Section 1: Transformation and Quality Program Information

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

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

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, community mental health programs, 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 development 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.

C. OPTIONAL

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

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

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

A. **Project or program short title**: Access Project 1: EOCCO Network Utilization Analysis

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

B. **Primary component addressed**: Access

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

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

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

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

EOCCO is committed to ensuring members have access to covered services. 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, access to some services may be 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.

EOCCO utilizes reports to evaluate referral patterns and identify providers who are delivering services to members. Also, to identify gaps in the network and if non-contracted providers are available within the service area. Contracting efforts are then employed to attempt to have the providers join the network.

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

EOCCO utilizes reporting as followed:

Quarterly, we generate a report to monitor OON claims utilization. The goal is to maintain <90% OON utilization. Our 2018 analyses showed that inpatient and outpatient hospital OON claims were <10%; for calendar year 2016-2018 our OON utilization ranged between 5% to7%, never exceeding 10%. In 2017, EOCCO's analyses identified that pain management care was an area of opportunity to reduce out-of-network claims. Based on claims trends, two providers were identified as providing services to members. EOCCO attempted to execute a contract and was successful in moving one provider to in-network status. This quarterly report is presented to the EOCCO QIC for evaluation and feedback. In 2018, we identified that OHSU Hospital, even though outside of the service area, was an increasing contributor to OON claims. The contract with OHSU was initiated in 2018 and is currently under negotiations.

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.

Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Our activity is to continue to evaluate the network adequacy reports annually and quarterly OON claims utilization report to identify areas of opportunity to contract providers. Our initial goal, reported in our March 2018 TQS, was to reduce the percent of professional specialty claims that are performed by out of network providers to 10% or less.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Monitoring is measuring the percent of specialty claims that are performed by an out of network provider.

Baseline or current state	Target / future state	Target met by (04/2019)	Benchmark / future state	Benchmark met by (04/2020)
16.8% for CY 2016	<12% for CY 2018	Note: Target date is updated. Reporting for 2018 available in April 2019	<10% for CY 2019	Note: Target date is updated. Reporting for 2019 available in April 2020

Activity 2 description (continue repeating until all activities included): Increase network adequacy in EOCCO counties showing deficiencies.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: EOCCO analyzes reports for deficiencies and evaluates the network to identify providers to contract. EOCCO has increased network adequacy in Grant (+6.6%), Lake (+26.5%), Sherman (+8%), Union (+5.4%), Wallowa (+3.3%) and Wheeler (+8%). While there were small decreases in 4 counties, all of which were less

than 1% or less, except Malheur (-3.3%). Overall, we moved form 4 counties being at 90% adequacy in March 2017 to 6 counties being at 90% adequacy on September 2018.

Baseline or current state	Target / future state	Target met by (09/2019)	Benchmark / future state	Benchmark met by (07/2020)
As of September 2018: Baker: 90.9% Gilliam 92.3% Grant 82.3% Harney 64.2% Lake 58.9% Malheur 89% Morrow: 94% Sherman 99% Umatilla 84.3% Union 88.3% Wallowa 92.3% Wheeler 95.7%	7 counties being at 90%> adequate	Note: Target date is updated. Next available report will be in September 2019	8 counties at 90%> adequate	Note: Target date is updated. Next available report will be in September 2020

A. **Project or program short title**: Access Project 2: EOCCO Access to Behavioral Health Services

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

B. **Primary component addressed**: Access

iv. Secondary component addressed: Choose an item.

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

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

☐ Behavioral health integration ☐ Oral health integration

C. **Primary subcomponent addressed**: Access: Cultural considerations

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

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

GOBHI is committed to ensuring that EOCCO members with limited English proficiency and/or other communication needs have equitable access to behavioral health 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.

Based on the prior year's evaluation, the analysis of the interpreter and translation services data collected from community mental health programs show the following:

- Spanish interpreter services are the most often language requested. Arabic and Somali are other requested languages but in small numbers. Requests for interpreter services vary by region and county, with some CMHPs having no requests for services.

In the baseline secret shopper survey of July 2017, a GOBHI staff member fluent in Spanish phoned contracted CMHPs speaking only Spanish and asked about access to services. Less than half of CMHPs (10 of our 16 for a 37.5% rate) were able to quickly connect members with a translation service during a phone call. In the August 2018 secret shopper survey, a bilingual and bicultural GOBHI Member Services staff member fluent in Spanish phoned CMHP provider offices and speaking Spanish asked "Can I speak to someone that speaks Spanish please?" Ten out of 16 or 62.5% of CMHP

provider locations were able to assist the Spanish-speaking caller over the phone in a timely manner and answer questions about access to a behavioral health appointment.

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

GOBHI continues to collaborate with contracted providers to ensure easy access to interpreter and translation services to members with limited English proficiency and/or other communication needs.

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

Activity 1 description (continue repeating until all activities included): Ensure EOCCO CMHPs are aware of and appropriately utilize language interpretation and translation services to communicate with members with limited English proficiency and/or other communication needs and assist with access to behavioral health services.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: The report on this project focuses on the work to address the challenges reported in the September TQS progress report. The challenge was to ensure CMHPs are able to smoothly provide language access services to limited English persons over the phone. GOBHI's strategy to resolve the barrier was to provide awareness, education and training to CMHPs on language access and to ensure that CMHPs tested their internal process to ensure equipment and programming were functioning and front desk staff were aware of telephonic interpretation procedures.

GOBHI monitors CMHPs to ensure language access procedures are in place at the CMHP. CMHPs are expected to train and educate staff in accessing interpreters/translation services as needed, and informing all members about the ready availability of interpreter services in their preferred language at no cost to them.

CMHPs who do not provide access to non-English language are notified by the GOBHI quality and/or compliance department with a written warning of non-compliance with regulatory and contracted requirements. Providers must submit evidence of translation services contracts and training material provided to their internal staff. GOBHI follows up at an unscheduled time to check on the progress of staff training. As part of site review process, CMHPs are also required to submit translation and/or interpretative services log, and GOBHI checks to ensure the CMHP uses health care interpreters who are state trained/certified or are in the process of acquiring certification.

Measurable objectives

- Number of qualified/certified interpreters with GOBHI/CMHPs
- Number of successful secret shopper calls
- Healthcare interpreter training, interpreter access, interpreter utilization
- Number of CMHP interpreter utilization reports
- Provide CMHPs with member county data on the language preferences

As shown in the tables below, the data collected in 2018 shows no significant change to our baseline analysis: Spanish interpreter services are the most often language requested followed by Arabic and Somali, but in significantly smaller numbers.

Language used by interpreter services	2017	2018	2017	2018	2017	2018
	# of visits		# of minutes		Avg. minutes/visit	
Spanish	1,120	1,098	17,295	18,079	15	16
Arabic	9	17	548	879	61	51
Somali	13	15	458	525	35	35

Interpreter services by CMHP	2017 # of Spanish visits	2018	2017 # of Arabic visits	2018	2017 # of Somali visits	2018
Community Counseling Solutions	247	324	0	0	0	0
Center for Human Development	19	20	0	0	0	0
GOBHI	164	140	0	0	0	0
Lifeways	655	585	9	17	13	15
Mid-Columbia Center for Living	31	25	0	0	0	0
Wallowa	3	3	0	0	0	0
Tillamook Family Counseling	-	1	-	0	-	0

Secret Shopper Study:
The next scheduled secret shopper study is in March 2019.

Baseline or current state	Target / future state	Target met by (12/2019)	Benchmark / future state	Benchmark met by (MM/YYYY)
July 2017 baseline: 37.5 % of Community Mental Health providers were able to answer questions regarding access to a non-English speaker via phone.	July 2018 survey: 62.5% of CMHP providers were able to answer questions about access to a GOBHI Member Services team member speaking only in Spanish	80%	12/2019	TBD

A. **Project or program short title**: Access Project 3: EOCCO Healthcare Services Staff Education & Training

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

B. **Primary component addressed**: Access

vii. Secondary component addressed: Choose an item.
viii. Additional component(s) addressed: Add text here
ix. If *Integration of Care* component chosen, check all that apply:
☐ Behavioral health integration ☐ Oral health integration

C. **Primary subcomponent addressed**: Access: Cultural considerations

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

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

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 21 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 (DCO) clinical and non-clinical staff. In 2018, Moda Health employees took online diversity training courses on Implicit Bias, Working in an Inclusive Environment and Cultural Competence. Additional education topics at Moda Health and GOBHI 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.

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

Moda Health Healthcare Services performs one cultural competency training each year. The 2018 training was on personal bias, both implicit and explicit. Moda Health uses an evaluation tool to measure post-training knowledge and understanding of the training topic.

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

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

Gael Martin, RN, MSN, Moda Health Nurse Trainer/Process Auditor, provided education focusing on personal bias, both implicit and explicit. She presented to an audience of clinical and non-clinical staff. Clinical staff were nurses representing care coordination, case management, outpatient care coordination, in-patient care coordination and claims review. Non-clinical staff represented population health.

The objectives of the training were to: define culture, identify at least three components of culture, name the four components of cultural competence, name the key difference between the “reflex response” and the “post reflex response,” name the difference between implicit and explicit bias, and name the two key requirements to address personal bias. The training provided an opportunity for self-reflection and self-awareness of personal bias, followed by a discussion during which Ms. Martin provided strategies for addressing personal bias.

The training was well-attended and received positive verbal feedback. Approximately two months after the presentation, the slide deck was provided to the participants for review. In addition, an open book post-quiz was administered. All but one attendee completed the post-quiz and all who participated in the post-quiz scored 100%.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement:

Moda Health implemented the evaluation tool to measure post-training knowledge and understanding of training topic, quality of training, relevance to current issues staff encounter, and suggestions for improvement.

Baseline or current state	Target / future state	Target met by (12/2018)	Benchmark / future state	Benchmark met by (12/2019)
None for 2017	85% post-training level of knowledge and understanding of cultural training topic	100.0%	95% post-training level of knowledge and understanding of cultural training topic	12/2019 and each year thereafter

A. **Project or program short title**: Access Project 4: EOCCO Provider Directory with Cultural & Linguistic Data Enhancement

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

B. **Primary component addressed**: Access

x. Secondary component addressed: Choose an item.
xi. Additional component(s) addressed: Add text here
xii. If *Integration of Care* component chosen, check all that apply:
☐ Behavioral health integration ☐ Oral health integration

C. **Primary subcomponent addressed**: Access: Cultural considerations

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

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

EOCCO is committed to providing resources to aid members' searches for physical, behavioral or dental health providers that have the capability to accommodate their cultural and linguistic preferences or physical disabilities. Pursuant to the 2018 contractual requirement for provider directories (based on CFR §438.10), EOCCO realized an improvement opportunity to establish a systematic method to collect cultural and linguistic capabilities from our provider community.

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

In 2018, we initiated a continuous survey of our provider panel to inquire about cultural and linguistic capabilities along with office/facility accommodations for people with physical disabilities. We use the responses to update a searchable PDF EOCCO provider directory that includes the cultural and linguistic data we collect. The directory includes information collected from our physical, mental and dental health providers. The directory, posted on the EOCCO website, is updated monthly. On request, we mail a copy of the PDF file to a member.

Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Our activity is to survey our contracted providers to collect data regarding cultural and linguistic capabilities, and office/facility accommodations for people with physical disabilities. Our initial goal, reported in our March 2018 TQS, was to achieve a 75% collection rate from contracted providers in the 12 EOCCO counties by June 2018.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Monitoring is measuring the rate of the contracted providers in the 12 EOCCO counties that returned all data about their cultural and linguistic capabilities and accommodations for people with physical disabilities. As of January 2019, 61 percent of providers in the 12 EOCCO counties have returned all requested data, short of our June 2018 goal; 70 percent of providers have returned a response about at least one data category.

Baseline or current state	Target / future state	Target met by (07/2019)	Benchmark / future state	Benchmark met by (07/2020)
1/1/2019: 61% of contracted providers in the 12 EOCCO counties	75% of contracted providers in the 12 EOCCO counties	Note: Target date is updated from 6/2018	75% of the entire EOCCO provider panel.	Note: Benchmark date updated from 1/2019

A. **Project or program short title**: Access Project 5: EOCCO CAHPS Survey

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

B. **Primary component addressed**: Access

xiii. Secondary component addressed: Choose an item.

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

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

☐ Behavioral health integration ☐ Oral health integration

C. **Primary subcomponent addressed**: Access: Cultural considerations

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

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

Each year in the spring, OHA administers an adult and child Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys on behalf of the 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. Historically two composite measures (Access to Care and Satisfaction with Care) have been CCO incentive measures. Currently the Access to Care composite measure is the only incentive measure based on CAHPS responses.

EOCCO uses survey results to inform next steps and decisions regarding the direction of the project.

Two questions make up the Access to Care composite measure: how often did the member get the care for an illness/injury/condition as soon as he/she thought needed (urgent care), and how often did the member get an appointment for routine care as soon as he/she thought needed.

EOCCO has targeted for improvement two subsets of data within the Access to Care question related to routine care: CAHPS survey results for access to routine care for female adults of Hispanic ethnicity and CAHPS survey results for access to routine care for children of Hispanic ethnicity.

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

EOCCO is targeting interventions on two population segments (female adults of Hispanic ethnicity and children and Hispanic ethnicity) to see whether significant improvement in access to routine care rates will positively impact CCO Access to Care improvement targets.

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 target rates for routine care.
- When applicable, work with Community Benefit Initiative awardees on targeted culturally competent messaging regarding access to children's and women's services.
- Consider "on the ground engagement" interventions and technical assistance that are clinic specific and align best with the practice and its resources. The objective is to work through the practice (practitioners

and office staff) to impact the behavior of women and children of Hispanic ethnicity on obtaining routine care.

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

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

EOCCO reviewed CAHPS 2017 scores in December 2018.

The overall target for the Access to Care composite measure was 83.7%. The results of the CAHPS 2017 score fell short at 81.1%.

The survey was sent to 1,760 randomly selected EOCCO adults and children. There were 564 valid responses for an overall 32.0% response rate (33.6% in 2016 and 34.2% in 2015). The adult survey response was slightly higher than that of the child survey and the response rate of females was slightly higher than that of male respondents. By county, Grant (3.12% of the survey population) had the highest response rate – 40.7% – while Union (13.6% survey population) had the lowest response rate – 23.3%.

10.6% of respondents indicated their primary language was Spanish (49.7% response rate) versus 89.4% who reported English as their primary language (29.9% response rate). A valid breakdown of respondents by race and ethnicity was not reliable due to the large percentage of Unknowns.

By county, Umatilla, Wallowa, Lake and Gilliam met the Access to care target rate; Union, Sherman had the lowest scores of 66.7% and 50.0% respectively.

Key findings:

- CAHPS 2017 survey results for access to routine care for female adults of Hispanic ethnicity increased from 73.3% (CAHPS 2016) to 78.3%
- CAHPS 2017 survey results for access to routine care for children of Hispanic ethnicity decreased slightly from 82.6% (CAHPS) to 82.1%
- Child survey scores for both access measures were higher than the adult scores and both exceeded the 83.7% target rate
- The counties with the lowest overall access scores were Sherman (50%), Union (66.7%) and Wheeler (66.7%)
- Gilliam (100%), Wallowa (90.9%), Umatilla (84.2) and Lake (84.2%) counties met the target rate of 83.7%
- Adult Spanish speaking respondents gave higher scores for overall access to care than English speaking members: 84.2 versus 75.7%, whereas child English speaking respondents scored higher in overall access to care compared with child Spanish speaking respondents: 90% versus 83.9%
- Missing data for race, ethnicity and age were barriers to reliable analysis
- As in last year's results, child (89.1%) and Adult (78.3%) males reported greater access to overall care compared with child (87.6%) and Adult (75.1) females

Next steps:

- ☐ Explore pilots with providers/clinics in Union and Umatilla counties - the most populated EOCCO service areas
- ☐ Identify processes and workflows performed within those clinics; interventions that are outside the larger population that target children and adult women of Hispanic ethnicity clinic
- ☐ Use clinic specific-CAHPS results is available
- ☐ Find common ground for economy of scale, if possible

Considerations:

The EOCCO health promotion & quality improvement specialists, a team of two, are the drivers of this project, which is individualized and labor intensive; we anticipate progress will be slow

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement (Measurement 1): EOCCO will use CAHPS survey results for access to routine care for female adults of Hispanic ethnicity.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
CAHPS 2017-78.3%	83.7%.	12/2020	Identify workflows targeting adult women of Hispanic ethnicity clinic aimed at improving access to routine care	12/2019

Monitoring activity 1 for improvement (Measurement 2): EOCCO will use CAHPS survey results for access to routine care for children of Hispanic ethnicity.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
CAHPS 2017-82.1%	83.7%.	12/2020	Identify workflows targeting children of Hispanic ethnicity clinic aimed at improving access to routine care	12/2019

A. **Project or program short title**: Access Project 6: EOCCO Case Management Engagement

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

B. **Primary component addressed**: Access

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

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

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

☐ Behavioral health integration ☐ Oral health integration

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

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

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

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 2018, we mailed 15,190 HRAs to new members and 1,299 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, 225 were referred to health coaching 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 EOCCO incentive measure rate for cigarette smoking prevalence, 30.9% for 2017, is gathered through an annual submission process from clinic electronic health record systems; this is the most comprehensive data available to measure cigarette smokers among EOCCO members. The HRA used to be the primary method used to identify EOCCO members who use tobacco. Our EOCCO CAHPS surveys in 2016 and 2015 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 did not have a systematic process in place to follow up on the HRA referrals for tobacco cessation and document outcomes until 2018.

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 established 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.
- Individualize education regarding current healthcare practices, i.e., surrounding surgical interventions and smoking.
- Establish a 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 participated in health coaching versus those who did not.
- Track members who engage in tobacco cessation services.

In March, we adjusted the current Case Management database to account for additional data collection.

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

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 are developing systematic processes to: improve member access to services, utilize the best method of engagement with the member, and maintain documentation to measure the effectiveness of the contact.

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

Activity 1 description: Improve member engagement initiated by referrals to health coaching.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Quarterly committee meetings, including Intensive Case Management (ICM), Health Coaching, Care Coordination, and Behavioral Health

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Identify members with multiple co-morbidities who are also current tobacco users.	Make phone call to member to offer health coaching services in addition to letter outreach.	06/2019	Refer members to dental services when dental needs are identified through engagement in health coaching services.	12/2019

Activity 2 description: Track and analyze member engagement initiated by referrals to health coaching.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Quarterly committee meetings, including Intensive Case Management (ICM), Health Coaching, Care Coordination, and Behavioral Health

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Use Patient Activation Measure to assess level of self-empowerment.	Identify the percentage of members who are successful with tobacco cessation and also feel empowered.	12/2019	Obtain Patient Activation Measure score upon initial health coaching services call; monitor activation throughout health coaching services.	12/2020

Activity 3 description: Centralize referrals to tobacco cessation services for EOCCO members.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Quarterly committee meetings, including Intensive Case Management (ICM), Health Coaching, Care Coordination, and Behavioral Health

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Identify members with behavioral health and addiction diagnoses who use tobacco or smoke. Coordinate referrals to behavioral health/SUDS (GOBHI).	Refer members who use tobacco or smoke to health coaching services for tobacco cessation if the member does not enroll in behavioral health services.	12/2019	To be determined	To be determined

A. **Project or program short title**: Access Project 7: EOCCO Follow Up Care After SNF Discharge

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

B. **Primary component addressed**: Access

xix. Secondary component addressed: Choose an item.

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

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

☐ Behavioral health integration ☐ Oral health integration

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

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

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

The Memorandum of Understanding requires all skilled nursing facility admissions to be reported to Aging and People with Disabilities (APD). This partnership between EOCCO and APD ensures EOCCO members are receiving the right kind of care and level of care or assistance after discharge from a skilled nursing facility (SNF).

When the referral source recognizes a need for additional services for the member, community health workers, community medical professionals, Greater Oregon Behavioral Health, Inc. (GOBHI), APD, and Moda Health provide referrals to the MDT to facilitate organized assistance with those needs. In 2018, 44 members were referred to the East 6 Multi-Disciplinary Team (MDT) and 78 members were referred to the Umatilla/Morrow MDT. In January 2018, we implemented the West 4 MDT in Gilliam, Lake, Sherman, and Wheeler counties; in 2018, it received 14 referrals.

Of the 136 referrals in 2018, 90 were made to engage with APD services, including long-term care, in-home caregivers, or new home placements. Of those 90 referrals, 46 were made upon admission to a SNF or a swing bed. 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.

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, requiring additional time to apply the new benefit if the member qualifies. By referring the member upon admission rather than when a potential barrier to discharge applies, we reduce the time that the member is in the facility with no clear payer source in addition to reducing additional days approved by EOCCO beyond the 20-day benefit.

In 2018, we developed a process for referring skilled nursing facility admissions to APD through the multidisciplinary teams and implemented a monthly report from our core operating system, Facets, to differentiate skilled nursing facility from hospital admissions. We are refining our processes in 2019 to ensure all skilled nursing facility and swing bed admissions are captured in this report, as we documented more skilled nursing facility admission notifications to APD through the MDT than the authorizations that were captured in this report for 2018; however, we send referrals to APD for services in addition to providing these notifications. We will add a field to the referral log to specifically identify these notifications. In 2019, we expect to perform the comparison of the authorization report to the log of notifications to APD of skilled nursing facility and swing bed admissions.

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

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 APD. The purpose of the collaborative, known as a 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.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Use authorization data to monitor skilled nursing facility and swing bed admission notifications to the MDT. The goal is 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 in a cost-effective manner.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: We will run the Facets report on a regular basis and compare it with the log of notifications and/or referrals to the MDTs.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
We are able to distinguish skilled nursing facility admissions from hospital admissions.	Update our workflow and train staff to report swing bed admissions in the same category as skilled nursing facility admissions so that we can monitor using the report we created.	04/2019	Report 95% of all SNF and swing bed admissions to the MDTs.	12/2019

A. Project or program short title: Access Project 8: EOCCO Second Opinion Analysis

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

B. Primary component addressed: Access

xxii. Secondary component addressed: Choose an item.

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

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

☐ Behavioral health integration ☐ Oral health integration

C. Primary subcomponent addressed: Access: Second opinions

viii. Additional subcomponent(s) addressed: Grievance and appeal system

D. Background and rationale/justification:

EOCCO has a policy and procedure regarding second opinions. While the approach may vary among Moda Health, GOBHI, and our dental care organization partners, our intent is to ensure EOCCO members have the right to access a 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 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; since no prior authorization is required, in-network second opinions cannot be tracked.

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; in 2018, there were zero out-of-network requests for second opinions.

Dental services:

- Advantage Dental: In 2018, Advantage Dental performed ongoing evaluation and improvement with monitoring of adequate member access to second opinions and ensuring adequate standards for accessing care for second opinions. The Advantage Dental member handbook and member website advise members that a second opinion is available from a qualified health care professional from outside the provider network at no cost to the member. Advantage Dental's evaluation was performed through ongoing monitoring of access to availability of second opinions within and outside our network through the following processes: prior authorization requests, referral requests, reported grievances, and member call center notes. Our goal as a plan is to ensure access to second opinion services to all members. In 2018, there were zero second opinion requests for EOCCO, which is low compared to the number of members assigned to Advantage Dental. The fact that no second opinion requests were made may indicate that additional education is needed for members and contracted providers.

- 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 2018, ODS Community Dental noted five second opinion requests for EOCCO members. Of those requests, two were for oral surgery, one was for endodontics, and one was for another general practice dental provider. Four of the five members who received a second opinion for services followed up with their appointment with the specialist. The one member who did not follow up with the referral switched dental plans and is no longer with ODS Community Dental.

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 EOCCO covers second opinions at no cost to the member.

Our current policy supports direct access to in-network providers, and our current procedures for tracking and monitoring access to second opinions are sufficient to identify concerns about member access to second opinions.

Monitoring second opinion requests and complaints by year	2016	2017	2018
Physical health second opinion request	0	8	0
Behavioral health second opinion request	0	0	?
Dental health second opinion request	0	3	5
Member complaints related to lack of access to or denial of a second opinion	0	0	0

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

EOCCO prioritizes member access to second opinions. We monitor requests for second opinions and member complaints about access to second opinions through our grievance and appeal system.

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

Activity 1 description: Continue monitoring member complaints regarding barriers, trends, or denials of second opinion requests.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Discuss complaints, trends, and barriers with the EOCCO Quality Improvement Committee (QIC).

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0 member complaints related to lack of access to or denial of a second opinion	0 member complaints related to lack of access to or denial of a second opinion	12/2018	0 member complaints related to lack of access to or denial of a second opinion	12/2019

Activity 2 description: Advantage Dental will require providers to obtain a Member Rights/Responsibilities Attestation form from each member annually to ensure members are aware of their access to second opinions.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: We will monitor this through chart audits for charts requested beginning January 1, 2019.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
In 2018, Advantage Dental educated providers on the second opinion policy, improved the monitoring process for all reported second opinions, and created a Member Rights/Responsibilities Attestation that in-network providers must provide to the member at the time of their initial appointment	Verify that members are receiving the Member Rights/Responsibilities Attestation so they are aware of the second opinion policy	12/2019	To be determined	To be determined

A. **Project or program short title**: Access Project 9: EOCCO Authorization and Referral Timeliness

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

B. **Primary component addressed**: Access

xxv. Secondary component addressed: Choose an item.

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

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

☐ Behavioral health integration ☐ Oral health integration

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

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

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

EOCCO partners and delegated entities completed the following requests in 2018:

Behavioral Health (GOBHI):

- In 2018, a total of 575 behavioral health service pre-service authorization requests were received and completed; 315 were expedited requests and 260 were standard requests.
  - Expedited pre-service authorizations: 96.83% completed within 3 calendar days
  - Standard pre-service authorizations: 95% completed within 14 calendar days
- 2018 Summary: In 2018, EOCCO improved overall performance relating to behavioral health turnaround times combined for standard and expedited requests by approximately 12% over the 84% in 2017.

Dental Care Organizations:

- Advantage Dental processed prior authorization requests in an average of 7.11 calendar days; 100% of requests were processed within 14 calendar days.
- ODS Community Dental does not require prior authorizations for services.

Physical Medicine:

- In 2018, a total of 35,989 physical health service requests were received and completed; 31,371 were pre-service authorizations and 4,618 were for referrals to out-of-network providers.
- Pre-service authorizations – 31,371:
  - 99.69% completed within 14 calendar days
  - 98.79% completed within 10 calendar days
  - 73.96% completed within 3 calendar days
- Referrals – 4,618:
  - 99.74% completed within 14 calendar days
  - 98.14% completed within 2 business days
- 2018 Summary: In 2018, EOCCO improved overall performance relating to physical medicine turnaround times combined for standard and expedited requests, and referrals by approximately 4% over the 95% in 2017.

EOCCO reviewed its timely access-related complaint data in detail to identify opportunities for improvement. Though the complaints were few in number, a common theme is the opportunity to support improved communications between members and providers. EOCCO will prioritize training providers on communicating with members in 2019 to facilitate improvements in members' perception of access to their providers and/or referrals.

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

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.

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

Activity 1 description: 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.

In 2018, we completed targeted training for staff in each business unit 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 we experience turnover. In June 2018, we also implemented a procedure that all non-compliant cases will be reported to the departmental leaders to perform a root-cause analysis and assess training opportunities or systemic issues.

☒ Short term or ☒ Long term

Monitoring activity 1 for improvement: We monitor turnaround times through weekly and monthly reporting.

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

Activity 2 description: GOBHI implemented the Altruista medical management/utilization management software application in September 2016. As of January 2018, issues continue with the accuracy in reporting of timelines with the

new application thereby requiring manual calculations. GOBHI continues to work with 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.

GOBHI has demonstrated success with this activity in 2018 and will continue to monitor the accuracy of reporting of timelines in 2019.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: We monitor through UM reports to the Medicaid Compliance Officer.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Expedited prior authorizations – 83.0% Standard prior authorizations – 92.8%	95%	06/2018	95%	12/2019

A. **Project or program short title**: CLAS Standards and Provider Network Project 1: EOCCO Health Literacy Initiatives

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

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

xxviii. Secondary component addressed: Health equity

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

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

☐ Behavioral health integration ☐ Oral health integration

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

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

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

EOCCO recognizes that 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. EOCCO has implemented employee trainings related to health literacy, cultural competence, and workplace diversity to create employee awareness/education. In 2017 there was limited use of the interpreter services available to the EOCCO member population. In 2018 there was an increase in use however, the number of utilized services was still low. EOCCO plans to focus on provider awareness of the available services.

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

Communication and Language Assistance Services Implementation Plan:

1. Ensure that members receive linguistically appropriate materials from EOCCO.
2. Ensure that EOCCO network providers know how to access interpreter services for member appointments.
3. Ensure that all EOCCO staff and partners are trained in workplace diversity and cultural competency.

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

Activity 1 description: **Member Communications and Materials via EOCCO**

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 uses a vendor called Barbier to translate materials. Our EOCCO member informational materials have been revised to meet our organization's health literacy standards. We use the Flesch-Kincaid Readability Statistics to assess member communications and website member materials are written between a sixth and seventh grade reading level. In 2018, Moda Health implemented a monthly employee training course called "How to Write in Plan Language". EOCCO plans to evaluate the number of EOCCO employees who attend this course as an effort to create companywide awareness on the importance of writing in plain language and how to assess their own work. Employees are then encouraged to teach what they've earned both inside and outside of the organization.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Evaluate the number of employees who have participated in the plain language training course.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
67	134	12/2019	223	12/2020

Activity 2 description: **Interpreter Services for Member Appointments**

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 medical office visits at no charge to the member. In 2018, EOCCO arranged for interpreters at 588 medical office visits which was a 26% increase in utilization of Passport to Languages from 2017. EOCCO has noticed that in the past very few providers knew about the interpreter services available to their EOCCO patients. EOCCO plans to outreach to providers to increase awareness and utilization of the Passport to Languages service. EOCCO also evaluates the percentage of interpreter services by language in relation to the percentage of enrolled EOCCO members by language each year (see chart below).

Language	2018 Total Calls/Visits	% of Interpreter Calls/Visits	% of Non English Speaking Members
Spanish	445	75.68%	83.13%
Sign	63	10.71%	0.02%
Somali	36	6.12%	0.50%
Arabic	41	6.97%	1.47%
Mandarin	1	0.17%	0.24%
Farsi	1	0.17%	0.08%
Swahili	1	0.17%	0.22%
TOTAL	588	100%	100%

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Evaluate the number of interpreter calls/visits at medical provider appointments for EOCCO members.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
588	740	03/2020	932	03/2021

Activity 3 description: **Cultural Competency Employee Training**

EOCCO launched a three part inclusion training series in 2017 on the following topics: Working in an Inclusive Environment, Implicit Bias, and Cultural Competence. These are offered through an online webinar training system to all employees at Moda Health. Each session is self-paced and takes approximately 5-7 minutes to complete. There are approximately 40 employees at Moda Health whose primary role is to support EOCCO. It is a priority that these individuals complete the cultural competence training at minimum because they work with the provider and member population in Eastern Oregon. EOCCO plans to implement an annual health equity training with all EOCCO partners at the EOCCO annual staff and clinician summit.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement:

1. Evaluate which EOCCO employees have been trained in working in an inclusive environment.
2. Evaluate which EOCCO employees have been trained on implicit bias.
3. Evaluate which EOCCO employees have been trained on cultural competence.
4. Measure participation in the annual health equity training with EOCCO partners at the clinician summit.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
67.5%	75%	12/2019	85%	12/2020
57.5%	65%	12/2019	75%	12/2020
52.5%	65%	12/2019	75%	12/2020
0%	25%	12/2019	50%	12/2020

A. **Project or program short title**: Grievance and Appeal System Project 1: EOCCO Appeals & Grievance Compliance

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

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

xxxi. Secondary component addressed: Choose an item.

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

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

☐ Behavioral health integration ☐ Oral health integration

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

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

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

Our goal for 2018 was to become 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.

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

Add text here

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

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

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: All appeal and grievance policies and procedures have been updated with the 2018 process changes and approved by the EOCCO Quality Improvement Committee (QIC). All appeal and grievance staff have been trained on the 2018 contract changes. They also received refresher trainings on ensuring that their due dates are met. The letter templates used to send correspondence to members has been updated with the appropriate timelines and information. In order to ensure timeliness are met, additional staffing has been added to the appeal and grievance department.

We have reaffirmed the process with the medical management team to help indemnify appeals accurately and forward to the appeal team in a timely manner. We reviewed expedited appeal timeframe with the dental claims department to ensure timely response to the appeal team.

A dashboard was created to monitor timelines. 3 times a week the dashboard is reviewed by the supervisor and lead and then sent to the appeal coordinators to ensure timelines are met. This has prevented cases from being overlooked during the appeal and grievance process. Quarterly, the number of timely and untimely cases are reported to the Compliance Officer for review and corrective action as necessary.

EOCCO presents quarterly and annually grievance/appeal reports to EOCCO QIC on the following:
i) Number of grievances/appeals obtained from Access database
ii) Completeness and accuracy
iii) Persistent or significant grievances/appeals
iv) Timeliness of receipt, disposition, and resolution

The EOCCO QIC reviews the reports and analyze issues raised by members in grievances and appeals and their resolution and makes recommendations for improvements, as necessary. Annually, the EOCCO QIC reviews the grievance/appeal process and recommend process improvement, as appropriate.

Outstanding items:

- None. This project is now complete.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (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.	Q1 2018 Appeals: We processed 95.3% of the appeals within 16 calendar days of receipt, 3.1% processed within the 30 calendar days of receipt and 1.6% was not processed within the 30 calendar days allowed per the Oregon Administrative Rules. Expedited: 88% of expedited cases were processed in 72 hours (14/16 cases). Q1 2018 Grievances: Percent of complaints resolved in one phone call: 19.2% Percent of complaints resolved within five working days: 53.8% Percent of complaints resolved between eight to 30 calendar days: 42.3% Percent of complaints exceeding regulatory timelines: 3.8%	Q3 2018 Appeals: We processed 82% of the appeals within 16 calendar days of receipt, and 11% were not processed within the 30 calendar days allowed per the Oregon Administrative Rules. Expedited: 91% of expedited cases were processed in 72 hours (10/11). Q3 2018 Grievances: Percent of grievances resolved in one phone call: 10% Percent of grievances resolved within five working days: 32% Percent of grievances resolved between eight to 30 calendar days: 61% Percent of grievances exceeding regulatory timelines: 6% Q4 2018 Appeals: We processed 72% of the appeals within 16 calendar days of receipt, and 7% were not processed within the 30 calendar days allowed per the Oregon Administrative Rules. Expedited: 82% of expedited cases were	Our goal is to increase our timeliness for appeals to 98% for standard requests and 92% for expedited appeals. We would also like to decrease our grievances resolved in over 30 days to less than 2.5% of cases.	12/31/2018

		processed in 72 hours (18/22). Q4 2018 Grievances: Percent of grievances resolved in one phone call: 13% Percent of grievances resolved within five working days: 35% Percent of grievances resolved between eight to 30 calendar days: 60% Percent of grievances exceeding regulatory timelines: 5.0%		

A. **Project or program short title**: Health Equity Project 1: EOCCO Health Disparity Data Analysis

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

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

xxxiv. Secondary component addressed: Choose an item.

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

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

☐ Behavioral health integration ☐ Oral health integration

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

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

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

EOCCO analyzed language, race and ethnicity data to identify trends in underutilized services leading to poorer performing incentive measures within certain cultural and ethnic groups. The measures that were analyzed included Adolescent Well Care, Effective Contraceptive Use, Emergency Department Utilization, and Developmental Screening. There were no significant disparities among language, race, and ethnicity for the Developmental Screening measure. The lowest performing group of members for the Adolescent Well Care measure were members who identified as a race other than Caucasian. The lowest performing group of members for the Effective Contraceptive Use measure were members who speak another language other than English. Lastly, the group of members with the highest ED utilization are those who identified as Caucasian, non-Hispanic, and English speaking.

Project or program brief narrative description:

EOCCO is committed to eliminating health disparities and providing the highest quality care to all EOCCO members, regardless of race, ethnicity or primary language. To provide culturally and linguistically appropriate services to EOCCO members, we stratified race, ethnicity, and language data to reveal health disparities. EOCCO plans to implement strategies in response to the identified health disparities and gaps in care.

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

Activity 1 description: Health Disparities by Language, Race, and Ethnicity

EOCCO's data analysis revealed three disparity populations within three different areas of care. EOCCO plans to implement a strategy to increase adolescent well care visits among members who identify as another race other than Caucasian. EOCCO also plans to implement a strategy to increase effective contraception rates among members who speak another language other than English. Lastly, EOCCO plans to implement a strategy to decrease ED utilization among members who identify as Caucasian, non-Hispanic, and English speaking.

	English, Caucasian, non-Hispanic	**Other languages, races, and ethnicities**	**Unknown**
Language	86.81%	11.37%	1.82%
Race	41.4%	3.08%	55.52%
Ethnicity	47.94%	14.15%	37.91%

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement:

1. Percent of members who identify as another race other than Caucasian (excluding those who are unknown) who completed an adolescent well care visit.
2. Percent of members who speak a language other than English (excluding those who are unknown) who have evidence of effective contraception.
3. Rate of ED utilization by EOCCO members who identify as Caucasian, non-Hispanic, and English speaking per 1,000 member months (lower is better).

Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
39.6%	42.6%	03/2020	45.6%	03/2021
27.2%	30.2%	03/2020	33.2%	03/2021
55.2/1,000	53.5	03/2020	51.8	03/2021

A. **Project or program short title**: Health Equity Project 2: Advantage Dental Provider and Staff Cultural Competence Education & Training

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

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

xxxvii. Secondary component addressed: Choose an item.

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

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

☐ Behavioral health integration ☐ Physical health integration

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

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

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

Advantage Dental ensures contracted providers and staff have awareness and sensitivity to cultural differences. "Culture" is the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics. Culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetimes. "Competence" is the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. ADP views cultural competence as the integration of knowledge about individuals and groups of people into specific policies, practices, and attitudes to increase the quality of services, thereby producing better outcomes. ADP also views culture competency as the capacity to function within the context of diverse cultural groups.

During evaluation in 2018, Advantage Dental identified areas that need improvement: implementing individualized work around and processes to ensure health equity for all members.

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

In 2018, Advantage Dental implemented solutions to ensure providers and staff have awareness and sensitivity to cultural differences among the CCO members they serve.

1. Advantage Dental requires that all new providers and staff complete a cultural competency training.
2. Advantage Dental requires annual review of the cultural competency training for all staff and providers.
3. Advantage Dental promoted an employed Licensed Clinical Social Worker to the role of Health Equity and Special Populations Manager to assist with implementing "outside the box" processes to assist all members.

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

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

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Advantage Dental offers an online webinar for Cultural Competency Training. Primary Care Dentists are required to take this training annually to assist in cultural sensitivity and awareness.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
In review for improvements prior to implementation.	100%	7/31/2019	100%	7/31/19 and annually thereafter.

Activity 2 description: Quarterly Health Equity Training Programs

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Advantage Dental's new Health Equity and Special Populations Manager will be implementing Health Equity trainings for all staff and providers throughout 2019.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
In development	100%	10/31/2019	100%	10/31/2019 and annually thereafter.

A. **Project or program short title**: Health Information Technology Project 1: EOCCO EHR Adoption

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

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

xl. Secondary component addressed: Choose an item.

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

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

☐ Behavioral health integration ☐ Oral health integration

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

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

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

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 Collective Medical (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. These methods of data sharing are ongoing processes as we continue to expand the network of providers who can connect to and access the information. For this reason, we plan to continuously monitor and expand these activities.

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

In order to successfully share electronic health information across the majority of EOCCO primary care providers our goal is to have at least 80% of our patient population represented in each platform. This requires the engagement of at least 17 of our largest health systems to reach the desired patient population. We plan to monitor and work as a liaison between our health systems and the two technology systems to ensure success of connecting and the appropriate use of the platforms for data sharing and care management.

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

Activity 1 description: EOCCO and Arcadia Analytics established a contract to support the connection, implementation, and utilization of the platform with our EOCCO clinics. Arcadia Analytics is a population health management platform that incorporates the practice EHR and health plan claims data. EOCCO and Arcadia Analytics meet on a weekly basis to discuss the status of the onboarding process. This allows for continued communication to ensure barriers are addressed as they arise.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: EOCCO and Arcadia Analytics meet on a weekly basis to discuss the status of the onboarding process. This weekly meeting tracks the health systems as they move through the on-boarding process to becoming live with the platform.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
10/17 clinics are live with Arcadia	17/17 clinics will be live with Arcadia	12/2024	Oral health practices integrated into the platform. (Behavioral health practices are already in the on-boarding process)	12/2024

Activity 2 description: 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 or ☒ Long term

Monitoring activity 2 for improvement: Through the bi-weekly meeting, EOCCO will track the number of clinics that adopt PreManage into their clinic workflows.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
9/17 clinics are live with PreManage	17/17 clinics will be live with PreManage	12/2024	Expand PreManage access to Public Health partners and appropriate specialty providers.	12/2024

A. **Project or program short title**: Health Information Technology Project 2: EOCCO/Arcadia Analytics

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

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

xliii. Secondary component addressed: Choose an item.

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

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

☐ Behavioral health integration ☐ Oral health integration

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

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

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

EOCCO understands the need and benefit to offer our clinics methods to facilitate population management and to track performance metrics. EOCCO has contracted with Arcadia Analytics to meet this need. Arcadia Analytics is a platform that will allow for the inclusion of all claims and clinical incentive measures, outreach rosters for each measure, and the ability to identify gaps in care at the time of visit.

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

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.

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

Activity 1 description: EOCCO will track the utilization of Arcadia Analytics for quality metric performance tracking and reporting. To do so, we will track the number of clinics who use Arcadia Analytics to submit their annual clinical quality measures. These measures include depression screening and follow-up, controlling hypertension, diabetes HbA1c poor control, cigarette smoking prevalence, and weight assessment and counseling.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement:

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
3/17 clinics used this tool to submit their clinical quality measures.	17/17 clinics will use this tool for their clinical quality measure submission.	12/2024	To be determined.	To be determined.

A. **Project or program short title**: Health Information Technology Project 3: EOCCO Non-Pharmacological Pain Treatment Program

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

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

xlvi. Secondary component addressed: Access

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

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

☐ Behavioral health integration ☐ Oral health integration

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

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

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

EOCCO piloted a new online non-pharmacological chronic pain treatment program in July 2018. Due to the short evaluation period, we are continuing the program for the 2019 TQS.

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

EOCCO piloted a new online non-pharmacological chronic pain treatment program in July 2018. This Pain School program is a four-week online program (offered 1.5 hours, 1 day per week) and includes education, cognitive behavioral techniques and movement therapy. Course participants receive tools and resources that help reduce pain, as well as improve quality of life and function. This program is focused on the total person, and not just the pain. Also, no referral is required! Part of the education provided by ICMs, is to discuss and provide resources for pain management to

enhance members' self-management skill set. One of these resources given to the members when engaged with ICM services is the On-Line Pain Management School and how to access this service for free. Pain School Online is being offered through a grant from the Eastern Oregon Coordinated Care Organization. It is free for Eastern Oregon CCO Members living in Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, & Wheeler Counties. Note: This program is intended to compliment, not replace, the existing non-pharmacological pain clinic programs currently operating at the Center for Human Development in La Grande and Total Health in Baker City.

Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Our activity is to evaluate member participation in the online pain school.

☒ Short term or ☒ Long term

Monitoring activity 1 for improvement: Monitoring is measuring the percent of members that participate in the program versus enrolled.

Baseline or current state	Target / future state	Target met by (04/2019)	Benchmark / future state	Benchmark met by (04/2020)
# of pts enrolled July '18 = 25 # of pts who actually attended = 17 % attended of those that signed up = 68%	50% of those signed up with attend	Note: Target date is updated from 6/2018.	60% of those signed up with attend	Note: Benchmark date updated from 1/2019

A. **Project or program short title**: Integration of Care Project 1: EOCCO Multidisciplinary Teams

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

B. **Primary component addressed**: Integration of care (physical, behavioral and oral health)

xlix. Secondary component addressed: Grievance and appeal system

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

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

☒ Behavioral health integration ☒ Oral health integration

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

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

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

In 2018, 44 members were referred to the East 6 multidisciplinary team (MDT) and 78 members were referred to the Umatilla/Morrow MDT, which is an 11% increase from 2017. In January 2018, we implemented the West 4 MDT in Gilliam, Lake, Sherman, and Wheeler counties; in 2018, it received 14 referrals. We started 2018 with 16 active cases that were active from 2017.

- 90 of 136 cases were referred to Aging and People with Disabilities (APD).
- 44 of 136 were referred for behavioral health or substance use disorders.

- 26 of 136 were referred for a combination of interventions.

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

- 101 of 136 cases referred had goals successfully met.
- 13 of 136 cases referred had a lack of member engagement so the goals were not successfully met
- 6 of 136 cases referred were unsuccessful in meeting goals for various reasons, including rapid decline in condition, imprisonment, and inability to reach the referral source once the referral was made.
- The remaining 16 cases are currently active.

These county-based multidisciplinary teams have become known to individual communities in eastern Oregon and have become a trusted resource in each community. Our success rate has grown over the last three years based on the level of engagement with our partners. The MDTs are evolving regularly; our goal is for these teams to become better known and more effective, measured through quantifiable outcomes.

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

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.

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

Activity 1 description: Increase the specificity of initial goals and identify barriers to meeting those goals.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Monitoring takes place through quarterly stakeholder oversight meetings. In 2018, we were able to increase the specificity of initial goals and separate goals when there is more than one reason for referral.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Currently, initial goals can only be categorized into one grouping.	Break goals into primary, secondary, and tertiary.	12/2018	Identify barriers to individual goals and categorize.	12/2019

Activity 2 description: 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 or ☐ Long term

Monitoring activity 2 for improvement: Active participation from representatives of physical, behavioral, and dental health EOCCO partners at health fairs throughout the 12 counties.

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

To be determined	Participation in health fairs in at least 3 counties	12/2018	Participation in health fairs in at least 5 counties	12/2019

Activity 3 description: Increase referral sources for the multidisciplinary teams.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Monitoring takes place through quarterly stakeholder oversight meetings.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Referrals are made from Behavioral Specialists, Care Coordinators, Care Managers, Case Managers, hospitals, and providers.	Engage the EOCCO appeals and grievances team as an MDT referral source so they will direct any members they encounter in the grievance or appeals process to the MDT to address needs the member expresses through the complaint process.	01/2019	Increase provider awareness of the MDTs by providing education to the providers on this resource.	12/2019

A. **Project or program short title**: Integration of Care Project 2: EOCCO Community Health Fairs

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

B. **Primary component addressed**: Integration of care (physical, behavioral and oral health)

lii. Secondary component addressed: Access

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

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

☒ Behavioral health integration ☒ Oral health integration

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

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

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

Increase EOCCO participation at Health Fairs.

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

Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): 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 or ☒ Long term

Monitoring activity 2 for improvement: EOCCO will monitor by the number of Health Fairs attended throughout EOCCO territory. This will include representative from Behavioral Health, Dental and Medical.

Baseline or current state	Target / future state	Target met by (12/2019)	Benchmark / future state	Benchmark met by (12/2020)
In 2018, 0 Health Fairs were attended by representatives from Behavioral, Dental and Medical areas of the CCO.	3 Health Fairs attended by representatives from Behavioral, Dental and Medical areas.	Note: Target date is updated from 12/2018.	5 Health Fairs attended by representatives from Behavioral, Dental and Medical areas.	Note: Benchmark date updated from 12/2019

A. **Project or program short title**: Severe and Persistent Mental Illness Project 1: EOCCO ED Utilization by Members with SPMI

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

B. **Primary component addressed**: Severe and persistent mental illness

lv. Secondary component addressed: Special health care needs

lvi. Additional component(s) addressed:

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

☐ Behavioral health integration ☐ Oral health integration

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

xix. Additional subcomponent(s) addressed: Utilization review

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

High ED utilization is often a sign of problems in community – based outpatient care such as primary care, specialty care, dental care and/or behavioral health. High ED utilizations is also an indicator of rising risk for acute and/or chronic illnesses. Members who are using the ED frequently may be experiencing an increase in symptoms that could indicate a worsening condition. ED care does not provide as many opportunities for integration and coordination of care. GOBHI will assure that EOCCO members who are showing patterns of high ED utilization have a care plan and will be used by community behavioral health providers for coordination of the member's care.

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

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.

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

Activity 1 description (continue repeating until all activities included): A care plan will be entered into EDIE/Pre-Manage for all members with >5 ED visits in the past 12months. All CMHPs are utilizing PreManage and get a daily report for ED visits for BH reasons under scheduled reports in PreManage.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: 610 people had 5 or more visits of which 168 (38%) have a care guideline in PreManage. EDIE/PreManage is now available to GOBHI staff and CMHP providers, GOBHI will track and monitor number of Members who meet criteria have the care coordination plan in EDIE/PreManage and receive services by the corresponding CHMP. GOBHI will continue to work with CMHP providers as well as increase communication and coordination of care among community partners.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
38%	50%	12/2018	95%	12/2019

A. **Project or program short title**: Social Determinants of Health Project 1: EOCCO Grants Enhancing Community Involvement

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

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

lviii. Secondary component addressed: Access

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

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

☐ Behavioral health integration ☐ Oral health integration

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

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

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

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. EOCCO is dedicated to continue to provide services and funding to communities and individual members that address the social determinants of health and health disparities.

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.

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.

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

Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Count and monitor the number of 2019 EOCCO-approved grant projects that address social determinants of health including the dollars associated with those grants.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: 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.

Baseline or current state	Target / future state	Target met by (07/2019)	Benchmark / future state	Benchmark met by (7/2019)
For the 2018 grant cycle EOCCO funded $240,000 in projects that address health disparities and social determinates of	Fully understand the number of projects, the counties impacted and the dollars associated with EOCCO grant	Note: Grant funding for 2019 are in the final approval stage.	Continue grant funding in 2020 and fully understand the number of projects, the counties impacted and the	Note: Grant funding for 2020 will be approve in April 2020.

health in nine EOCCO counties.	funded projects that address health disparities and social determinants of health.		dollars associated with EOCCO grant funded projects that address health disparities and social determinants of health.	

Activity 2 description (continue repeating until all activities included): 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 or ☒ Long term

Monitoring activity 2 for improvement: EOCCO will continue to work one on one with providers that employ CHW's and provide technical assistance to implement CHW billing.

Baseline or current state	Target / future state	Target met by (06/2019)	Benchmark / future state	Benchmark met by (06/2020)
Between June 2016 and May 2017, EOCCO paid 688 CHW claims	Between June 2018 and May 2019, increase the number of CHW claims by 30% over baseline results.		Between June 2019and May 2020, increase the number of CHW claims by 40% over baseline results.	

Activity 2 description (continue repeating until all activities included): Both entry level CHW training courses and Continuing education courses will be offered throughout 2019. We are in the process of collecting data for the 1st activity to be able to report progress in April 2019.

☒ Short term or ☒ Long term

Monitoring activity 2 for improvement: EOCCO will survey the number of CHWs providing services within the EOCCO service area. 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

Baseline or current state	Target / future state	Target met by (04/2019)	Benchmark / future state	Benchmark met by (04/2020)

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.	Note: Target date is updated from 01/2019.	Increase the number of employed CHW's by 15% over baseline results.	Note: Target date is updated from 01/2020.
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 program in 2018. Note that data for 2018 is not yet collated to produce reporting.	Note: Target date is updated from 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. Note that data for 2018 is not yet collated to produce reporting.	Note: Target date is updated from 01/2020.

A. **Project or program short title**: Special Health Care Needs Project 1: EOCCO Special Health Care Needs Case Management

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

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

lxi. Secondary component addressed: Choose an item.

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

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

☐ Behavioral health integration ☐ Oral health integration

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

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

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

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 made based on information received through care coordination, health risk assessments, high-dollar reporting, the county collaborations known as multidisciplinary teams, and technology such as PreManage.

Intensive case managers (ICMs) provide EOCCO members with information about case management once a referral is made. 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 assisting with overcoming barriers to care, such as difficulty accessing specialists, services, and supplies

In 2018, ICMs received 432 referrals, which is an increase of 44% from 2017's report of 301. 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 People with Disabilities. The members served have needs related to cancer, chronic pain, trauma, systemic infections, renal disease, cardiac disease, and neurological disorders. Intensive case managers utilize the data from PreManage to reach out to members who are hospitalized with certain trigger diagnoses prior to leaving the hospital or upon discharge in an attempt to engage these members in ICM services.

ICM for members with special healthcare needs	2015	2016	2017	2018
# of members with ongoing intensive case management	95	99	89	165

In 2018, EOCCO ICMs nearly doubled the number of members served in 2017. EOCCO is implementing a different approach to addressing the needs of members with special health care needs in 2019. During 2018, we developed a report to track members who may have special health care needs based on the flags identified by OHA's enrollment file. This report will be used to assign more members with special health care needs to services such as health coaching, intensive case management, and care coordination.

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

EOCCO identifies members with special health care needs and addresses their needs through health coaching, care coordination, and intensive case management services.

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

Activity 1 description: Develop a process for members with special health care needs to have direct access to specialists.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Monitoring will take place through work groups.

Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
Members have direct access to specialists with a funded diagnosis and service code	Develop a process for members with special health care needs to have direct access to specialists, even without a funded diagnosis and service code	06/2019	Members with special health care needs will have direct access to specialists, even without a funded diagnosis and service code	To be determined

Activity 2 description: Document the process for monitoring direct access to specialists.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Monitoring will take place through EOCCO QIC.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
To be determined	Create document outlining the process for monitoring direct access to specialists for members with special health care needs	06/2019	To be determined	To be determined

Activity 3 description: Expand our capacity to report services provided to members with special health care needs.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Monitoring will take place through our government programs work group.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
We currently report members served through intensive case management	Update workflow to incorporate special health care needs flags into our referral process	06/2019	Report members served through health coaching, care coordination, and intensive case management services	12/2019

A. **Project or program short title**: Utilization Review Project 1: EOCCO Cost and Utilization Dashboard

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

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

lxiv. Secondary component addressed: Choose an item.

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

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

☐ Behavioral health integration ☐ Oral health integration

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

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

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

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. In 2018, EOCCO created county level cost and utilization dashboards for its 12 respective counties. These were distributed to community partners within the counties. Currently the EOCCO cost and utilization dashboard is distributed on an ad hoc basis when an official presentation and discussion can be conducted. In order to distribute the cost and utilization reports on a quarterly bases, EOCCO needs to determine a way to distribute the dashboard in a format that is easy to interpret. EOCCO experienced barriers to implementing the dental and behavioral health cost and utilization dashboards due to staffing constraints. However, EOCCO now has a designated employee to begin the project. Additionally, EOCCO strives to optimize the internal provider progress reports to include additional data.

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

Data Distribution Plan:

1. Provide the EOCCO Cost and Utilization Dashboard to key stakeholders on a quarterly basis to review regular data trends between the most recent 12 month period and the prior 12 month period in categories including inpatient, outpatient, professional, behavioral health, dental, and pharmacy.
2. Optimize provider progress reports to include updated incentive measure data and distribute them to EOCCO providers on a monthly basis.
3. Create a detailed Dental and Behavioral Health Cost and Utilization Dashboard in order to further evaluate utilization of services in all realms of healthcare.

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

Activity 1 description: **EOCCO Cost and Utilization Dashboard**

The EOCCO cost and utilization dashboard 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. The 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. 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 or ☐ Long term

Monitoring activity 1 for improvement: Frequency of distribution of the Cost and Utilization Dashboard.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Ad hoc	Quarterly	12/2019	Quarterly	12/2019

Activity 2 description: **Provider Progress Reports**

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 is working to optimize the provider progress reports to include additional data. In 2018, EOCCO added the clinical quality measures, dental sealants, colorectal cancer screening and timeliness of prenatal care. Updates to the 2019 provider progress reports will include the addition of SBIRT, oral evaluation for adults with diabetes, and the postpartum care measures. By doing this, the goal is for clinics to focus on all incentive measures and not just the claims based measures that they currently receive.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Percentage of incentive measures included in the provider progress reports.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
82%	84%	06/2019	To be determined based on future OHA measures	06/2020

Activity 3 description: **Dental and Behavioral Health Cost and Utilization Dashboard**

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 or ☒ Long term

Monitoring activity 3 for improvement: EOCCO will develop detailed Dental and Behavioral Health Cost and Utilization Dashboards.

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

A. **Project or program short title**: Value-Based Payment Models Project 1: EOCCO VBP Models to Increase PCPCH Adoption

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

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

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

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

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

☐ Behavioral health integration ☐ Oral health integration

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

xxiii. Additional subcomponent(s) addressed: Patient-Centered Primary Care Home

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

Over the past six 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 six 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.

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

Activities and monitoring for performance improvement:

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

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: The number of PCPCH practices that have adopted capitation with quality incentive and shared savings opportunity. As a note, EOCCO met its previous goal set for 9/2018 of 17 clinics.

Baseline or current state	Target / future state	Target met by (09/2019)	Benchmark / future state	Benchmark met by (09/2020)
19 PCPCH practices have adopted capitation with quality incentive and shared savings opportunities	21 PCPCH practices have adopted capitation with quality incentive and shared savings opportunities	Note: Since the last target was met, we have updated the target and target met by based on current state.	23 PCPCH practices have adopted capitation with quality incentive and shared savings opportunities	Note: Benchmark date updated from 9/2019

Activity 2 description (continue repeating until all activities included): Include quality- based payment opportunities in DCO contracts.

☒ Short term or ☒ Long term

Monitoring activity 2 for improvement: 2019 DCO contract changes are in draft. We anticipate that we will have implemented DCO contracts that include risk/reward performance incentive payment provisions for meeting quality measure targets.

Baseline or current state	Target / future state	Target met by (1/2020)	Benchmark / future state	Benchmark met by (1/2020)
2019 DCO contract amendments are in in effect and we have met our previous target for 1/2019, where all of the	2020 EOCCO's contracted DCO's include risk/reward performance incentive payment provisions for	Note: Target date is updated from 1/2019.	2021 EOCCO's contracted DCO's include risk/reward performance incentive payment provisions for	Note: Target date is updated from 1/2019.

contracted DCO's have risk/reward performance incentive payment provisions for meeting quality measure targets.	meeting quality measure targets.		meeting quality measure targets.	

Activity 3 description (continue repeating until all activities included): Include quality- based payment opportunities in DCO contracts.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: 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.

Baseline or current state	Target / future state	Target met by (1/2020)	Benchmark / future state	Benchmark met by (1/2020)
0 EOCCO hospitals are on a capitated VBP model.	EOCCO to determine if a capitated VBP model is a viable option.	Note: Target date is updated from 1/2019.	One of EOCCO's in-area hospitals has a capitated VBP model contract in place if EOCCO determines capitation is a viable option.	Note: Target date is updated from 1/2019.

Activity 4 description (continue repeating until all activities included): 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 or ☒ Long term

Monitoring activity 4 for improvement: 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.

Baseline or current state	Target / future state	Target met by (9/2019)	Benchmark / future state	Benchmark met by (9/2020)
84% on 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.	Note: Target date is updated from 9/2018.	90% of in-area primary care utilization is from providers participating in an EOCCO VBP model that includes shared savings with quality incentive payments.	Note: Target date is updated from 9/2019.

Activity 5 description (continue repeating until all activities included): 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 or ☒ Long term

Monitoring activity 5 for improvement: Measure the percent of EOCCO members assigned/attributed to a PCPCH that receives case management payments as one form of VBP.

Baseline or current state	Target / future state	Target met by (1/2020)	Benchmark / future state	Benchmark met by (1/2021)
As of February 2019: No certification: 12% Tier 1: Tier 2: Tier 3: 24% Tier 4: 40% Tier 5: 24% Total: 100%	No Certification: 10% Tier 1: 0% Tier 2: 0% Tier 3: 20% Tier 4: 45% Tier 5: 25% Total: 100%	Note: Target date is updated from 1/2019.	No Certification: 9% Tier 1: 0% Tier 2: 0% Tier 3: 15% Tier 4: 50% Tier 5: 26% Total: 100%	Note: Target date is updated from 1/2020.

Activity 6 description (continue repeating until all activities included): Activity 6 is new in 2019. EOCCO will look to base a portion of the PCPCH enhanced payments to providers based on member risk scores.

☐ Short term or ☒ Long term

Monitoring activity 6 for improvement: EOCCO will work in collaboration with its Actuarial team and in coordination with its Performance-based Medical Home Subcommittee, to determine if hospital capitation can be a viable VBP model in a rural service area.

Baseline or current state	Target / future state	Target met by (7/2020)	Benchmark / future state	Benchmark met by (7/2021)
0% of PCPCH payment paid based on member risk score.	20% of PCPCH payment paid based on member risk score.	New in 2019	30% of PCPCH payment paid based on member risk score.	New in 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.

Submit your final TQS by March 15 to CCO.MCODeliverableReports@state.or.us.