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:

The Eastern Oregon Coordinated Care Organization (EOCCO) Board of Directors is the authority of and has the responsibility for the EOCCO transformation and quality program strategy (TQS). The board of directors has designated the EOCCO Quality Improvement Committee (QIC), with the responsibility for the operations of the transformation and quality improvement program.

The EOCCO QIC provides oversight to transformational and quality assurance and performance improvement activities to ensure that EOCCO members receive high quality physical, behavioral and dental care and services. The multidisciplinary committee is a decision making body that has the authority and representation to develop and implement integrated quality improvement and transformative activities with the goal of advancing the Triple Aim for EOCCO members. Membership includes representation from Greater Oregon Behavioral Health, Inc., Moda Health and the three delegated dental care organizations.

EOCCO uses continuous quality improvement methodologies to assess, plan and improve the quality of care and service we provide to EOCCO members. The most used is the Plan-Do-Study-Act (PDSA) methodology. This tool is the basis for P) assessing the current situation and completing root cause analysis, determining interventions, identifying the required resources and timeline, and the tracking/monitoring/reporting methods; D) implementing the intervention to the targeted population segments; S) measuring and evaluating the results of the intervention and A) deciding next steps: adapt, adopt, abandon.

Designated EOCCO representatives and/or subcommittees are responsible to complete and report TQS and other OHA contractual assignments and outcomes to the EOCCO QIC. These include the development and implementation of integrated policies and procedures and performance improvement projects, progress toward incentive measures improvement targets and preparedness for OHA mandated external quality reviews. Ongoing responsibilities include the assessment and analysis of the quality and effectiveness of initiatives for access to services, integration of care, cultural competency of the CCO and our provider network and health equity, patient-centered primary care home, utilization review, the care management system (including severe and persistent mental illness and special healthcare needs), grievances and appeals system, health information technology and fraud, waste and abuse detection and prevention.

The EOCCO QIC meets at least quarterly. The EOCCO QIC is chaired by a member elected by the group once every two years. Agendas direct meetings, and documented minutes provide a record of the committee's activities, recommendations and actions.

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):

Administrative staff for EOCCO develop, monitor and manage the quality and transformation activities. The activities are determined through a combination of addressing contractual requirements and implementing activities that are aligned with the EOCCO Board of Directors, Clinical Advisory Panel (CAP) and our Regional Community Advisory Council (RCAC) and Local Community Advisory Council (LCAC) initiatives. See examples below. Staff activities include periodic follow-up with the "owners" of each respective transformation and

quality plan component to ensure adequate progress is being made to achieve the defined targets and benchmarks.

Examples of EOCCO's transformation activities that are aligned with EOCCO Board, CAP and our RCAC/LCAC activities are provided below:

The EOCCO Board of Directors and CAP are heavily involved in the development of activities that support and promote the use of high-functioning patient-centered primary care Homes (PCPCHs) and in the development of EOCCO's value based payment (VBP) strategies.

The EOCCO Board of Directors authorizes annual funding to our LCAC's, which they can use to improve incentive measure results within their respective communities and/or to address Community Health Improvement Plan (CHIP) initiatives identified for their respective communities.

The EOCCO Board of Directors has invested funding in the development of a regional OHA certified Community Health Worker (CHW) training program which includes training new CHW's and providing continuing education courses to existing CHWs. EOCCO has also developed a CHW billing and payment policy to help ensure a sustainable revenue source for the EOCCO provider partners that employ CHWs. The EOCCO Board of Directors CHW investment is one of our primary tools for addressing the social determinants of health and health disparities within our region.

It's important to note that the chair of the EOCOO RCAC serves on the EOCCO Board of Directors. The RCAC Chair and the RCAC members serve as the link between the EOCCO Board of Directors and the LCAC's.

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

The Regional CHIP guides activities of EOCCO staff and LCACs by providing a framework for decision making to allow individual communities to focus on needs that are present and important to their particular community.

CHIP Priority Area- Early Childhood Prevention/Promotion

Coordination between early learning hubs (ELH) and LCACS/RCAC continues. ELH participation in LCACs is present in many LCACs and joint meetings are held in Baker. The RCAC has held meetings in conjunction with the ELH leaders twice. In June of 2017, EOCCO provided a cost and utilization report of children age 0-6 for each county and also for each ELH region. OHA Child Systems staff was also present at the meeting and helped in facilitating a discussion regarding methods of collaboration between LCACs and ELHs.

We continue to make available tools and technical assistance resources to implement the Ages and Stages developmental screening for children 0-36 months.

In partnership with the Eastern Oregon Healthy Living Alliance grant funding was secured to implement a pilot program integrating mental health/depression screens at nurse-based home visiting programs.

The RCAC had Rex Larson, OHA Vaccines for Children Coordinator, present and discuss strategies to improve immunization rates. The RCAC also developed a white paper that describes the role of public health in helping EOCCO meet incentive measures. Specific emphasis on immunizations was noted in the document.

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:

There are a number of examples for how EOCCO works with community partners to advance the TQS.

EOCCO has a 17 member governing board that includes hospital, physician, clinic, local community mental health, public health and county commissioner/judge representation. As discussed above, the board of directors is heavily invested in a number of transformation activities.

Within our region an average of 250 individuals participate in our Local Community Advisory Councils (LCAC's). Each LCAC has broad community partner representation including health systems, clinics, community-based organizations, local public health, local mental health, local government, early learning hubs and OHP members. These community partners participate in the development of county-specific CHIP's, which is discussed in more detail below.

EOCCO has taken a unique approach to involving the community in our CCO. EOCCO has 12 Local Community Advisory Councils-- one for each county. From each LCAC, the chair, along with a county commissioner (or designee), serves on a Regional Community Advisory Council. The RCAC serves as the official CAC for EOCCO. Each LCAC completes its own CHA and CHIP, which is then combined and incorporated into a regional (CCO-wide) CHIP that includes both county-level needs/priorities and CCO- wide needs/priorities. The RCAC is also charged to help ensure each LCAC is responsive to member and community health needs.

Additionally, each year the RCAC produces and delivers an annual report to the EOCCO Board of Directors with an update on LCAC activities that EOCCO formally responds to. EOCCO utilizes the input from community partners and the CHIP plan to address transformation and quality strategies as applicable.

B. Review and approval of TQS

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

EOCCO convened a TQS implementation team that was made up of multidisciplinary, subject matter experts representing physical, behavioral and dental health across EOCCO. This team met in the fall of 2017 to review the TQS components and introduce the new format and process. These meetings were facilitated by the EOCCO Compliance Officer. Additionally, staff were provided TQS resource materials and encouraged to attend the TQS webinars and office hours that pertained to their area of transformation.

After the webinars were complete, a series of five TQS component creation meetings were conducted. These meeting were grouped by similar topics to ensure efficient use of staff and resource time. In these meetings, each TQS component was discussed in detail with the ultimate outcome being the creation of the TQS component, its quality assessment activity and performance improvement goals. Once the components, quality assessment activities and goals were created, point people were assigned to each TQS component. Each point person was responsible for gathering input from others as necessary and submitting the completed TQS template to the EOCCO Compliance Officer.

The EOCCO Compliance Officer gathered and combined all responses to create the final EOCCO TQS document. The TQS was then reviewed by EOCCO Leadership and marketing professionals to ensure the document, worked on by multiple people, conveyed the same or similar voice. The EOCCO TQS was then presented to, and approved by, the EOCCO Quality Improvement Committee. Subsequent updates or

changes to the TQS will be presented to, and approved by, the EOCCO QIC, which reports directly to the EOCCO Board of Directors.

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:

EOCCO provides coverage to nearly 50,000 members across 12 rural and frontier counties in Eastern Oregon. Our service area is approximately 50,000 square miles covering just over half the land area in the State of Oregon.

EOCCO has a diverse eight member ownership structure that includes a number of provider and hospital systems that provide care for OHP members within the EOCCO service area. EOCCO has a 17-member governing board, 12 Local Community Advisory Councils and a Regional Community Advisory Council that includes participation from 250 community partners and a Clinical Advisory Panel.

Within our service area there are 10 hospitals, 7 of which are Type A/Critical Access hospitals, five of 10 are part of health districts and there are no tertiary hospitals within the EOCCO counties. There are 60 widely dispersed clinics and individual primary care practices within or outside of our 12 counties that serve the primary care needs of EOCCO members. 23 of those clinics are Rural Health Clinics and seven are Federally Qualified Health Centers.

Despite some of our challenges with respect to our rural geography and a lack of access to services not available in our communities, EOCCO remains committed to moving forward with transformation and advancing the Triple Aim for our members. We believe that our commitment to transformation to date, including what we have planned throughout the next two years, will be evident throughout the TQS.

Section 2: Transformation and Quality Program Details

A. TQS COMPONENT(S)			
Primary Component:	Access	**Secondary Component:**	Choose an item.
Additional Components:	Add text here.		
Subcomponents:	Access: Availability of services	**Additional Subcomponent(s):**	Add text here.
B. NARRATIVE OF THE PROJECT OR PROGRAM			
EOCCO monitors and analyzes reporting to ensure members access to covered services. The analyses focus on out of network claims utilization and network adequacy by county.			
C. QUALITY ASSESSMENT			
Evaluation Analysis:	EOCCO uses two reports to monitor utilization of out-of-network (OON) providers and availability of participating providers. Quarterly, we generate a report to monitor OON claims utilization. The goal is to maintain <90% OON utilization. Our 2017 analyses showed that inpatient and outpatient hospital OON claims were <10%; for calendar year 2016 and quarters 1-3 2017, our OON utilization ranged between 5% to7%. Our 2017 analyses identified that pain management care was an area of opportunity to reduce out-of-network claims. Based on claims trends, the Medicaid Programs manager outreached to two providers and attempted to execute a contract, and we were successful in moving one provider to in-network status. This quarterly report is presented to the EOCCO QIC for evaluation and feedback. The second report is our annual network analysis using the CMS Medicare Network Adequacy standards. The report identifies areas of network insufficiency by county, below the 90% statewide access standard. The report results include geo-mapping, as well as adequacy by specialty. The Medicaid Program leadership team and EOCCO Compliance Officer review the documents for improvement opportunities to the access plan, if applicable. Due to the rural and frontier geological demographic of the EOCCO service area, the availability of certain provider specialties, whether in or out of network, within the appropriate time/travel distance is limited. Members are referred to contracted providers who can provide the level of care required and are most conveniently located from the member's residence.		

D. PERFORMANCE IMPROVEMENT					
Activity: Reduce the percent of professional specialty claims that are performed by out of network providers to 10% or less.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Measure the percent of specialty claims that are performed by an out of network provider.	16.8% for CY 2016	<12% for CY 2018	01/2019, reporting available April 2019	<10% for CY 2019	01/2020, reporting available April 2020
Activity: Increase network adequacy in EOCCO counties showing deficiencies.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Network Analysis Report	As of March 2017: Baker 91.1% Gilliam 92.4% Grant 75.7% Harney 64.2% Lake 32.4% Malheur 92.3% Sherman 91.0% Umatilla 85.7% Union 82.9% Wallowa 89.0% Wheeler 87.7%	To be determined	04/2018	To be determined	04/2019

A. TQS COMPONENT(S)			
Primary Component:	Access	**Secondary Component:**	CLAS standards and provider network
Additional Components:	Add text here.		
Subcomponents:	Access: Cultural considerations	**Additional Subcomponent(s):**	Add text here.

B. NARRATIVE OF THE PROJECT OR PROGRAM

EOCCO recognizes that access to healthcare begins with the sensitivity and cultural awareness of staff who touch the lives of a member, whether that touch is face to face, in the office visit setting, by phone, by print or web-based material or by review of clinical documentation. Cultural awareness includes societal, linguistic, racial/ethnic, environmental, and gender considerations.

EOCCO uses interpreter services to provide multilingual customer service. Interpreter calls are monitored for accuracy and response time. EOCCO and its healthcare partners contract with respective interpreter services at no charge that offer hundreds of languages and are available during regular CCO customer service and provider office visit hours. We contract with vendors that translate documents (notices of action or appeal resolutions) or provide them in alternative formats. Our significant EOCCO member communications and publications include a nondiscrimination tagline translated into the 15 non-English languages most prevalent within the State of Oregon. The tagline informs the reader that we provide free language assistance services, including options for using alternative formats. Our EOCCO member handbook informs enrollees that the handbook and other materials are available in other formats or languages.

To this end, cultural competency and consideration training is provided to EOCCO staff and delegated dental care organization clinical and non-clinical staff. Education topics are chosen by general consensus dependent upon societal and cultural shifts, national awareness movements, and awareness of under-served communities. Education is also influenced by a general need for education within the department for retraining or refreshed acknowledgement of services provided by EOCCO and its healthcare partners.

Examples of EOCCO cultural competency projects are:

- Interpreter services in Community Mental Health Programs
- Evaluation tool for cultural competency training
- Enhancing the provider directory with cultural and linguistic capabilities

C. QUALITY ASSESSMENT

Evaluation Analysis:

Activity 1. GOBHI is working to ensure that all members have access to culturally competent mental health and substance abuse services. Examination of interpreter and translation services provided by contracted community mental health programs (CMHPs), as well as a secret shopper phone survey, show opportunities for increasing ease of access for non-English speaking members. GOBHI will be collaborating with contracted providers to ensure easy access to interpreter services.

Interpreter services	# of visits	# of minutes	Avg. minutes/visit
Spanish	1,120	17,295	15
Arabic	9	548	61
Somali	13	458	35

Translation services	# of visits - Spanish	# visits - Arabic	# visits - Somali

Community Counseling Solutions	247		
Center for Human Development	19		
GOBHI	164		
Lifeways	655	9	13
Mid-Columbia Center for Living	31		
Wallowa	3		

Secret Shopper Study:
A GOBHI staff member fluent in Spanish called 13 contracted providers speaking only Spanish asked about access to services. Six out of 16 (37.5%) CMHP provider locations were able to access and deliver telephonic interpretation services to assist the GOBHI staff member.

Analysis:

- Spanish interpretative services are the most often language provided.
  - Average length of service is 15 minutes
- Lifeways also has some members who require Arabic and Somali interpretation and translation services.
- Requests for interpretative services vary by region, with some CMHPs having no requests for services.
- Less than half of CMHPs were able to quickly connect members with a translation service during a phone call.

Activity 2: In 2017, Moda Health selected gender dysphoria for training due to an increase in prior authorization requests related to gender reassignment. In addition, there was concern that staff lacked general knowledge of this medical condition.

Activity 3: EOCCO continuously collects provider directory data and posts the EOCCO provider directory to our website, in accordance with the new contractual requirement in 2018, based on CFR §438.10. We created a survey of our provider panel to inquire about cultural and linguistic capabilities along with office/facility accommodations for people with physical disabilities. Based on the responses, EOCCO compiled a searchable PDF of the responses and posted it to our website.

EOCCO's provider directory includes information collected from our physical, mental and dental health providers.

On a monthly basis, an updated PDF document is published on the EOCCO website, including any changes from the previous month's version. Upon request, a copy of the PDF file is mailed to a member.

D. PERFORMANCE IMPROVEMENT

Activity 1: GOBHI will work with providers to increase ability to provide information and answer questions over the phone for non-English speaking members.

☐ Short-Term Activity or
☒ Long-Term Activity

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Secret Shopper phone survey	37.5% of Community Mental Health	80%	12/2019	To be determined	To be determined

	providers were able to answer questions regarding access to a non-English speaker via the phone.				

E. PERFORMANCE IMPROVEMENT

Activity 2: The 2017 Moda Health training was provided by Ryan Loiselle, NCC, LPC intern, whose private practice is devoted to transgender, non-binary, queer, and questioning folks, as well as LGB individuals. Participants included behavioral health, care coordination, case management, population health, and appeals and grievances.

Mr. Loiselle provided education regarding the broad gender spectrum, including descriptions of 13 terms of identification along the gender spectrum. After an overview of the gender spectrum and a definition of gender dysphoria, he explained how gender dysphoria and associated co-occurring issues such as depression, anxiety, PTSD, substance abuse, personality disorders, etc., are identified. A broad view of treatment planning to address common issues associated with gender dysphoria were presented. Mr. Loiselle closed the presentation by sharing some of the barriers to care people along the gender spectrum experience and what we, in our roles, can do to minimize and/or eliminate those barriers.

The training received positive verbal feedback. It was well attended and participants asked questions. There were requests for additional training in gender dysphoria. There was no formal evaluation tool to measure knowledge base and awareness.

☒Short-Term Activity or
☐Long-Term Activity

How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
For each training, Moda Health will implement an evaluation tool to measure pre- and post-training knowledge and understanding of training topic, quality of training, and relevance to current issues staff deals with, suggestions for improvement.	None for 2017	85% post-training level of knowledge and understanding of cultural training topic.	12/2018	95% post-training level of knowledge and understanding of cultural training topic.	12/2019 & each year thereafter

F. PERFORMANCE IMPROVEMENT

Activity 3: Continue to collect data regarding cultural and linguistic capabilities, and office/facility accommodations for people with physical disabilities, from our contracted providers.

☒Short-Term Activity or
☐ Long-Term Activity

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Percent of providers who return cultural and linguistic capabilities data and office/facility accommodations for people with physical disabilities.	NA	75% of contracted providers in the 12 EOCCO counties.	06/2018	75% of the entire EOCCO provider panel.	01/2019

A. TQS COMPONENT(S)			
Primary Component:	Access	**Secondary Component:**	Choose an item.
Additional Components:	Add text here.		
Subcomponents:	Access: Cultural considerations	**Additional Subcomponent(s):**	Add text here.

B. NARRATIVE OF THE PROJECT OR PROGRAM

Each year the OHA administers the adult and child Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys in the spring on behalf of the 16 CCOs. The survey asks members to report on and evaluate their experiences with healthcare. The survey covers topics about ease of getting information from the health plan, communication skills of providers and ease of access to healthcare services. Two composite measures (Access to Care and Satisfaction with Care) are CCO incentive measures. EOCCO uses survey results to inform our decisions on improving the quality of healthcare services for our members.

C. QUALITY ASSESSMENT

Evaluation Analysis:	The 2017 survey was sent to 1,781 randomly selected EOCCO adults and children. There were 598 EOCCO valid responses for an overall 33.6% response rate. Two questions make up the Access to Care composite rating: how often the member got care for an illness/injury/condition as soon as he/she thought needed (urgent care) and how often the member got an appointment for routine care as soon as he/she thought needed. Our combined rate (adult and child surveys) for the Access to Care survey item was 82.6% compared with 82.0% in CAHPS 2016, but short of our 2017 83.7% target rate. EOCCO has yet to meet the yearly improvement target rates for the access measure. While the limited resources spread out within our wide and rural geographic service area makes the access to care measure a challenge for us, additional CAHPS survey data this year, e.g., FIPS codes, will help us to be more targeted in identifying and prioritizing improvement opportunities. Key findings: • Response rates for respondents who spoke Spanish or who reported Hispanic or Latino ethnicity was relatively high (52.5% Spanish speaking versus 31.3% for English speaking respondents)

	• Adult and Child Spanish speaking respondents gave lower scores for access to routine care than English speaking members: 66.7% for Spanish speaking adults compared with 74.3% for English speaking adults. • While the rate for access to routine care for EOCCO children of Hispanic ethnicity improved from CAHPS 2016 to CAHPS 2017, rates in both years lagged behind the rates of access to care for all EOCCO children. • Child and adult females reported lower rates for access to routine care compared with Child and Adult males. • The county with the lowest overall access score was Wallowa (64.3%), followed by Morrow (75.9%), Lake (76.9%) and Grant (77.8%). • Missing data for race and ethnicity were barriers to analysis in that each race/ethnicity category may not represent the true EOCCO membership. For example results for access to routine care were Unknown race at 75.3% versus 82.9 for White and Unknown ethnicity at 87.5% compared with Hispanic/Latino at 80.9% and Not Hispanic/Latino at 81.7%.

D. PERFORMANCE IMPROVEMENT

Activity: EOCCO incentive metrics work plan will include a project to improve CAHPS access to routine care measures for Hispanic women and children. We would like to target interventions to these two population segments to see whether significant improvement in access to routine care rates will positively impact our ability to meet the CCO access to care improvement targets. The project is scheduled to begin in Q3 2018 when we will have the results from the EOCCO CAHPS 2018 to refresh our data. Exploratory discussions have centered on: • Ensure culturally competent member material regarding access to care (i.e., effective contraceptive use, prenatal and postpartum care, colorectal cancer screening, childhood immunizations, early childhood development, weight assessment and counseling). • Ensure these population segments have established PCPs or PCPCHs; use the member advocate or community health worker outreach to establish a PCPCH or orient the member to PCPCH services. • Piloting outreach in counties that have the population density and did not meet the CAHPS 2017 target rates for routine care—Umatilla (82.8%), Union (83.1%), Wallowa (64.3%) and Morrow (75.9%). • When applicable, work with Community Benefit Initiative awardees on targeted culturally competent messaging regarding access to children's and women's services.	☐ Short-Term Activity or ☒ Long-Term Activity

How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
CAHPS survey results for access to routine care for female adults	CAHPS 2017-73.3%	Better aligns with CAHPS 2019 OHA improvement target.	6/2019	Better aligns with CAHPS 2020 OHA improvement target.	6/2020

of Hispanic ethnicity.					
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
CAHPS survey results for access to routine care for children of Hispanic ethnicity.	CAHPS 2017-82.6%	Better aligns with CAHPS 2019 OHA improvement target.	6/2019	Better aligns with CAHPS 2020 OHA improvement target.	6/2020

A. TQS COMPONENT(S)			
Primary Component:	Access	**Secondary Component:**	Choose an item.
Additional Components:	Add text here.		
Subcomponents:	Access: Quality and appropriateness of care furnished to all members	**Additional Subcomponent(s):**	Add text here.
B. NARRATIVE OF THE PROJECT OR PROGRAM			
EOCCO participates in county collaborative meetings with all 12 counties within the eastern Oregon territory. The collaborative meetings are held at regular intervals and include representatives from intensive case management, both behavioral and physical, as well as supervisors and directors from Aging and Peoples with Disabilities (APD). The purpose of the collaborative, otherwise known as Multidisciplinary Team (MDT), is to improve person-centered care, align care and service delivery, and to provide "the right amount of care in the right place at the right time" for beneficiaries across the continuum of care.			
C. QUALITY ASSESSMENT			
Evaluation Analysis:	All skilled nursing admissions are required to be reported to Aging and Peoples with Disabilities per the 2017 Memorandum of Understanding. By doing this, EOCCO partners with APD to ensure that our members are receiving the right kind of care and level of care or assistance after discharge. In 2017, 56 members were referred to the East 6 Multidisciplinary Team (MDT), and 54 were referred to the Umatilla/Morrow MDT. Referral sources vary between community health workers, community medical professionals, GOBHI, APD and Moda. In all cases, the referral source recognized a need for additional services for the member and required organized assistance. Thirty-nine of the 110 referrals were to receive additional services from Aging and Peoples with Disabilities such as long term care, in-home caregivers, or new home placements. Thirty-three of the 39 were referred upon admission to a skilled nursing facility (SNF) or a swing bed, to fulfill the contractual agreement. These members were assessed and provided additional services or were determined to not need them. Byproducts of the reported SNF or swing bed admission were that it provided additional review of each		

	member's personal situation, and engaged the member in thinking about personal healthcare needs. Six of the 39 members refused to engage with APD for assessment. The Oregon Health Authority post-hospital extended stay (SNF) benefit is limited to 20 days. Upon referral, dependent upon the case load of the APD transition/diversion coordinator, an assessment can take up to 3 weeks to complete, with additional time to apply the new benefit if the member qualifies. By notifying or referring the member upon admission rather than when a potential barrier to discharge arises, we can reduce the time that the member is in a facility with no clear payer source, as well as reduce additional days approved by EOCCO outside of the 20-day benefit. Currently, EOCCO has no streamlined process to determine skilled nursing facility or swing bed admissions from regular hospital stays for the EOCCO population.

D. PERFORMANCE IMPROVEMENT

Activity: We will develop a monthly report from our core operating system, Facets, to differentiate skilled nursing facility and swing bed admissions from hospital admissions. We will be able to ensure that admissions are reported accurately, thereby increasing the personal touch on each of these cases, which then allows for each discharge to be monitored for safety and appropriateness of care, more cost effectively.	☒Short-Term Activity or ☐ Long-Term Activity

How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Internal team of EOCCO case management, care coordination.	NA	Create a new policy and procedure or incorporate into an existing Users Procedure Manual for referring skilled nursing admissions to APD through the MDTs.	04/2018	Instruction formally implemented.	06/2018
Internal team of EOCCO case management, care coordination.	NA	Engage Benefit Configuration team to develop a separate reporting structure specifically for EOCCO skilled nursing and swing bed admissions.	04/2018	Report in use	06/2018
Internal team of EOCCO case management, care coordination.	NA	Compare admissions reported to MDTs with	07/018	Report 95% of all SNF and swing bed	12/2018

		hardcopy report of actual admissions obtained from Facets.		admissions to the MDTs.	

A. TQS COMPONENT(S)			
Primary Component:	Access	**Secondary Component:**	Integration of care (physical, behavioral and oral health)
Additional Components:			
Subcomponents:	Access: Quality and appropriateness of care furnished to all members	**Additional Subcomponent(s):**	Add text here.

B. NARRATIVE OF THE PROJECT OR PROGRAM
EOCCO promotes meaningful member outreach and has a variety of programs to help improve or maintain the health status of EOCCO members. Using the health risk assessment referrals, we would like to develop systematic processes to ensure follow-through that improves member access to services and ensures that the best method of engagement is utilized for them and that we have the documentation to help measure effectiveness. The overarching goal of our project is to create education based on the member's lifestyle.

C. QUALITY ASSESSMENT	
Evaluation Analysis:	EOCCO mails a health risk assessment (HRA) to every new EOCCO member coming onto the plan as part of the welcoming process. HRAs help us to assess new member engagement in their own healthcare, potential access concerns, modifiable high risk behaviors and current health status. In 2017, we mailed 1,472 HRAs to new members and 1,230 were returned to use for measurable data. Administrative staff review the HRAs to determine whether members meet case review criteria for enrollment into care coordination, case management (medical or behavioral health), health coaching or a short- term intervention. Of the returned HRAs, 257 were referred to health coaching of which 236 were primarily for smoking cessation. Our analysis showed that we lack processes to track the outcomes of the HRA referrals. Barriers to effective monitoring included staffing levels, lack of/incomplete tracking tools, staff training and lack of documented processes. The HRA is the primary method used to identify EOCCO members who use tobacco. Our EOCCO CAHPS surveys in 2017 and 2016 revealed that 30% and 29% of respondents, respectively, indicated they smoked cigarettes or used tobacco every day or some days compared with 29% of the overall Oregon Health Plan survey population in both years. In the 2014 Medicaid Behavioral Risk Factor Surveillance Survey report, more adult Medicaid members indicated they smoked cigarettes or chewed tobacco (32.9%) than all Oregon adults (19.8%). EOCCO members were included in this survey. We do not have a systematic process in place to follow up on the HRA referrals for tobacco cessation and document outcomes. Our program will use 2018 HRA referral activity to expand how Case Management tracks the HRAs and referrals. We want to extract the data and use them for the purposes that were intended. Our project will implement processes to better collect information on

	health coaching engagement rates, use of services, and member experience. The data collected in 2018 will help to establish baselines. Following are some details of the scope of our project: • Enhance HRA referral tracking to identify the specific health coaching program. • Develop specified education for tobacco cessation based on the member's lifestyle. • Establish process to have GOBHI handle HRA referrals for behavioral health and addiction diagnoses, including tobacco cessation services. • Use Patient Activation Measure (embedded in the HRA) data, i.e., compare the level of self-empowerment between those who accepted health coaching versus those who did not. • Track members who engage in tobacco cessation services.

D. PERFORMANCE IMPROVEMENT

Activity: Adjust current Case Management data base to account for additional data we want to collect.				☒Short-Term Activity or ☐Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Supervisor monitors to ensure staff is entering the data appropriately	NA	NA	03/2018	NA	NA
Activity: Track and analyze member engagement initiated by referrals to health coaching.				☐Short-Term Activity or ☒Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Quarterly committee meetings (Intensive Case Management (ICM), Health Coaching, Care Coordination, Behavioral Health).	NA	Identify members with multiple co-morbidities who are also current tobacco users.	01/2019	Individualize education regarding current healthcare practices, i.e., surrounding surgical interventions and smoking.	To be determined
Activity: Track and analyze member engagement initiated by referrals to health coaching.				☐Short-Term Activity or ☒Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Quarterly committee meetings (ICM, Health Coaching, Care Coordination, Behavioral Health).	NA	Use Patient Activation Measure to assess level of self-empowerment; compare between members who	1/2019	Identify percentage of members who are successful with smoking cessation and also feel empowered. Conversely,	To be determined

		accepted health coaching for smoking cessation versus those who did not.		identify members who don't engage with smoking cessation and feel as if their health concerns are out of their control.	
Activity: Track and analyze member engagement initiated by referrals to health coaching.				☐Short-Term Activity or ☒Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Quarterly committee meetings (ICM, Health Coaching, Care Coordination, Behavioral Health).	NA	Identify members with behavioral health and addiction diagnoses that use tobacco smoke. Coordinate referrals to behavioral health/SUDS (GOBHI).	01/2019	Identify percentage of members who are successful with smoking cessation and also feel empowered. Conversely, identify members who don't engage with smoking cessation and feel as if their health concerns are out of their control.	To be determined

A. TQS COMPONENT(S)			
Primary Component:	Access	**Secondary Component:**	Special health care needs
Additional Components:	ED utilization by members with an SPMI diagnosis		
Subcomponents:	Access: Quality and appropriateness of care furnished to all members	**Additional Subcomponent(s):**	Utilization review

B. NARRATIVE OF THE PROJECT OR PROGRAM

Increased emergency department utilization is often a sign of problems with access to primary care, specialty care, and behavioral health care or dental care. Ensuring that members who are showing high patterns of emergency department utilization have a care plan in the Oregon EDIE/Pre-Manage software system will help with the coordination of care and communication between the various organizations caring for our members.

C. QUALITY ASSESSMENT

Evaluation Analysis:

A review of the 2017 ED utilization data showed approximately 1,000 members who had > 5 ED visits during the year.

ED visits per 1,000 members	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
EOCCO	50.8	45.6	54.3	50.2	54.0	49.2	52.9	47.4	46.0	48.8	46.8

Patients with 5 ED visits in 12-months	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
EOCCO	19	39	60	68	76	94	99	111	130	128	108

D. PERFORMANCE IMPROVEMENT

Activity: A care plan will be entered into EDIE/Pre-Manage for all members with >5 ED visits in past 12 months.

☐ Short-Term Activity or
☒ Long-Term Activity

How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
% of members with > 5 visits in past 12 months who have a care plan in EDIE/Pre-Manage.	0	50%	12/2018	95%	12/2019

A. TQS COMPONENT(S)

Primary Component:	Access	**Secondary Component:**	Choose an item.
Additional Components:	Add text here.		
Subcomponents:	Access: Second opinions	**Additional Subcomponent(s):**	Add text here.

B. NARRATIVE OF THE PROJECT OR PROGRAM

EOCCO has a policy and procedure on second opinions. While the approach may vary among Moda Health, GOBHI and our dental care organization partners, the intent is to ensure EOCCO members have the right to access a new qualified healthcare professional within the network for a second opinion regarding services and care. If an in-network provider is not available, EOCCO and its delegated entities will arrange to obtain a second opinion outside the network, at no cost to the member.

Physical health services
Moda Health does not require members to receive physical health services second opinions prior to authorizing select or non-routine services or procedures. No referral is required to see in-network specialists and there is no limit on the number of visits to in-network specialists for first or subsequent opinions. Moda's operating system, Facets, has a dedicated and reportable "second opinion" data field in our utilization management (UM) application. We capture the data from the EOCCO prior authorization form, which includes yes and no checkboxes on whether the request is for a second opinion. This field is only used when the request is to an out-of-network specialist.

Behavioral health services
GOBHI does not require a prior authorization for second opinions for outpatient services if the provider is in-network. For second opinions by out-of-network outpatient providers, or for all specialty outpatient or inpatient services, the member or provider, on behalf of a member, contacts GOBHI to request the authorization. GOBHI's implementation of the Altruista medical management software application in September 2016 improved the tracking of inpatient and specialty outpatient services and out-of-network outpatient second opinions in 2017, through claims assessment codes and out-of-network analysis. Due to their easy accessibility (no authorization required) in-network outpatient second opinions cannot be tracked.

Dental services
Capitol Dental Care
Second opinion requests were historically difficult to track for Capitol Dental Care (CDC) due to the way that they were processed administratively. CDC logged requests for second opinions in the notes section of its claims processing platform. This involved significant time spent pulling and reading the notes section for second opinions. In 2017, CDC worked with the administrator of its clinical integration manager to implement a drop-down style classification to capture member requests such as second opinions and referrals. CDC is now able to generate accurate reports for second opinion requests more efficiently and to analyze the data by CCO, thus facilitating analysis. While CDC was able to track EOCCO referrals for oral surgeons, pedodontists and denturists in 2017, there were no EOCCO requests for second opinions.

ODS Community Dental
A member or a general dentist may access a second opinion from a specialty provider by calling ODS Community Dental customer service or by referring directly to any in-network ODS OHP provider. When the member or the general dentist calls ODS Community Dental customer service, the request is documented as a task note in Facets with the second opinion provider's name and contact information. In 2017, ODS Community Dental noted three second opinion requests for EOCCO members.

Advantage Dental
The case management (CM) team processes second opinion requests and schedules the office visit within 30 days of receiving a signed release of information. The CM team obtains chart notes and X-rays pertaining to the reason for the second opinion from the primary care dentist (PCD) and forwards the information to the assigned second opinion provider. When the second opinion provider reports back to the PCD and the CM team, the case manager follows-up with the member. If an Advantage Dental-contracted provider is available for the second opinion but the member declines the referral and requests to see a non-contracted provider, the member is responsible for the consultation fee. In the case where Advantage Dental does not have a qualified contracted provider, it arranges for a qualified non-contracted provider at no cost to the member and, in these cases, Advantage Dental forewarns the member that non-contracted providers may not completely understand the MAP Dental Services rulebook and may not be able to tell them what services are covered under their plan. The case manager documents second opinions in the operating system. In 2017, there were 0 second opinion requests for EOCCO.

Provider training
Provider training, during onboarding or onsite clinic visits, includes our policies on service authorizations, referrals and second opinions. Our provider handbook and the service authorization guidelines on the provider page of the EOCCO website indicate that we cover second opinions at no cost to the member.

C. QUALITY ASSESSMENT

Evaluation Analysis: The following table displays EOCCO second opinion requests reported in 2017 and 2016.

Service	Reported	
	2016	2017
Physical health	0	8
Behavioral health	0	0

Dental health (all DCOs)	0	3	

In both years, we received no member complaints related to lack of access to or denial of a second opinion.

Based on our current policy that, as much as possible, supports direct access to in-network specialty care, we do not see the need to change our practices for the tracking and monitoring of second opinions.

D. PERFORMANCE IMPROVEMENT

Activity: Will continue monitoring of member complaints regarding barriers, trends or denials of second opinion requests.

☒Short-Term Activity or
☐ Long-Term Activity

How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Second opinion complaints, trends and barriers will be tracked and discussed at EOCCO QIC.	NA	NA	NA	NA	NA

A. TQS COMPONENT(S)

Primary Component:	Access	**Secondary Component:**	Choose an item.
Additional Components:	Add text here.		
Subcomponents:	Access: Timely access	**Additional Subcomponent(s):**	Pre-Service Decision Making

B. NARRATIVE OF THE PROJECT OR PROGRAM

EOCCO partners and delegated entities have the following performance expectations for prior authorizations and referrals.

- 95% of standard prior authorization requests are processed within 14 calendar days
- 95% of expedited prior authorization requests are processed within 72 hours
- 95% of referrals are processed within 14 calendar days

Using data entered into our respective operating systems, we monitor these processes continuously for compliance with the Oregon administrative rules to ensure EOCCO members receive timely access to care, tests and treatment they need.

C. QUALITY ASSESSMENT

Evaluation Analysis:

Activity 1. Physical Medicine
In 2017, a total of 42,956 physical health service requests were received and completed; 29,378 were pre-service authorizations and 13,578 were for referrals to out-of-network providers.

Pre-service authorizations – 29,378:

- 95.65% completed within 14 calendar days.
- 92.15% completed within 10 calendar days.
- 66.5% completed within 3 calendar days.

Referrals – 13,578:

- 99.72% completed within 14 calendar days.
- 96.36% completed within 2 business days.

2017 Summary
In 2017, EOCCO improved overall performance relating to physical medicine turnaround times combined for standard and expedited requests, and referrals by approximately 11% over the 84% in 2016.

Activity 2. Behavioral Health (GOBHI)
2017 expedited EOCCO pre-service authorizations – 284:
- % completed within 3 calendar days: 83.0%

2017 standard EOCCO pre-service authorization – 43:
- % completed within 14 calendar days: 92.8% (8 months' data)

Activity 3. Dental Care Organizations
EOCCO's delegated dental care organizations report compliance with our benchmarks to the Medicaid Compliance Officer. A review of a sampling of standard DCO prior authorization files showed the following:

Dental Care Organization	Average turn-around time in calendar days	% processed within 14 calendar days
Advantage Dental	7.7	100%
Capitol Dental Care	1.2	100%
ODS	3.0	99%

D. PERFORMANCE IMPROVEMENT

Activity 1: In 2017, Healthcare Services implemented a plan to improve the overall timeliness of pre-service determinations, intra-departmental and inter-departmental communication in a meaningful way, and to standardize treatment of standard and expedited pre-service determination methods in the Government Programs department.

The initial implementation yielded an 11% increase in timeliness combined for standard and expedited pre-service determinations for a total of 95.08% of cases completed within the 14 calendar day turnaround time.

To increase the level of communication between departments and to standardize processing of standard and expedited pre-service determinations, and referrals, we expanded on an existing method used for Medicare requests and applied it to EOCCO.

One barrier to implementation of this project in 2017 largely includes the integration of new software and learning its nuances as well as training multiple departments on the specific uses of the software. Another barrier was standardizing communication methods between departments, and enforcing the new methods.

In 2018, this project continues in three different realms: 1. tracking standard vs. expedited requests consistently using additional data fields within the operating systems, 2. educating providers regarding current OAR definitions of an urgent or expedited request, 3. meeting each OHA mandated turnaround time for standard and expedited PA requests and referrals 95% of the time.

☐Short-Term Activity or
☒Long-Term Activity

Our plan is to train staff on correct procedures to differentiate within the systems between standard, expedited, retrospective and claims appeals requests. This is an ongoing activity because this requires constant re-visiting when departments shift or turnover is experienced.					
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Weekly committee meetings and assignments.	NA	Training created for individual business units that "touch" EOCCO requests on identifying expedited requests.	04/2018	Training completed for each business unit.	06/2018
Activity: Departmental accountability for recognizing non-compliant cases, determining where the process broke down, and creating an action plan for preventing a repeat occurrence for the same reason.				☒Short-Term Activity or ☐Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Weekly and Monthly Reports	NA	Committee will develop a process to monitor and report individual cases that fall outside of mandated turnaround times.	04/2018	All non-compliant cases will be reported to the departmental leaders to determine root-cause analysis.	06/2018
Activity: All turnaround times				☐ Short-Term Activity or ☒Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Weekly and Monthly Reporting	95% combined for standard, expedited PA requests and referrals.	95% for each OHA specified turnaround time (standard and expedited PAs, referrals) and notification requirements.	12/2018	Maintain 95% benchmark for each OHA specified turnaround time and notification requirements.	12/2019
E. PERFORMANCE IMPROVEMENT					
Activity 2: GOBHI implemented the Altruista medical management/utilization management software application in September 2016. As of the first of the year, issues continue with the accuracy in reporting of timelines with the new application thereby requiring manual calculations. GOBHI continues to work with				☒Short-Term Activity or ☐ Long-Term Activity	

the software vendor to improve reporting. Regarding meeting the 95% performance expectation for the processing of expedited and standard pre-service requests, GOBHI leadership has implemented/completed the following since October 2017: • Evaluated workflows to remove non-value added steps and improve efficiency. • Provided UM staff with additional training on expected workflows and timeframes. • Held weekly staff meetings to discuss questions, concerns and share best practices. • Measured individual team member's timeframes and shares with staff monthly. • Implemented process to ensure coverage during planned and unplanned time off work.					
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
UM reports to Compliance Officer.	Expedited PAs – 83.0% Standard PAs – 92.8%	95%	6/2018	NA	NA

A. TQS COMPONENT(S) – CLAS Standards and Provider Network, Health Equity (Cultural Competence)			
Primary Component:	CLAS standards and provider network	**Secondary Component:**	Health equity and data
Additional Components:	Add text here.		
Subcomponents:	Health Equity: Cultural competence	**Additional Subcomponent(s):**	Add text here.

B. NARRATIVE OF THE PROJECT OR PROGRAM
Communication and Language Assistance Services Implementation Plan: 1. Ensure that members receive linguistically appropriate materials from EOCCO. 2. Ensure that members receive multilingual customer service to facilitate effective communication. 3. Ensure that EOCCO network providers know how to access interpreter services for member appointments and that members are aware of the available service. 4. Ensure that all EOCCO staff and partners are trained in workplace diversity and cultural competency.

C. QUALITY ASSESSMENT	
Evaluation Analysis:	As the state of Oregon's population continues to become more diverse, EOCCO network providers serve members from diverse cultural and linguistic backgrounds. Providing linguistically appropriate healthcare in both verbal and written forms plays a crucial role in effectively delivering healthcare services. Barriers to providing culturally competent care include member engagement, health literacy, and language proficiency. There is limited use of the interpreter services available to the EOCCO member population.

D. PERFORMANCE IMPROVEMENT	
Activity 1: Member Communications and Materials via EOCCO	☐ Short-Term Activity or

Quarterly, EOCCO and its delegated entities verify the languages of the substantial population from the declared languages reported on the 834 eligibility files. As needed, EOCCO adjusts translated member materials for significant new languages in the EOCCO membership. EOCCO and their delegated entities use respective vendors to translate written material. Our EOCCO member informational material has been revised to meet our organization's cultural sensitivity and health literacy standards. We use the Patient Education Materials Assessment Tool (PEMAT) and our Cultural Sensitivity Health Literacy (CSHL) standard guidelines to assess member communications and website member materials. The PEMAT rates understandability and actionability of materials. We plan to restructure and edit materials to meet members' cultural and linguistic needs. The CSHL guidelines help to ensure member materials are educational; are easy to access, understand and act upon, engage members in their healthcare and result in better health outcomes. EOCCO has tools to assess materials, but needs to develop a way to track and catalog materials in order to assess the percentage of materials following PEMAT and CSHL standards. Year one, we plan to establish and track the materials we have by working with case management, health coaching, and the Medicaid team. Year two, we plan to evaluate how many need to be adjusted based on the score of the literacy standards. The ultimate goal by year three is to have all current and new EOCCO materials assessed and adjusted to be compliant with PEMAT and CSHL standards.	☒ Long-Term Activity

How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Track the percentage of EOCCO materials following PEMAT and CSHL guidelines.	To be determined	100%	12/2018	100%	12/2018
Evaluate how many EOCCO materials need to be adjusted to meet the guidelines.	To be determined	100%	12/2019	100%	12/2019
All current and new EOCCO materials follow PEMAT and CSHL standards.	To be determined	100%	12/2020	100%	12/2020

Activity 2: Multilingual Customer Service EOCCO and our delegated dental care organizations provide multilingual customer service at no charge to the member. For example, through respective business agreements with interpreter services vendors, Moda Health, GOBHI and the DCOs provide language services during regular business hours. When a member calls customer service and requires language assistance, the customer service representative will dial into Voiance via a conference call. A Voiance representative will come on the line and explain to the member that he or she is going to assist in the call to optimize communication. Members who are hearing impaired can contact EOCCO and its delegated entities through the TTY relay 711 phone number available to all members. The TDD/TTY phone numbers are included in the tag lines of all member materials. EOCCO and delegated entities are also prepared to meet the special health care needs of visually impaired	☐ Short-Term Activity or ☒ Long-Term Activity

members. EOCCO plans to evaluate the percentage of members who have identified a primary language other than English in order to best provide culturally and linguistically appropriate customer service. EOCCO will examine ways to increase data transparency through a gap analysis process.

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Percentage of members who have identified a primary language other than English.	To be determined	NA: This information will be used as the benchmark for increasing customer service interpretation over the phone.	09/2018	To be determined	09/2018
Percentage of members who have utilized Voiance for customer service interpretation over the phone.	To be determined	To be determined, to closer align with member who have identified a primary language other than English.	09/2018	To be determined	09/2020

Activity 3: Interpreter Services for Member Appointments

☐ Short-Term Activity or
☒ Long-Term Activity

EOCCO arranges for interpreter services at members' medical provider appointments. EOCCO member handbooks and participating provider manuals include instructions on how to request these services from Moda Health's interpreter service, Passport to Languages. In 2017, EOCCO arranged for interpreters at 434 EOCCO medical office visits, averaging 36 requests each month, at no charge to the member.

GOBHI requires each contracted provider to make available certified or qualified health care interpretive services free of charge to each potential member. EOCCO plans to evaluate if the percentage of utilized interpreter services at medical office visits aligns with the percentage of members who identified a primary language other than English. EOCCO will run an analysis to connect the state language data to our claims data to identify who specifically is not using a particular service. This will help us identify opportunities to increase awareness of the available interpreter services to both providers and members.

Language	2017 Total Calls/Visits	% of Interpreter Calls/Visits
Spanish	360	82.95%
Somali	52	11.98%
Arabic	13	3.00%
American Sign Language	8	1.84%
Mandarin	1	0.23%
TOTAL	434	100%

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Percentage of members who have identified a primary language other than English.	To be determined	This information will be used as the benchmark for increasing over- the-phone and in-person interpreter services.	09/2018	To be determined	09/2019
Percentage of members who have utilized Passport to Languages for interpretation at medical office visits.	To be determined	To be determined, to closer align with members who have identified a primary language other than English.	09/2018	To be determined	09/2019
Activity 4: Cultural Competency Training EOCCO implemented a new workplace diversity and cultural competency employee training that was launched in late 2017. Our partner dental care organizations already provide annual cultural competency training to their staff. By the end of year one, we will evaluate which EOCCO employees have been trained in workplace diversity and cultural competency. By the end of year two, we will standardize the trainings so that all EOCCO partners can participate. Our ultimate goal is that 100% of EOCCO team members who are member interfacing receive the training by 2020.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Evaluate which EOCCO employees have been trained in workplace diversity/cultural competency.	To be determined	50%	12/2018	To be determined	12/2018
Develop and standardize the trainings for all EOCCO partners.	To be determined	100%	12/2019	To be determined	12/2019
Implement annual training with all EOCCO partners.	To be determined	100%	12/2020	To be determined	12/2020

A. TQS COMPONENT(S)			
Primary Component:	Grievances and appeals	**Secondary Component:**	Choose an item.
Additional Components:	Add text here.		
Subcomponents:	Choose an item.	**Additional Subcomponent(s):**	Add text here.

B. NARRATIVE OF THE PROJECT OR PROGRAM

Changes to the OARs in 2018:

Our goal for 2018 is to be compliant with all 2018 updates to the Oregon Administrative Rules (OARs). The following major changes were put into place on January 1, 2018, and will have the biggest impact for the grievance system:

- State contested case hearings can no longer be requested simultaneously to the appeal. The member must first exhaust their appeal rights prior to requesting a contested case hearing.
- The member now has 60 days from the date of the Notice of Adverse Benefit Determination to file an appeal instead of 45 days.
- Standard appeals will need to be resolved in 16 days instead of 14 days and expedited appeals will need to be resolved in 72 hours instead of 3 business days.

2017 notices of action, appeals and complaints

EOCCO and its partners process Oregon Health Plan (OHP) complaints and appeals according to the OARs. We log complaints and appeals (medical, dental, pharmacy, behavioral health), whether received in writing or by telephone, into our OHP grievance database and report cases to the Oregon Health Authority (OHA). Please see the 2017 quarterly reports that we submitted to the OHA for details. The following table displays the complaints, notices of action (NOA), appeals and contested hearing requests that EOCCO received in 2017.

2017 EOCCO Grievance System

	2016 experience	1Q17	2Q17	3Q17	4Q17	2017 experience
# Complaints	177	98	87	84	79	348
# Notices of Action	4,105	934	1,179	1,063	968	4,144
# Appeals	234	55	51	49	53	208
# Contested hearing requests	79	12	12	10	8	42

The volume of case files dropped significantly in 2016 for NOAs, appeals and contested hearing requests. We attribute the decrease to the process change we made in September 2015 to discontinue post-service notices of action letters to members. Our former practice was to send NOAs on all claims denials, including those with zero member financial responsibility. In 2016 we experienced an 89% drop in NOAs issued and a 68% drop in appeals received compared with 2015. 2016 is our new baseline year to compare NOA, appeal and contested hearing volume going forward. In 2017, the NOA and appeal volume remained the same from the prior year, and the volume of contested case hearings dropped 53%. However, the number of complaints increased 51%.

Appeals

The significant service types in our 2017 appeals were specialty care (31.48%), pharmacy (24.68%) and dental services (21.75%), which were consistent with our 2016 appeal experience.

Process improvement for untimely appeals

While we continuously strive for 100% compliance with appeal OARs, the EOCCO appeal team aims to consistently respond to 95% of appeals within the appropriate timeframe: 14 days for standard appeals and 3 business days for expedited appeals. In Q4 2017, we exceeded our goal of 95% and were 100% compliant with the appropriate appeals timeframes. This shows significant improvement from 2016 in which the EOCCO appeals team averaged 74% compliance in Q4 2016.

Q4 2017 EOCCO appeal performance

Appeal type	Metric	Goal	October	November	December
Expedited Appeals	% of expedited appeals resolved within 3 working days or 17 with approved extension.	95%	100% (3/3)	100% (6/6)	100% (3/3)
Standard Appeals	% of standard appeals resolved within 14 calendar days or with approved extension.	95%	100% (21/21)	100% (8/8)	100% (7/7)

Quality assurance – complaint turnaround times

Of the complaints that we handled in writing, on average in 2017, we processed 72% within 5 working days and 25% within 6-30 days, and we missed the 30-day timeline in 3% of cases. While we continuously strive for 100% compliance with complaint OARs, the EOCCO appeal team aims to consistently respond to 95% of complaints within the appropriate timeframe. The appeals department supervisor meets regularly with the appeal team to review OARs regarding complaint processing, process for complaint resolution over the phone, and timely provider outreach when clinical records are needed; and facilitates discussion of issues that are potential process improvements.

C. QUALITY ASSESSMENT

Evaluation Analysis:	In 2018, our goal of 95% compliance will continue with new standards for appeal turnaround times. Standard appeals will be completed in 16 days and expedited appeals will be completed in 72 hours per OAR 410-141-3245. In 2018, our goal is to complete 95% of complaints within 5 business days whenever possible and within 30 days when additional time is needed, in accordance with OAR 410-141-3235.

D. PERFORMANCE IMPROVEMENT

Activity: Plan of action:

- Update our policies and procedures to be compliant with the 2018 contract updates.
- Provide training to the appeal coordinators to ensure that 2018 contract changes are understood and implemented.
- Update letter templates to ensure that all 2018 contract changes are followed.
- The appeal supervisor and lead will continuously monitor compliance with the 2018 updates to the OARs.

☒ Short-Term Activity or
☐ Long-Term Activity

• Reaffirm process to check cases daily and be aware of due dates. • Reaffirm process with medical management team to help identify appeals accurately and forward to the appeal team in a timely manner. • Review expedited appeal timeframe with the dental claims department to ensure timely response to the appeal team.					
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
• Continuously monitor delays in obtaining clinical records from providers to look for trends and opportunity to do provider education. • The appeal supervisor and lead will continuously monitor turnaround times. • The appeal supervisor and lead will continuously monitor compliance with the 2018 updates to the OARs.	To be determined	To be determined	To be determined	To be determined	To be determined

A. TQS COMPONENT(S)			
Primary Component:	Fraud, waste and abuse	**Secondary Component:**	Choose an item.
Additional Components:	Add text here.		
Subcomponents:	Choose an item.	**Additional Subcomponent(s):**	Add text here.

B. NARRATIVE OF THE PROJECT OR PROGRAM
As part of EOCCO's Fraud, Waste and Abuse program service verification letters are sent to a randomly selected sample of members each month. The purpose of the letters is to ensure members received the services that we were billed to EOCCO. Since the member selection is random different provider types and groups are represented in each selection. At the conclusion of each quarter the EOCCO Compliance Officer collects the number of letters sent, response rates and the number of cases that were referred to the EOCCO SIU. Data collected is tracked, trended and reported to the EOCCO Quality Improvement Committee.

C. QUALITY ASSESSMENT	
Evaluation Analysis:	In 2016 4,579 Service Verification Letters were sent and 878 (19.1%) were returned. In 2017 4,555 Service Verification Letters were sent and 935 (20.5%) were returned. The average response rate for both years was 19.8%. The EOCCO Compliance Officer will gather response rates on a quarterly, versus yearly, basis to better track response rates and explore methods to increase those rates.

D. PERFORMANCE IMPROVEMENT					
Activity: EOCCO Compliance Officer will monitor Service Verification Letter response rate on a quarterly basis, report those results with the EOCCO Quality Improvement Committee and work on initiatives to increase response rate.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Service Verification Letter response rate.	19.8%	≥25%	12/2018	≥30%	12/2019

A. TQS COMPONENT(S) –Health Equity Data			
Primary Component:	Health equity and data	**Secondary Component:**	Choose an item.
Additional Components:	Add text here.		
Subcomponents:	Health Equity: Data	**Additional Subcomponent(s):**	Add text here.

B. NARRATIVE OF THE PROJECT OR PROGRAM
EOCCO is committed to eliminating health disparities and providing the highest quality of care to all EOCCO members, regardless of race, ethnicity or primary language. To provide culturally and linguistically appropriate services to EOCCO members, we plan to stratify data from the following sources to reveal health disparities. • EOCCO disseminates monthly provider progress reports to all clinics within the service area. These provider progress reports contain information about both race and ethnicity. This allows clinics to minimize gaps in care while also outreaching and delivering services in a culturally competent manner. • EOCCO receives race, ethnicity, and language data from the state. • The state provides a CAHPS Access to Care survey to EOCCO members on an annual basis. Once the results are received EOCCO stratifies this data by language, race, and ethnicity.

C. QUALITY ASSESSMENT	
Evaluation Analysis:	EOCCO plans to implement strategies in response to health disparities and gaps in care that are revealed by these reports. EOCCO will analyze claims data and compare OHA race and ethnicity data to identify trends in underutilized services leading to poorer preforming incentive measures within certain cultural or ethnic groups.

D. PERFORMANCE IMPROVEMENT

Activity 1:
EOCCO receives race/ethnicity and language data in the member eligibility files from the state. EOCCO also disseminates monthly provider progress reports that contain race/ethnicity and language data from Moda Health's internal data system. We plan to run an analysis of the state data and Moda Health's data to first identify the number of members in each race/ethnicity category and each language category. The objective of this analysis is to identify health disparities and to understand the makeup of our member population. Using the analysis as well as CAHPS Access to Care survey data, EOCCO will identify opportunities for improvement in gaps in care.

☐ Short-Term Activity or
☒ Long-Term Activity

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Percent of members who have identified a primary language other than English.	To be determined	NA: Will be used to identify utilization trends in the EOCCO population.	09/2018	NA: Will be used to identify utilization trends in the EOCCO population.	09/2018
Percent of members who have identified as another race/ethnicity besides Caucasian.	To be determined	NA: Will be used to identify utilization trends in the EOCCO population.	09/2018	NA: Will be used to identify utilization trends in the EOCCO population.	09/2018
Incentive measure metrics segmented by members who have identified as another race/ethnicity besides Caucasian and whose primary language isn't English compared to the outcomes of the rest of the EOCCO population.	To be determined	To be determined	12/2018	EOCCO incentive measure targets.	09/2020

A. TQS COMPONENT(S)			
Primary Component:	Health information technology	**Secondary Component:**	Choose an item.
Additional Components:			
Subcomponents:	HIT: Health information exchange	**Additional Subcomponent(s):**	Add text here.

B. NARRATIVE OF THE PROJECT OR PROGRAM

EOCCO understands the need and benefit to offer a health information exchange among our network of providers. This includes our medical, behavioral health, and dental partners. EOCCO has contracted with both Arcadia Analytics and PreManage to facilitate this sharing of information. Arcadia Analytics allows for clinic EHR data to be combined with Moda Health claims data in a format that is easily viewable and accessible. Clinics are able to see services provided to their patients that may not have occurred within their clinic however are valuable to the patients overall health. This allows the clinic to identify gaps in care and address them in real time. PreManage is a platform that is utilized by Moda Health, GOBHI, DCOs, and clinics. This platform allows for case management of our shared patients in a manner that is viewable by all parties previously stated. This allows for the opportunity to share pertinent information about a member's health in order to provide optimum care to that member.

C. QUALITY ASSESSMENT	
Evaluation Analysis:	In order to successfully share electronic health information across the majority of EOCCO providers our goal is to have at least 80% of our patient population represented in the platform. This requires the engagement of 17 of our largest health systems.

D. PERFORMANCE IMPROVEMENT

Activity: EOCCO and Arcadia Analytics established a contract to complete this implementation process. This contract includes the onboarding of 17 practices as well as the inclusion of CCO Incentive Measures. This process incorporates a connection between Arcadia Analytics, the practice EHR, and claims. EOCCO and Arcadia Analytics meet on a weekly basis to discuss the status of the onboarding process. This allows for continual communication to ensure barriers are addressed as they arise.	☐ Short-Term Activity or ☒ Long-Term Activity

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
EOCCO and Arcadia Analytics meet on a weekly basis to discuss the status of the onboarding process.	5/17 clinics are live with Arcadia.	17/17 clinics will be live with Arcadia.	12/2019	Additional clinics to be on-boarded.	12/2019

Activity: To implement PreManage across our population, EOCCO first shared this list of clinics with PreManage implementation staff to gauge the workload this will require. Based on this workload, PreManage requested to deploy clinics in batches to ensure appropriate PreManage capacity and clinic readiness to engage. To facilitate a smooth process between PreManage, EOCCO, and our clinics, EOCCO and PreManage staff meet on a bi-weekly basis to discuss the progress. During this status call any barriers are discussed and action items are determined based on need. EOCCO and PreManage will share a tracking document with clinic names and implementation status. This document will be discussed at each bi-weekly meeting.	☐ Short-Term Activity or ☒ Long-Term Activity

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
The number of clinics that adopt PreManage into their clinic workflows.	3/17 clinics are live with PreManage.	17/17 clinics will be live with PreManage.	12/2019	Additional clinics to be on-boarded.	12/2020

A. TQS COMPONENT(S)			
Primary Component:	Health information technology	**Secondary Component:**	Choose an item.
Additional Components:			
Subcomponents:	HIT: Analytics	**Additional Subcomponent(s):**	Add text here.

B. NARRATIVE OF THE PROJECT OR PROGRAM
EOCCO understands the need and benefit to offer our clinics methods to facilitate population management and to track performance metrics. EOCCO offers tools to our providers for this in the form of monthly Provider Progress Reports and with the Arcadia Analytics platform.

C. QUALITY ASSESSMENT	
Evaluation Analysis:	There are limitations in offering performance metrics and population management tools due to a claims lag or lack of ample data to do so. EOCCO strives to overcome these barriers to offer this information robustly and in a timely manner through the two aforementioned methods. EOCCO currently produces Provider Progress Reports on a monthly basis to each clinic with our membership. This Excel report includes a face sheet of the claims-based incentive measures and the clinic's performance of each. On the spreadsheet tabs to follow, there is a Member Roster tab to indicate all EOCCO members at the clinic's practice, their demographic information, and the member's performance for each measure. There is also a separate tab for each corresponding measure that includes a list of patients eligible for outreach. These reports allow for the clinic to contact the member and invite the member into the clinic to complete the overdue service. This allows the clinic to manage its population and also gauge whether or not its interventions are in fact improving performance. The limitations of this report include a three-month claims lag and the minimal incentive measures included. Arcadia Analytics is a platform that will allow for the inclusion of all 17 incentive measures, outreach rosters for each measure, and the ability to identify gaps in care at the time of visit. The limitations for this platform include the length of time in which it takes to implement the program, the data validation to ensure it is an accurate representation, and establishing this tool within the clinic workflow.

D. PERFORMANCE IMPROVEMENT					
Activity: To address the barriers to the Provider Progress Reports, we plan to make improvements to the already existing reports. We unfortunately cannot eliminate the three-month claims lag however, we can include additional measures on the report. By adding measures beyond the claims-based measures, clinics will be continually reminded of the other important metrics to track, as well as the target to strive for.				☒ Short-Term Activity or ☐ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**

EOCCO will meet with internal analytics team to make adjustments to reports. These meetings will exist until the reports have been updated accordingly.	7 measures included on report.	15 measures will be included on report.	04/2018	To be determined	04/2018
Activity: EOCCO plans to implement Arcadia Analytics in at least 17 of our practices. Once this has been accomplished we will ensure our practices are able to utilize the platform to its upmost capabilities. This includes reviewing their performance measure progress on a real-time basis for all incentive measures, utilizing the outreach lists to recall patients who are overdue for services and generating gap in care reports for patients who are scheduled to be seen that day. We will measure whether this tool is being used for both performance monitoring and population management. EOCCO will meet with Arcadia weekly to discuss clinic progress and reach out to clinics as needed for assistance.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
The number of clinics that implement Arcadia into their EHR reporting.	2/17 clinics are using this tool for performance monitoring and population management.	17/17 clinics will be using this tool for performance monitoring and population management.	12/2020	To be determined	12/2020

A. TQS COMPONENT(S)			
Primary Component:	Health information technology	**Secondary Component:**	Access
Additional Components:	Add text here.		
Subcomponents:	HIT: Patient engagement	**Additional Subcomponent(s):**	Access: Availability of services

B. NARRATIVE OF THE PROJECT OR PROGRAM

To assist facilitation of patient engagement with their care, EOCCO members with chronic pain will receive EOCCO assistance to sign up for an online pain school, which is a non-pharmacological chronic pain treatment program. EOCCO will send out member and provider communication on how to enroll in this program. EOCCO, through a grant, has sponsored this pilot program.

The pain school is a four-week program that provides pain education, movement therapy, tools and resources to reduce pain. Due to the vast geological landscape of EOCCO, it can be challenging for a member to travel to a pain school. This provides EOCCO members the option to stay at or close to their residence.

The program has been developed but not yet deployed to members. EOCCO is working through the communication strategy and plan to launch the program in Q2 2018.

C. QUALITY ASSESSMENT

Evaluation Analysis:	A review of EOCCO's claims data, suggests that we have a significant number of members with chronic pain. Due to the vast geological landscape of the EOCCO service area, we have

	an opportunity to engage them in an alternative treatment to assist in reducing chronic pain and opioid dependency, while making the services more accessible to EOCCO members.

D. PERFORMANCE IMPROVEMENT

Activity: Launch program to assist members in enrolling in the online pain school.				☒Short-Term Activity or ☐Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Number of members enrolled in the online pain school.	0	To be determined	06/2018	To be determined	01/2019

A. TQS COMPONENT(S)

Primary Component:	Integration of care (physical, behavioral and oral health)	**Secondary Component:**	Choose an item.
Additional Components:	Add text here.		
Subcomponents:	Choose an item.	**Additional Subcomponent(s):**	Add text here.

B. NARRATIVE OF THE PROJECT OR PROGRAM

EOCCO integrates care between the physical, behavioral and dental health perspectives as often as possible, and when the opportunity arises. The county collaborations, also known as multidisciplinary teams, are wonderful examples of the integration of care that EOCCO is capable of.

C. QUALITY ASSESSMENT

Evaluation Analysis:

In 2017, 56 members were referred to the East 6 Multidisciplinary Team (MDT), and 54 were referred to the Umatilla/Morrow MDT.

- 75 of 110 cases were referred uniquely to Aging and Peoples with Disabilities (APD) for services.
- 30 of 110 were referred uniquely for Behavioral Health or Substance Abuse Disorders.
- 2 of 110 were referred specifically for dental and behavioral intervention.
- 18 of 110 were referred for the combination of Behavioral and Physical Health Intervention.

Specific goals included long-term housing, behavioral intervention through counseling, physical health or behavioral health case management services; increased levels of service such as home caregivers or long-term physical health placement, and obtaining dental services when there are physical barriers to standard treatment options.

- 70 of 110 cases referred had goals successfully met.
- 14 of 110 cases referred had goals unsuccessfully met due to lack of member engagement. There was an even split of members that did not engage that were referred for behavioral and physical reasons, however 12 of the members who did not engage had multiple chronic conditions.
- 5 of 110 cases referred had goals unsuccessfully met for various reasons including rapid decline in condition, imprisonment, and inability to reach the referral source once the referral was made.

	• The remaining cases are currently still active. These county-based multidisciplinary teams have become known to individual communities in Eastern Oregon, as well as becoming a trusted addition to the resource list in each community. Our success rate has grown over the last three years based on the level of engagement with our partners. The MDT's are evolving regularly, and are an ongoing project to become better known and more effective as well as more transparent through the use of quantifiable and measurable outcomes. EOCCO actively participates in Health Fairs through the 12 EOCCO counties.

D. PERFORMANCE IMPROVEMENT

Activity: Increase specificity of initial goals and separate goals if there is more than one reason for referral.				☒ Short-Term Activity or ☐ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
This activity continues to be monitored via quarterly stakeholder oversight meetings.	Currently initial goals can only fall into one grouping.	Break goals into primary, secondary, and tertiary.	07/2018	Identify barriers to individual goals and categorize.	12/2018

Activity: EOCCO will participate in health fairs throughout the EOCCO region. With representation from physical, behavioral and dental EOCCO stakeholders, the goal is to better integrate care throughout the communities served.				☒ Short-Term Activity or ☐ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Active participation from physical, mental and dental at health fairs throughout the 12 EOCCO counties.	To be determined	>3 counties	12/2018	>5 counties	12/2019

A. TQS COMPONENT(S)			
Primary Component:	Value-based payment models	**Secondary Component:**	Patient-centered primary care home
Additional Components:	Add text here.		
Subcomponents:	Choose an item.	**Additional Subcomponent(s):**	Add text here.

B. NARRATIVE OF THE PROJECT OR PROGRAM
Continue to expand and evolve EOCCO's VBP models with its providers and increase the tier certification of EOCCO's PCPCHs.

C. QUALITY ASSESSMENT	
Evaluation Analysis:	Over the past five years EOCCO has made significant progress in adopting various forms of value-based payment (VBP) models across its network of in-area PCPCHs, hospitals and specialty providers. An in-area provider is defined as a provider that is located within the 12 counties of the EOCCO service area. For example, 75% of in-area primary care utilization is from providers participating in EOCCO's shared savings model, which includes performance incentive payments. 100% of in area hospitals participate in EOCCO's shared savings/shared risk model. Additionally, at this time, 91% of EOCCO members are assigned to a state certified PCPCH. EOCCO's contracted PCPCHs receive case management Per Member Per Month (PMPM) payments for each assigned EOCCO member. The PMPM payment increases based on the PCPCH's tier level of certification. Our goals and activities for this element will be to enhance and evolve what we have accomplished over the past five years. We also note that our activities around Value-Based Payment models will evolve based on the ultimate targets developed for EOCCO derived from the work currently in development between OHA and CCO's to adopt CCO specific VBP targets.

D. PERFORMANCE IMPROVEMENT					
Activity: 12 PCPCH practices will adopt a capitated payment VBP model with quality and shared savings opportunities				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Measure the number of PCPCH practices choosing a capitated VBP model contract.	11 PCPCH practices have adopted capitation with quality incentive and shared savings opportunities.	17 PCPCH practices have adopted capitation with quality incentive and shared savings opportunities.	09/2018	23 PCPCH practices have adopted capitation with quality incentive and shared savings opportunities.	09/2019
Activity: Include quality- based payment opportunities in DCO contracts.				☒ Short-Term Activity or ☐ Long-Term Activity	

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Modify current DCO contracts to include risk/reward performance incentive payment provisions for meeting certain quality measure targets.	DCO contracts do not include risk/reward performance incentive payment provisions for meeting quality measure targets.	Each of EOCCO's contracted DCO's include risk/reward performance incentive payment provisions for meeting quality measure targets.	01/2019	Each of EOCCO's contracted DCO's include risk/reward performance incentive payment provisions for meeting quality measure targets.	01/2020
Activity: Explore the possibility of implementing a capitated VBP model including a shared risk contract with an in-area EOCCO hospital.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
EOCCO will work in collaboration with its Actuarial team and in coordination with an EOCCO hospital to determine if hospital capitation can be a viable VBP model in a rural service area.	100% of in-area EOCCO hospitals participate in a VBP model that includes shared risk/rewards.	EOCCO to determine if a capitated VBP model is a viable option.	01/2019	One of EOCCO's in-area hospitals has a capitated VBP model contract in place if EOCCO determines capitation is a viable option.	01/2020
Activity: Increase the percent of in area primary care utilization that is from providers participating in EOCCO's VBP model that includes shared savings with quality incentive payments.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Measure the percent of in area primary care utilization that is from providers participating in an EOCCO VBP model that includes shared savings with quality incentive payments.	75% of in-area primary care utilization is from providers participating in an EOCCO VBP model that includes shared savings with quality incentive payments.	85% of in-area primary care utilization is from providers participating in an EOCCO VBP model that includes shared savings with quality incentive payments.	09/2018	90% of in area primary care utilization is from providers participating in an EOCCO VBP model that includes shared savings with quality incentive payments.	09/2019
Activity: Increase the number of currently certified PCPCH's to achieve tier 4 and higher certification. Continue to provide enhanced PMPM case management payments to PCPCH's as a VBP and as an enhancement to pursue higher tier levels of certification.				☐ Short-Term Activity or ☒ Long-Term Activity	

How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Measure the percent of EOCCO members assigned/attributed to a PCPCH that receives case management payments as one form of VBP.	Current percent of EOCCO members assigned to a PCPCH based on tier level of certification: No certification: 9% Tier 1: 1% Tier 2: 1% Tier 3: 27% Tier 4: 48% Tier 5: 14% Total: 100%	Percent of EOCCO members assigned to a PCPCH based on tier level of certification: No certification: 9% Tier 1: 0% Tier 2: 0% Tier 3: 20% Tier 4: 55% Tier 5: 16% Total: 100%	01/2019	Percent of EOCCO members assigned to a PCPCH based on tier level of certification: No Certification: 8% Tier 1: 0% Tier 2: 0% Tier 3: 7% Tier 4: 65% Tier 5: 20% Total: 100%	01/2020

A. TQS COMPONENT(S)			
Primary Component:	Severe and persistent mental illness	**Secondary Component:** Integration of Care	Special health care needs
Additional Components:	Follow-up after hospitalization for mental illness was selected as a measure because of the importance of timely follow-up in preventing hospital readmissions. Reducing hospital admissions is a key component in achieving the Triple Aim (better care, better health, lower cost).		
Subcomponents:	HIT: Health information exchange	**Additional Subcomponent(s):**	Add text here.

B. NARRATIVE OF THE PROJECT OR PROGRAM

Based on the importance of follow-up post-hospitalization and the 2016 rates, GOBHI prioritized this measure for performance improvement. Improved performance on this measure is also a priority for the State of Oregon and the U.S. Department of Justice. The interventions selected by GOBHI primarily focus on discharge planning at the time of admission, improving access to real-time data, and clarifying roles and responsibilities regarding post-hospitalization follow-up. GOBHI endeavors to improve performance on this measure annually in alignment with the State of Oregon performance plan and nationally benchmarked HEDIS measures.

- Beginning discharge planning at the time of admission is a recognized best practice, ensuring that patients are receiving the right care, in the right place for the right amount of time. It also helps to reduce lengths of stays, thus freeing up bed space for those who need it. Cost reductions have been realized from early discharge planning.

C. QUALITY ASSESSMENT

Evaluation Analysis:	GOBHI did not meet the 2016 goal for follow up post hospitalization, but did meet the improvement target. The reported rate of 72.7 % was slightly below the goal of 79.9 %. The goal of 79.9 % was based on the State goal in 2016. For 2018, GOBHI selected a goal of 85% based on what would show statistically significant improvement. In order to show meaningful improvement and to achieve the 2018 goals, GOBHI will need to focus efforts on improving performance with this measure based on the barrier analysis discussed below.

Item being measured	Num.	Denom.	Rate	2016 Goal	Goal Met (Y/N)	2018 Goal
BASELINE January 1 – December 31, 2016	137	188	72.7%	79.9%	No	85.0%

D. PERFORMANCE IMPROVEMENT

Activity:

1) Discharge Planning at time of admission: GOBHI Utilization Management team receives notification in EDIE/Pre-Manage (via ADT feed) that member has been hospitalized for behavioral health diagnosis. UM staff forwards information to GOBHI Care Management, who then contacts the CMHP that is caring for the patient. GOBHI and the CMHP begin working on a discharge plan for that patient. Discharge plans will be updated daily for short-term hospitalizations and at regular intervals for longer stays.

2) GOBHI will assist CMHP provider organizations with gaining access to PreManage by covering the costs and coordinating access. GOBHI will provide outreach and education to those providers that have not enrolled with PreManage. GOBHI will encourage facilities to use this information to outreach to members and call them in for a follow-up visit.

☐ Short-Term Activity or
☒ Long-Term Activity

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Potentially avoidable days.	Will be developed from Q4 2017 data.	Baseline determined	03/2018	Statistically significant decrease in potentially avoidable days.	12/2019
CMHP connection to Pre-Manage Software.		All 11 GOBHI affiliated CMHPs connected to Pre-Manage Software.	12/2018		

A. TQS COMPONENT(S)			
Primary Component:	Social determinants of health	**Secondary Component:**	Access
Additional Components:	Add text here.		
Subcomponents:	Access: Quality and appropriateness of care furnished to all members	**Additional Subcomponent(s):**	Add text here.
B. NARRATIVE OF THE PROJECT OR PROGRAM			
Continue providing services and funding to communities and individual members that address the social determinants of health and health disparities.			
C. QUALITY ASSESSMENT			
Evaluation Analysis:	EOCCO has funded various programs/initiatives that address the social determinants of health and health disparities at both a community level and at the individual member level. At the community level, EOCCO provides annual grant funding available to the communities and to our Local Community Advisory Councils. These funds are used to address incentive measures and local CHIP initiatives that are directed toward social determinants of health. Below are examples of 2017 grants: The Sherman County LCAC Veggie Rx program screens patients at the Sherman County Health and WIC Clinics and offers vouchers for fresh fruit and vegetables to Sherman County residents experiencing food insecurity. Funding for the Union County Sheriff's Office helped fund a mentor who is a certified CHW to work with offenders transitioning back to society, including accessing mental and primary care treatment, housing, transportation and employment. The Morrow County Community Access for Resources Effectiveness (CARE) program works with families referred to them focusing on both physical and social determinants needs The Union County LCAC received funding to work on several priority areas that address social determinants of health, including poverty training and funding for a warming center for homeless in Union County. These initiatives tie to the county's CHIP plan. Separate from community-focused efforts, EOCCO has invested in the promotion and use of Community Health Workers. These investments include the development of OHA-approved CHW training programs in partnership with Oregon State University and the development of a billing and payment policy for employed CHWs. CHWs can be reimbursed for time spent with EOCCO members. Examples of reimbursable services including face-to-face time spent with members to address social determinants of health, assistance navigating community resources and obtaining assistance with food or housing. EOCCO continued its partnership with Health Integrated, which focuses on identifying higher-cost EOCCO members with medical, behavioral and social barriers that are resulting in inappropriate use of the healthcare delivery system. Health Integrated helps identify solutions that improve member use of the healthcare delivery system and links members to appropriate medical, behavioral and social resources. In 2017, Health Integrated averaged 559 engaged members per month.		

D. PERFORMANCE IMPROVEMENT					
Activity: Assess the number of EOCCO grants and dollars allocated to communities that are addressing the social determinants of health and health disparities.				☒ Short-Term Activity or ☐ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Count the number of 2018 EOCCO-approved grant projects that address social determinants of health including the dollars associated with those grants.	While EOCCO has funded projects in the past that address health disparities and social determinants of health EOCCO has not tracked the number of projects or dollars associated with these specific investments.	Fully understand the number of projects, the counties impacted and the dollars associated with EOCCO grant funded projects that address health disparities and social determinants of health.	09/2018	Fully understand the number of projects, the counties impacted and the dollars associated with EOCCO grant funded projects that address health disparities and social determinants of health.	09/2018
EOCCO to continue providing grant funding to communities and LCAC's that allow investment in health disparities and social determinants of health.	EOCCO has allocated grant funds for 2018, but funding for 2019 and beyond must be approved by the EOCCO board and is contingent in part on the amount of quality measure funding EOCCO receives in 2018 based on EOCCO's quality measure performance.	Continue grant funding in 2019.	09/2018	Continue grant funding in 2019.	09/2018
Activity: Billing for CHW activities allows EOCCO to understand the impact CHWs are having on the members they interact with. While we recognize that not all CHW services provided directly impact members social determinants of health the billing provides us with a good measure of CHW activities overall. Although EOCCO has had a billing policy in place since 2016, we would like to see an increase in billing for CHW services.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**

EOCCO will continue to work one on one with providers that employ CHW's and provide technical assistance to implement CHW billing.	Between June 2016 and May 2017, EOCCO paid 688 CHW claims.	Between June 2017 and May 2018, increase the number of CHW claims by 20% over baseline results.	06/2018	Between June 2018 and May 2019, increase the number of CHW claims by 30% over baseline results.	06/2019
Activity: EOCCO remains committed to increasing the use of CHWs within our service area and educating the CHW workforce. We believe the use of CHWs are key to healthcare transformation as they assist our members before, after and in-between provider visits including addressing individual members social determinants of health.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
EOCCO will survey the number of CHWs providing services within the EOCCO service area.	EOCCO's December 2016 survey showed approximately 100 CHWs are employed by EOCCO providers.	Increase the number of employed CHWs by 10% over baseline results.	01/2019	Increase the number of employed CHW's by 15% over baseline results.	01/2020
EOCCO will track the number of new CHWs who attend EOCCO sponsored trainings provided by OSU. EOCCO will track the number of existing CHWs who attend EOCCO-sponsored continuing education courses provided by OSU. The EOCCO-sponsored continuing education courses include: Management of Chronic Conditions Poverty and Related Social Determinants of Health Mental and Behavioral Health Disorders	EOCCO trained 30 new CHWs through the OHA- approved EOCCO-sponsored OSU training program from 2016-2017. EOCCO trained two students in the first OHA-approved EOCCO-sponsored OSU continuing education course in late 2017.	Increase the number of newly certified CHWs who received certification through OSU by 50% over baseline results. EOCCO will track and establish a baseline for the number of existing CHWs who receive CHW continuing education training provided by OSU by course in 2018. OSU will launch a CHW leadership certificate	01/2019	Increase the number of newly certified CHWs who received certification through OSU by 100% over baseline results. EOCCO will establish a benchmark goal for the number of CHW's who receive continuing education training provided by OSU once a baseline has been established in January 2019.	01/2020

		program in 2018.			

A. TQS COMPONENT(S)			
Primary Component:	Special health care needs	**Secondary Component:**	Choose an item.
Additional Components:	Add text here.		
Subcomponents:	Choose an item.	**Additional Subcomponent(s):**	Add text here.
B. NARRATIVE OF THE PROJECT OR PROGRAM			
To identify EOCCO members with special health care needs and provide Intensive Case Management (ICM) services.			
C. QUALITY ASSESSMENT			
Evaluation Analysis:	EOCCO has implemented referral mechanisms to assess members with special health care needs in order to identify ongoing health care conditions that might require Case Management for physical health, substance use disorders, or mental health treatment. Referrals are provided via numerous avenues, including, but not limited to, internal care coordination referrals, health risk assessments, technology such as Pre Manage, high-dollar reporting, and the county collaborations known as Multidisciplinary Teams (MDT's). In 2017, ICMs received 301 referrals, which is an increase of 54% from 2016's report of 140. The increase can be partly attributed to technology advances with PreManage, which identifies from a list of trigger diagnoses, and partly attributed to the expansion and awareness of the county collaborative to all 12 counties. Referrals made in the collaborative are from community health workers, clinic or hospital professionals, behavioral and substance abuse providers, and aging and peoples with disabilities. **ICM enrollment of members with special health care needs** In 2016, the EOCCO ICM nurses provided ongoing case management to 99 members with special health care needs including cancer, chronic pain, trauma, systemic infections, renal disease, cardiac disease, and neurological disorders. This was a 4% increase over the number of special healthcare needs members we provided services to in 2015. In 2017, the EOCCO ICM nurses provided ongoing case management to 89 members with special healthcare needs, including cancer, chronic pain, trauma, systemic infections, renal disease, cardiac disease, and neurological disorders. This was approximately a 10% decrease from 2016.		

ICM for members with special healthcare needs	2015	2016	2017
# members with ongoing case management	95	99	89

In a retrospective review, the decrease in ICM enrollment can be somewhat attributed to staffing changes and different approaches between nursing staff. This is being corrected with one-on-one training, as well as in monthly case management meetings.

D. PERFORMANCE IMPROVEMENT					
Activity: Provide EOCCO members with an accurate reflection of the case management processes. This includes discussing enrollment as a benefit to members in order to help them navigate the healthcare system, determine and reach clearly defined and self-identified goals making them an integral part of the management process, and assist with overcoming barriers to care, such as difficulty accessing specialists, services and supplies.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Monthly case management meetings.	89 enrolled members in ICM services in 2017	To be determined	01/2019	To be determined	To be determined
Activity: An ICM RN will work with EOCCO members who are hospitalized with certain trigger diagnoses to identify members with special healthcare needs prior to leaving the hospital or upon discharge. This will increase the number of members contacted, as well as potentially increasing the numbers of members who choose to enroll in ICM services.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Monthly case management meetings.	NA	NA	01/2019	To be determined	To be determined

A. TQS COMPONENT(S)			
Primary Component:	Utilization review	**Secondary Component:**	Choose an item.
Additional Components:	Add text here.		
Subcomponents:	Choose an item.	**Additional Subcomponent(s):**	Add text here.

B. NARRATIVE OF THE PROJECT OR PROGRAM

In late 2017 the EOCCO Cost and Utilization Dashboard was modified based on a need for EOCCO Board of Directors members and other stakeholders to review regular data trends. This data reveals how EOCCO is performing in a number of broad categories as well as identifies specific key areas regarding the cost and utilization of services. A prior version of this dashboard was cumbersome to update on a routine basis, it did not include analysis of key areas of interest or integrate capitation data, mental health data or dental data. Additionally, the prior dashboard was intended to be a county-level view, so there was not a high level view of EOCCO as a whole.

The new dashboard contains 13 pages of high level and detailed information including an overview of overall spending, membership, dollars paid per member per month, and services per 1,000 members. Comparisons are made between the most recent 12 month period and the prior 12 month period in categories including inpatient, outpatient, professional, behavioral health, dental, and pharmacy. Users can also find how spending for members of each OHA rate group is compared to the allocated budget. Pages dedicated to “Key Indicators” are intended to highlight trends and provide insightful details in strategic categories including emergency department, primary care, non-primary care (specialist) office visits, non-maternity inpatient stays, and pharmacy.

This new dashboard has been reviewed by EOCCOs Clinical Advisory Panel, the EOCCO Board of Directors, as well as Moda and GOBHI staff. All feedback was taken into consideration when developing the final version of the Cost and Utilization Dashboard.

C. QUALITY ASSESSMENT

Evaluation Analysis:	Until recently, cost and utilization data was not provided regularly to stakeholders in a user friendly format. The need for this data was driven by a desire to identify the utilization of services and the associated costs. EOCCO would like to strengthen the distribution of this data as well as create additional dashboards to analyze county level data.

D. PERFORMANCE IMPROVEMENT

Activity 1: Thus far EOCCO has been providing this report to stakeholders on an ad- hoc basis. EOCCO plans to implement a strategy to update and distribute the Cost and Utilization Dashboard on a more regular basis to key stakeholders in order to evaluate appropriate use of medical resources and services. These stakeholders include the Clinical Advisory Panel, Local Community Advisory Councils, and EOCCO Board Members. The dashboard will also be shared internally at the EOCCO Quality Improvement Committee.

☒ Short-Term Activity or
☐ Long-Term Activity

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Frequency of distribution of the Cost and Utilization Dashboard.	Ad hoc	Quarterly	12/2018	Quarterly	12/2018

Activity 2: In the past, EOCCO has provided the cost and utilization data at a county level on an ad hoc basis. EOCCO is currently in the process of developing new Cost and Utilization Dashboard reports on a county level for all 12 counties in our service area. The county level data could then be compared to the overall EOCCO data to better identify utilized services by area. This data will be used to determine an action plan that can address the findings in order to provide the most effective and economic use of health care services.

☒ Short-Term Activity or
☐ Long-Term Activity

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
EOCCO will develop county level Cost and Utilization Dashboards.	0	12	09/2018	12	09/2018

Activity 3: EOCCO distributes provider progress reports on a monthly basis to clinic staff. These reports include information on claims based incentive measure performance, a member roster, follow-up lists, an MED roster, and a list of patients enrolled in Health Integrated. Providers use this information to assess performance and reach out to patients. As utilization of these reports has increased among clinic staff, EOCCO plans to optimize the provider progress reports to include additional data. Updates include adding more of the incentive measures to the face sheet such as the clinical quality measures, dental sealants, colorectal cancer screening, PCPCH, DHS and timeliness of prenatal care. By doing

☐ Short-Term Activity or
☒ Long-Term Activity

this, the goal is for clinics to focus on all incentive measures and not just the claims based measures that they currently receive.					
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Percentage of incentive measures included in the provider progress reports.	33%	94%	12/2018	To be determined	12/2019
Activity 4: EOCCO will develop a detailed Dental and Behavioral Health Cost and Utilization Dashboard. EOCCO will prioritize the expansion of this report in order to further evaluate utilization of services in all realms of healthcare.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
EOCCO will develop detailed Dental and Behavioral Health Cost and Utilization Dashboards.	A high-level Behavioral Health and Dental Cost and Utilization report is currently available.	A detailed Cost and Utilization report for Behavioral Health and Dental Health will be available.	12/2019	A detailed Cost and Utilization report for Behavioral Health and Dental Health will be available.	12/2019

Section 3: Required Transformation and Quality Program Attachments

A. Attach your CCO's quality improvement committee meeting minutes from three meetings

B. Attach your CCO's consumer rights policy

C. OPTIONAL: Attach other documents relevant to the above TQS components, such as policies and procedures, driver diagrams, root-cause analysis diagrams, data to support problem statement, or organizational charts.