all activities included): Update materials for provider network

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Develop materials for provider network that clearly outline prior authorization process and documentation requirements

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Current materials are outdated	Assess and update materials	1/31/2019	New materials disseminated to network	05/01/2019

Activity 2 description (continue repeating until all activities included): Monitor overturns related to inadequate clinical documentation

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Monthly workgroup to identify trends related to overturns and adequacy of clinical documentation.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
75% of pre-service requests have adequate clinical documentation	85% of reviewed pre-service requests have adequate clinical documentation	6/30/2019	90% of reviewed pre-service requests have adequate clinical documentation	12/31/2019

A. **Project or program short title**: Social Determinants of Health Project 9: Regional Community Health Assessments

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

B. **Primary component addressed**: Social determinants of health

lviii. Secondary component addressed: Health information technology

lix. Additional component(s) addressed: Add text here

lx. If *Integration of Care* component chosen, check all that apply:

☐ Behavioral health integration ☐ Oral health integration

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

xx. Additional subcomponent(s) addressed: Add text here

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

CPCCO is starting its second five-year community health improvement plan where regional health needs have been assessed. The plan, including the community needs assessment, has been created using a participatory process that included key community stakeholders who support health and wellbeing from the health care and social safety net sectors, CPCCO members and others associated with providing and facilitating good community health. CPCCO's Regional Advisory Council members have oversight over the development of and process attached to the creation of the 2020-2024 regional health improvement plan, including engaging in a shared decision-making process to make final recommendations for priority areas of focus

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

In the fourth quarter of 2018 a portion of the community health needs assessment in the region included collecting the voices of community members with an emphasis on those who have CPCCO as their health plan coverage. Using this approach, collecting micro-narratives on health and well-being, not only allowed us to collect the experiences of community members in their own voices, the process gave us a framework of meaning related to not only health care needs but also the social determinants of health and health equity.

In the first quarter of 2019 CPCCO held 15 community presentations in the service region to approximately 200 people. The goal of these presentations was to provide the community with community health assessment data and community voice and get feedback from the community regarding what health improvement areas should be prioritized for the 2020-2024 regional health improvement plan.

Overall objectives using these method(s) included but were not limited to: prioritizing community driven strategies, empowering community members to make sense of their environment by using this process, promoting collaboration across the coalition of partners seeking similar goals, and amplifying service user voices and perspective of health plan members with a special focus on Latino and Tribal communities.

The Regional Health Needs Assessment will include, "county-specific", population data, Medicaid data and hospital data. and will be conducted collaboratively with multiple community stakeholders to promote collaboration across sectors, to share data, and to strategize and plan for addressing the priorities of the Regional Health Improvement Plan.

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

Activity 1 description: Conducting a collaborative regional health needs assessment with multiple community stakeholders to promote collaboration across sectors, to share data, and to strategize and plan for addressing priorities.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Using results of primary and secondary health indicator data, choose priority areas for focus and investment for the 2020-2024 regional health improvement plan.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Primary and Secondary health indicator data has been collected.	Health Indicator data has been assessed and priority areas have been chosen for the regional health improvement plan	06/2019	Public Health, hospitals and CPCCO have shared process for community health needs assessment and formal agreement regarding the sharing of data and analysis.	06/2019

Activity 2 description: Creating a regional health improvement plan in partnership with multiple community stakeholders creating shared investment opportunities to address health improvement at the community level.

☒ 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)
Completion of Regional Health Improvement plan.	Regional health improvement plan that addresses health equity and the social determinants of health	06/2019	Shared community health improvement plan that is data-enabled and designed to measure and report on progress towards goals.	01/2020

A. **Project or program short title**: Social Determinants of Health Project 9: Traditional Health Worker

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

B. **Primary component addressed**: Social determinants of health

lxi. Secondary component addressed: Access

lxii. Additional component(s) addressed: Add text here

lxiii. If *Integration of Care* component chosen, check all that apply:

☐ Behavioral health integration ☐ Oral health integration

C. **Primary subcomponent addressed**: Choose an item.

xxi. Additional subcomponent(s) addressed: Add text here

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

As Columbia Pacific has rolled out Regional Care Teams (RCTs) and focused on reviewing high risk members via multidisciplinary case review and in-depth case conferences, the need for traditional health workers has become apparent. Case conferences and RCTs were created to reduce duplication of efforts, gain better insight into who is working with the patient, and provide support cross-organizationally. Through the RCT work it has become clear that there is a need for THWs within our communities, as they are poised to provide peer to peer support focused on individual psychosocial and physical health needs, as well as the individual substance use disorder treatment journey.

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

Hire and integrate THWs into each county RCT to provide peer to peer support for members, specifically peer support recovery allies and Community Health Workers (CHWs).

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

Activity 1 description (continue repeating until all activities included): Hire a Community Health Worker (CHW) in each county to provide support to each regional RCT. There is one RCT per county, with three RCTs total.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Add text here

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0 CHWs	1 CHW in 1 RCT	12/2019	Minimum of 1 CHW in all RCTs	12/2020

Activity 2 description: Add text here

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Hire peer support recovery allies in each county to provide support to each regional RCT. There is one RCT per county, with three RCTs total.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
2 recovery allies working with 1 RCT	A minimum of 1 recovery ally in 2 RCTs	12/2019	A minimum of 1 recovery ally in all RCTs	12/2020

A. **Project or program short title**: Utilization Review Project 11: Cohorts with high acute and ED utilization with BH diagnosis

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

B. **Primary component addressed**: Utilization review

lxiv. Secondary component addressed: Severe and persistent mental illness

lxv. Additional component(s) addressed: Add text here

lxvi. If *Integration of Care* component chosen, check all that apply:

☐ Behavioral health integration ☐ Oral health integration

C. **Primary subcomponent addressed**: Choose an item.

xxii. Additional subcomponent(s) addressed: Add text here

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

We know that members with serious and persistent mental illness (SPMI) have poorer outcomes when it comes to physical, social, and mental health; in addition to higher rates of utilization across the health care delivery system. We also know that members with SPMI diagnoses have comorbid physical health conditions that are poorly managed. As a result, the OHA created a new CCO quality metric in 2018 that captures Emergency Department (ED) visits for physical health concerns among those with an SPMI diagnosis. The CCO has readily adopted the use of the HIT tool, PreManage, to manage and coordinate follow up of ED visits and other hospitalizations. The OHA partnered with Collective Medical Technologies (CMT) to proactively create a registry of CCO members who meet the SPMI diagnosis criteria, and utilize the registry ("group") to inform a cohort in PreManage for monitoring hospital utilization, follow up, and care coordination. Concurrently, the work we are currently doing to bring the behavioral health benefit in house, presents a unique opportunity to improve and expand our suite of behavioral health care coordination and better serve our members.

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

We will utilize the SPMI group in our PreManage portal to build out enhanced cohorts which will inform future workflows for follow up and care coordination.

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

Activity 1 description (continue repeating until all activities included): Add text here

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Add text here

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Use of ED Disparity cohort in PreManage, which captures ED visits for non-behavioral concerns	Creation of 1 new cohort using the SPMI group with associated workflows	12/2019	Creation of 2 new cohorts using the SPMI group with associated workflows	12/2020

A. **Project or program short title**: PCPCH Project 7: Patient Centered Primary Care

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

B. **Primary component addressed**: Patient-centered primary care home

lxvii. Secondary component addressed: Choose an item.

lxviii. Additional component(s) addressed: Add text here

lxix. If *Integration of Care* component chosen, check all that apply:

☐ Behavioral health integration ☐ Oral health integration

C. **Primary subcomponent addressed**: Choose an item.

xxiii. Additional subcomponent(s) addressed: Add text here

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

Columbia Pacific believe in the collaborative model of learning for our network. We believe this allows for a space to bring learnings and share barriers to learn from one another. We have chosen to follow this model to help increase the number of PCPCH clinics and to increase the tiers for already participating clinics in PCPCH.

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

Columbia pacific provides coaching and continuous transformation community-level learning opportunities through our recurrent coaching-led Patient & Population Centered Primary Care Learning Collaboratives (PC3), behavioral health peer-to-peer meetings, and clinic-based one-on-one coaching and technical assistance support. These venues, established prior to or within the 1st year of CCO operations, are specifically designed to facilitate, disseminate, and share best practices, workflows, and staffing models of patient-centered medical homes. These venues support action planning and accountability through quality improvement monitoring and data transparency that directly motivates and equips our primary care partners to increase their levels of medical home status and progress towards achieving the quadruple aim.

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

Activity 1 description (continue repeating until all activities included): Add text here

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Add text here

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
7 clinics participating in PC3	8 clinics participating in PC3	12/2019	9 clinics participating in PC3	12/2020