InterCommunity Health Network CCO

Transformation and Quality Strategy Report

March 2018

Stronger, healthier, together.

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Section 1: Transformation and Quality Program Information

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

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

InterCommunity Health Plans serve Oregon Health Plan members in Linn, Benton and Lincoln Counties under InterCommunity Health Network-Coordinated Care Organization (IHN-CCO).

Our Quality Management Program is designed to monitor the quality of healthcare provided to all IHN-CCO members to meet the Institute for Healthcare Improvement's (IHI) Triple Aim Initiative of improving the patient experience of care, improving the health of populations and reducing the per capita cost of health care. Our Quality Management Plan and Utilization Management/Medical Management Plan are reviewed and updated annually and approved by the internal Quality Improvement Committee (QIC) and external Quality Management Committee (QMC).

The goals and objectives of the program include but are not limited to:

1. Maintain an effective Quality Management Program:
   - Meet or exceed the expectations and standards of Federal, State and contractual entities regarding maintaining a quality management program including an annual evaluation of the program
2. Ensure continual high-level member satisfaction and access to appropriate healthcare services:
   - Monitor member complaints/grievances/appeals internally on an ongoing basis to identify areas for improvement
   - Monitor member satisfaction via external agencies such as through Consumer Assessment of Healthcare Providers & Systems Survey (CAHPS), etc. per Federal, State and contractual requirements to identify areas for improvement
   - Implement and monitor appropriate interventions when areas for improvement in member satisfaction or access to appropriate healthcare are identified
   - Report results of monitoring member satisfaction and access to appropriate healthcare to the Quality Management Committee and to the Board of Directors as indicated but at least on a yearly basis
   - Maintain a collaborative relationship with the provider network and community entities
3. Develop programs and interventions to improve member health outcomes:
   - Promote preventive medical and dental services and early detection of disease through the member education and the case management programs
   - Promote self-management of chronic diseases through the member education and the case management programs
   - Monitor health outcomes on an individual basis through the case management program
   - Monitor health outcomes on an overall basis through various methods including Healthcare Effectiveness Data & Information Set (HEDIS) data, internal data, etc.
   - Meet or exceed expectations for all quality projects required by state contractual requirements
   - Report results from programs and intervention monitoring to the Quality Management Committee and the Board of Directors on at least a yearly basis or more frequently as indicated

Our Quality Management Program monitors four key areas: utilization of services, member satisfaction, clinical services (including behavioral health/mental health, dental services, prevention, chronic care improvement, maternal/ child services, case management, member health education and quality improvement projects, etc.) and various administrative services. IHN-CCO believes that the integration, monitoring and balance of findings in these areas reflect the achievement of effective and efficient health care that is high quality and cost-effective and meets the IHI's Triple Aim Initiative.

The IHN-CCO Board of Directors retains authority and accountability for all quality activities and oversees our Quality Management Program. The Quality Management Committee provides oversight to quality planning, quality monitoring and improvement activities. The Plan's Quality and Health Outcomes Manager is responsible for the daily operations of the Quality Management Program and works closely with the Chief Medical Officer, the Director of Medical Management and other managers/directors and reports indirectly to the Chief Executive Officer and directly to the Director of NCQA Accreditation.

See QMC Charter: Attachment 01. See QIC Charter: Attachment 02.

Utilization Management Program & Utilization Management Plan

The Utilization Management Program falls under the scope of our Quality Management Program. As noted above our Quality Management Committee functions as the required IHN-CCO "Utilization review oversight committee" with assistance from the QIC.

We have a Utilization Management/Medical Management Plan that is reviewed and updated annually and approved by our Quality Management Committee. It reviews over/under utilization of services; documents their findings and makes recommendations for follow up actions.

Opportunities for Improvement for 2017 include:

- The Dental Integration Subcommittee to determine actions in 2017 related to dental utilization service location
- Improvement in access to preventive/ambulatory health services for adults
- Improvement in access to primary care for children and adolescents

The Mental Health Advisory Council has discussed over/under utilization of services related to the members in need of mental health services such as a lack of adult acute care.

Creation of reports specific to the needs of the Mental Health Advisory Council were developed for discussion, planning and monitoring of compliance related to the goals that were established. The reports used for analysis included:

1. Utilization Trend Report
    a. Inpatient hospitalization claims for clients serviced in ACT
2. Inpatient, Sub-acute, Psychiatric residential and Psychiatric day treatment
3. PCPCH-Behavioral Services utilization
4. Mental Health penetration rates

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):

InterCommunity Health Network CCO (Coordinated Care Organization) was formed in 2012 by local public, private, and non-profit partners to unify health services and systems for Oregon Health Plan (Medicaid) members in Benton, Lincoln, and Linn Counties.

Our organization structure has the IHN-CCO Board of Directors which consists of many community partners and stakeholders. The Board receives various updates on quality and transformation activities via the InterCommunity Health Network CCO (IHN-CCO) Chief Executive Officer, the IHN-CCO VP, Chief Operations Officer, and the IHN-CCO Medical Director. The Chief Executive Officer also presents a Board Report back to the Community Advisory Council (CAC) at Regional CAC meetings.

The Board Members consist of:

- Samaritan Health Services – CEO/President – Chair of Board
- Samaritan Health Services – Hospital CEO – Vice Chair/Secretary/Treasury
- 2 Physicians
- 1 Dentist
- 1 Mental Health Provider (LCSW)
- 1 CAC Chairperson
- 2 Community Members
- 1 CPA
- 2 County Commissioners
- 1 County Administrative Officer

The Regional Planning Council (RPC) develops tools and strategies to transform and integrate the system of care; recommends funding needed for transformational activities; assures cross-system coordination and care transitions, and sponsors an effective quality improvement process to drive positive system change. The Regional Planning Council is co-chaired by the Samaritan Health Plans' (SHP) Chief Executive Officer and the Benton County Health Director. The CAC Chairperson attends the RPC, as well as many community partners and stakeholders.

The IHN-CCO Delivery System Transformation (DST) Committee builds on current resources and partnerships in Benton, Lincoln, and Linn counties to support, sustain, and spread Transformation efforts for the Medicaid population and pursue the Triple Aim. The DST formally reports to and takes direction from the Regional Planning Council. The DST recommends transformation projects to the RPC for funding consideration. The DST is co-chaired by the SHP Chief Operations Officer and the Executive Director for the Community Health Centers of Benton and Linn Counties. The Community Advisory Council Chairperson and the Community Advisory Council Coordinator are both members of the DST.

See Community Relationship: Attachment 03. See RPC Charter: Attachment 04. See DST Charter: Attachment 05.

Currently there is representation on the IHN-CCO Quality Improvement Committee (QIC) by the Transformation Manager, and representation from the CAC coordinator on the Quality Management Committee (QMC), of which both committees are described above in Section A. i. Additional coordination of activities will need to be developed in view of the new TQS structure.

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

The IHN-CCO Delivery System Transformation Committee, responsible for oversight of transformation pilot projects, has a history of using the Community Health Improvement Plan (CHIP) Health Impact Areas of; Access, Behavioral Health, Child Health, Chronic Disease and Prevention, and Maternal Health to inform strategic planning of transformational pilot projects.

Transformation pilot funding requests are vetted through a Request for Proposal process that includes requiring pilots to address at least one of the CHIP Health Impact Areas in order to be considered for funding.

Additionally, a CHIP workgroup has been formed that is meeting this spring to develop a proposal for how to update the CHIP. The March TQS Report will be provided to this workgroup as another potential way to align our work.

We were told by OHA (Lisa Bui) that the CHIP would not be involved with the TQS in this initial submission since it was considered that there were too many stakeholders for involvement with it. Consideration will be given for future involvement of the CHIP with the TQS with the appropriate stakeholders identified.

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

IHN-CCO builds on current resources and partnerships within Benton, Lincoln, and Linn counties to outline processes and strategies to support transformation of the delivery system for the community. IHN-CCO and community partners strive to improve community health by coordinating health initiatives, seeking efficiencies through blending services and infrastructure, and engaging all stakeholders in a regional effort to ensure all individuals have equal opportunities to be healthy where they live, work, learn and play in Benton, Lincoln, and Linn counties. IHN-CCO's breadth of partnerships is displayed in the following committees.

The Delivery System Transformation Committee (DST) was developed with membership to include anyone that can positively affect the health outcomes of IHN-CCO members in Benton, Lincoln, and Linn counties. Currently partners include, Education Service Districts, Mental Health, health systems, clinics, Public Health, Early Learning Hub, Department of Human Services, physical health, social service agencies, Community Advisory Council members, oral health, and other community-based organizations. The DST oversees pilot projects that must address at least one TQS area. There are currently 19 active pilots that address 1 or more TQS areas all of which are with different community, clinical, or health system partners. See DST Pilots: Attachment 06.

The Quality Management Council (QMC) is made up of mental, physical, behavioral and dental health practicing providers or partners, health plan staff, addictions specialists, community representatives, care management personnel, and ad hoc subject matter experts as needed. QMC oversees and monitors quality improvement and performance activities of Samaritan Health Plans and Intercommunity Health Network Coordinated Care Organization.

The Quality Improvement Committee (QIC) is made up of designated Samaritan Health Plan Operations staff including the Chief Medical Officer and/or Medical Director and department representation from Quality, Appeals/Grievances, Claims, Customer Care, Customer Experience, Dental, Health Information, Medical Management, Pharmacy, Network Contracting and Strategy, Account Management, and ad hoc as applicable. The QIC's purpose is to improve quality of care and service by providing oversight, feedback and integration of data and other information across the health plan.

B. Review and approval of TQS

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

At IHN-CCO, Transformation and Quality are operationally managed in different departments.

Our approach for developing the TQS was to begin by leveraging what we were already doing or what was already in development, and use this as our baseline.

The Transformation Manager and Quality Director collaborated with various Samaritan Health Plan departments such as Medical Management, Community Solutions and Government Affairs, Compliance, Appeals and Grievances, Account Management, Reimbursement, Health Information, and Member Provider Engagement to collaborate on the development of the various TQS components.

Part of our strategy was to take advantage of the many OHA TQS webinars and office hours looking for guidance on the expectations surrounding the development of the TQS Plan. These Technical Assistance opportunities broadened our understanding and were found to be a valuable use of our time.

Communication channels included the IHN-CCO Board of Directors, Regional Planning Council, Delivery System Transformation Committee, Health Equity Workgroup, Quality Improvement Committee, Quality Management Council, Community Advisory Council Coordinator, and the Community Advisory Council.

Project management included an introductory meeting, Q & A check-ins, working sessions, and timeline development shared with the project team. The timeline included reverse engineering of internal draft due dates, review and clarification timeframes, and the planned final submission date. See TQS Timeline: Attachment 07.

A retrospective review of the process will be conducted, this along with the anticipated OHA feedback will help inform process improvements for the September progress report.

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:

IHN-CCO currently serves approximately 74,000 members that reside in Benton, Lincoln, and Linn counties. The counties within the IHN-CCO region include a swath of area that ranges from the heart of western Oregon, through a portion of the agriculturally rich Willamette Valley and out to, and including, 60 miles of Pacific coastline, spanning 3,968 square miles. The diverse region is separated by the Coastal Mountain range which contributes to some transportation and communication challenges as a quarter of the region resides on the Oregon Pacific Coast. Over 51% of IHN-CCO members live in rural areas (38,174).

The area is predominantly white and poverty levels are high, particularly in Lincoln and Linn Counties. Latinos represent the largest minority population in the region (3,572 IHN-CCO members). Nearly 10% (6,869) of IHN-CCO members speak a household language other than English.

Specific demographics that are disproportionately impacted by disease and illness include those with mental illness and disabilities. Approximately 34% (25,282) of IHN-CCO members have been diagnosed with a mental illness with 16% (11,544) diagnosed with Severe and Persistent Mental Illness (SPMI). 9% (6,420) of IHN-CCO members have at least one disability that limits their ability to work.

IHN-CCO Member Demographic Source: OHA Dashboard January 2018

Section 2: Transformation and Quality Program Details

Component Crosswalk

Component		Component	
1a.	Access: Availability of services	6a.	Health Information Technology: Health Information Exchange
1b.	Access: Cultural Considerations	6b.	Health Information Technology: Analytics
1c.	Access: Quality and Appropriateness of Care Furnished to all Members	6c.	Health Information Technology: Patient Engagement
1d.	Access: Second Opinions	7	Integration of Care (physical, behavioral and dental health care)
1e.	Access: Timely	8	Patient-Centered Primary Care Home (PCPCH)
2	CLAS Standards and Provider Network	9	Severe and Persistent Mental Illness (SPMI)
3	Complaints and Grievances	10	Social Determinants of Health (SDoH)
4	Fraud, Waste and Abuse	11	Special Health Care Needs (SHCN)
5a.	Health Equity: Data	12	Utilization Review
5b.	Health Equity: Cultural Competency	13	Value-based Payment Models

A. TQS COMPONENT(S) #1b.			
Primary Component:	Access	**Secondary Component:**	
Additional Components:	Members with complex and special health care needs.		
Subcomponents:	Access: Cultural considerations	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM

IHN-CCO will further enhance training for the health care guide program, which is a free service provided to members. IHN-CCO will establish a training program around cultural considerations and impacts to access for members with complex and special health care needs. Health care guides are available to assist members with complex health needs in accessing care. Health care guides coordinate care and engage members in shared decision-making, including development of care and treatment plans, coordinating with the interdisciplinary care team and community agencies, gaining access to services and supplies and problem-solving barriers. IHN-CCO provides materials in other languages and at 6th grade literacy level. Program staff will receive additional cultural awareness and skills training to include, but not limited to Adverse Childhood Experiences (ACEs), the culture of poverty, motivational interviewing and resiliency.

C. QUALITY ASSESSMENT	
Evaluation Analysis:	The health care guide program exists to reduce health disparities and ensure members with special and complex health care needs have access to dental, physical, and mental health care and other services. It is well understood that members with special needs often lack ability to navigate the complex health care system and access necessary services. Trained and skilled health care guides are able to effectively advocate for members and educate health care providers and garner access to the necessary services for members.

D. PERFORMANCE IMPROVEMENT

Activity: Use evidence-based materials and established training and subject matter experts to create and implement cultural awareness training curricula.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**

Training series developed.	Informal and on the job training exists.	Program staff become experts in advocating for and improving health outcomes for members with special health care needs.	01/2019	Highly effective skilled staff advocates and improves outcomes for members with special health care needs.	06/2019
Staff trainings completed.	Initial training to be held throughout the year as curricula developed.	Training available for health plan staff.	06/2019		

A. TQS COMPONENT(S) #1c			
Primary Component:	Access	**Secondary Component:**	Utilization review
Additional Components:	Add text here.		
Subcomponents:	Access: Quality and appropriateness of care furnished to all members	**Additional Subcomponent(s):**	Add text here.

B. NARRATIVE OF THE PROJECT OR PROGRAM
IHN CCO will further refine the health care guide program, hire and train health care guides and establish performance metrics around care coordination and members served to ensure quality care is furnished to members with special health care needs. Health care guides are available to assist members with complex health needs in accessing care. Health care guides are available to coordinate care and engage members in shared decision-making, including development of care and treatment plans, coordinating with the interdisciplinary care team and community agencies, gaining access to services and supplies and problem-solving barriers.

C. QUALITY ASSESSMENT	
Evaluation Analysis:	Members with complex health needs are often challenged with accessing appropriate care and resources and typically do not understand how to navigate the health care system in order to get appropriate care. Utilization review criteria and tools will be used to monitor and evaluate the quality and appropriateness of care provided to members with special and complex health needs.

D. PERFORMANCE IMPROVEMENT	
Activity: 1) Develop data set; 2) develop processes and tools to accurately segment and risk stratify population to identify members with special and complex health care needs. Develop workflow and processes to apply criteria and access benchmarks to population. Establish consensus on data use with stakeholders. 3) Data and tools are used effectively to monitor access, quality and the appropriateness of care.	☐ Short-Term Activity <u>or</u> ☒ Long-Term Activity

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Population health data set developed to include social determinates of health.	Data exists in disparate sources.	Comprehensive population health data and risk tools identify population with special health needs.	1/2019.	Data and tools manage access for members with complex and special health needs.	6/2019.
Apply utilization criteria and tools to population health data to analyze appropriateness of care and determine access benchmarks. Establish consensus on data use with key stakeholders.	Data and tools exist. Processes and workflows must be established for data to be useful for health care team. Multiple sources and data sets must be combined.	Data and tools are used to monitor and evaluate quality and appropriateness of care. Consensus achieved from key stakeholders.	6/2019	Access and quality and appropriateness of care is demonstrated through data and reports. Reports are shared and used by the health care team to ensure quality.	12/2019
Data and UM tools are used effectively to monitor and improve quality and appropriateness of care.	Not available.	Data and tools vetted by stakeholders and effective for use.	6/2019	Effective use of data and UM tools demonstrate access to quality and appropriate care.	

A. TQS COMPONENT(S) 1d. Access-Second Opinions			
Primary Component:	Health equity and data	**Secondary Component:**	Access
Additional Components:	Second Opinions		
Subcomponents:		**Additional Subcomponent(s):**	Add text here.
B. NARRATIVE OF THE PROJECT OR PROGRAM			
IHN-CCO wants to know if members requesting a second opinion are receiving them in a timely fashion, or if they have an extended wait time.			
C. QUALITY ASSESSMENT			
Evaluation Analysis:	The denominator will be identified as all IHN-CCO members who requested a second opinion in each quarter of 2017; numerator will be those members who had to wait more than one week for a second opinion appointment during this time period. The threshold of		

	acceptable timeliness will need to be determined by benchmarking of some kind, and by using 2017 data as the baseline data for future comparison.

D. PERFORMANCE IMPROVEMENT

Activity: Track and trend utilization of second opinions to ensure timeliness of requests, and to determine the average length of time it takes in the process of the request being received until a decision is made and communicated to the member/provider.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Analysis of data	Baseline	TBD	1/2017 – 12/2017	TBD	Baseline rate for 2017
Analysis of data	Current state	TBD	Quarterly, 2018	TBD	Quarterly

A. TQS COMPONENT(S): #2 CLAS standards and provider network; #5b Health equity and data (cultural competence)

Primary Component:	CLAS standards and provider network	**Secondary Component:**	Health equity and data
Additional Components:			
Subcomponents:	Health Equity: Cultural competence	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM

The IHN-CCO Delivery System Transformation Committee Health Equity Workgroup supports delivery system transformation that identifies and reduces health disparities and advances health equity. The Workgroup supports the culturally diverse needs of members (cultural competence training, provider composition reflects member diversity, Certified Traditional Health Workers composition reflect member diversity). Quality improvement focused on eliminating racial, ethnic, linguistic, and other disparities in access, quality of care, experience of care, and outcomes is a large part of the Strategic Plan as well as supporting IHN-CCO's Community Health Needs Assessment and Community Health Improvement Plan. The National Standards for Culturally and Linguistically Appropriate Services (CLAS) are accepted as a base standard for the work of the workgroup.

The Healthy Equity Workgroup developed a five-year Strategic Plan to assist IHN-CCO in meeting the culturally diverse needs of members and eliminating health disparities, including promoting a diverse workforce with an overall vision of a community where all members of IHN-CCO can meet their potential for optimum health and well-being. See Health Equity Strategic Plan: Attachment 08.

C. QUALITY ASSESSMENT

Evaluation Analysis:	A person's overall health and well-being is affected by a combination of factors. With an increased awareness of how culture and language affect overall health, it is crucial that trainings and supports are in place and the workforce reflects the diversity of the region. Having a culturally responsive workforce increases member engagement and health literacy, and in turn, leads to better health outcomes. Cultural diversity is more than knowing the values, beliefs, practices and customs of racial classification and national origins. It also includes religious affiliation, language, physical state, gender, sexual orientation, age, disability (both physical and mental), political orientation, socio-economic status, occupational status, geographical location and more. Through education and training, the Health Equity Strategic Plan will assist IHN-CCO staff and providers in delivering care that is:

	• Culturally and linguistically appropriate • Communicated clearly and effectively • Using a health equity lens for better health outcomes

D. PERFORMANCE IMPROVEMENT

Activity: Develop training plan for IHN-CCO Health Equity Workgroup, IHN-CCO staff, IHN-CCO providers, and other community stakeholders based on the CLAS framework.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Plan is developed.	No current plan.	Plan is developed.	12/2018	Plan is developed.	12/2018
Plan is approved and adopted.	No current plan.	Plan is approved and adopted.	03/2019	Plan is approved and adopted.	03/2019
Activity: Collect demographic data (race, ethnicity) on current IHN-CCO provider workforce.				☒ Short-Term Activity or ☐ Long-Term Activity	
Research whether demographic data is collected on IHN-CCO provider workforce.	Unknown.	Determination is in progress.	04/2018	Determination is made.	05/2018
Determine plan for data collection.	No current plan.	Plan is developed.	07/2018	Plan is developed.	07/2018
Activity: Evaluate and establish baseline regarding provider diversity. Dependent on available data, may include physicians, THWs, physician assistants, nurses, management, and/or other providers.				☐ Short-Term Activity or ☒ Long-Term Activity	
Evaluation completed.	No current plan	Plan is developed.	12/2018	Plan is developed.	12/2018
Establish baseline percentage of providers by race/ethnicity and language.	Unknown	Baseline established.	03/2019	Baseline established.	03/2019

A. TQS COMPONENT(S) #3

Primary Component:	Grievances and appeals	**Secondary Component:**	
Additional Components:	Add text here.		
Subcomponents:	Access: Quality and appropriateness of care furnished to all members	**Additional Subcomponent(s): Availability of Services**	Timely access and Cultural Considerations

B. NARRATIVE OF THE PROJECT OR PROGRAM

Appeals and Grievances Department tracks and trends the issues that our members face when receiving health services or the lack of services from the providers. Grievance categories tracked are access, interaction with providers of IHN-CCO, consumer rights, Quality of care, quality of service, and client billing issues. Reports are run quarterly and presented to various internal committees, as well as our external Quality Management Committee, which is comprised of providers and key IHN-CCO management staff. Opportunities for improvement are currently being explored as well as the reason for the grievances. All

grievances and appeals are processed according to the "GA-01 Grievance/Complaint Policy for IHN": Attachment 09 and "AT-02 Policy and Procedure-Appeals-IHN ": Attachment 10, which are attached.

C. QUALITY ASSESSMENT

Evaluation Analysis:	The analysis is part of the deliverable that IHN-CCO provides to OHA on a quarterly basis through the submission of Exhibit I. Also, an internal analysis is completed and reported to internal committees of IHN-CCO each quarter. An internal year-end analysis is also completed by IHN. The Attachment 11 entitled "IHN-CCO Appeals and Grievances Analysis" details the top three grievance categories as well as rates per thousand for both grievances and appeals. The top three grievance categories for 2017 were Interaction with Provider or Plan, Quality of Care, and Access.

D. PERFORMANCE IMPROVEMENT

Activity: Track, trend, and analyze grievances according to OHA categories.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Quarterly reports detailing grievance/appeals, presented at QIC and QMC meetings	Baseline	2017 rates: Grievances: 8.32 per 1000 Appeals: 8.2 per 1000	12/2018	N/A	TBD
Activity:				☐ Short-Term Activity or ☐ Long-Term Activity	
Add text here.	Add text here.	Add text here.	Add text here.	Add text here.	Add text here.

E. TQS COMPONENT(S): #4 Fraud, waste, and abuse

Primary Component:	Fraud, waste and abuse	**Secondary Component:**	
Additional Components:			
Subcomponents:		**Additional Subcomponent(s):**	

F. NARRATIVE OF THE PROJECT OR PROGRAM

As part of IHN-CCO's compliance program integrity work, member confirmation of services (COS) letters are sent each quarter to verify services billed by providers. An internal report randomly selects 700 members, a portion of which are Spanish-speaking members. IHN-CCO creates a letter which is mailed with postage-paid return envelopes to each member on the report. The compliance team collects the returned letters and records the number of completed confirmation letters returned, and tracks response rate and number of Special Investigations Unit (SIU) referrals. The data collected and outcome of SIU investigations are shared with the IHN-CCO Compliance Officer.

G. QUALITY ASSESSMENT

Evaluation Analysis:	In 2017, 2800 COS letters were mailed to IHN-CCO members; 700 in each quarter. Response rates were consistently within -/+1% each quarter, with Q1 at 32%.

	69 of the 2800 (2.5%) COS mailed in 2017 were Spanish-language. The response rate varied by quarter with the highest rate, 15%, occurring in Q3 and Q4. The compliance team will focus on increasing participation rate for Spanish-speaking members. Of the 847 COS letters returned, 4 (0.5%) responses warranted a referral to SIU for further investigation. While no fraud, waste, or abuse was discovered in any of the referred cases, the responses provided insight on areas of the letter and/or medical billing practices which could be misinterpreted by the member.

H. PERFORMANCE IMPROVEMENT

Activity: Monitor COS response rate. • See FWA Analysis: Attachment 12.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
COS response rate per quarter	32%	35%	03/2018	≥38%	03/2019
Activity: Increase outreach to Spanish-speaking membership. • See attached initial analysis. • Revise current process for COS.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Spanish-language COS response rate per quarter.	15%	≥20%	03/2018	≥25%	03/2019

A. TQS COMPONENT(S): #5a Health equity and data; #10 Social determinants of health

Primary Component:	Health equity and data	**Secondary Component:**	Social determinants of health
Additional Components:			
Subcomponents:		**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM

In order to identify the unique needs of our members and prevent consequences of health inequity, Medical Management will develop tools and reports to analyze health status of sub-populations within our IHN-CCO population. We will begin with Special Needs Plan (SNP) members who are dually enrolled in IHN-CCO as well as our Medicare Advantage Plan. Using data and reports we will be able to identify determinants of health and disparities among members. Population assessment and other sources of data will allow us to risk stratify members into specific subsets to ensure we are targeting resources and interventions to the individuals who can most benefit from them. The data will include relevant characteristics such as access to health care, food supply, housing, location of residence, age, race, language, gender, as well as disabilities, chronic conditions and comorbidities. Through this dataset we will also be able to evaluate whether current care coordination approaches are addressing the unique health care needs of our SNP members and positively impacting their lives.

C. QUALITY ASSESSMENT

Evaluation Analysis:	While our SNP membership is a small subset of our IHN-CCO population (approximately 1,500 members) there are many challenges in accessing accurate and current data on this population. These challenges include: datasets currently using multiple algorithms across

	the health plans (ex: HEDIS vs. IHN-CCO vs. CMS); lack of information on community partners involved with members; lag time in claims to get current information on chronic conditions.

D. PERFORMANCE IMPROVEMENT

Activity: Create report utilizing enrollment and claims data to properly review and characterize SNP membership. The report will be evaluated on a quarterly basis to determine approaches and interventions needed to assist SNP membership.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Develop report criteria for population assessment. Establish whole person data set.	Multiple data sets and disparate sources of data without consistent criteria.	Year over year comparison reports.	07/2018	Reports are useful for identifying issues impacting health equity.	03/2019
Metrics created to measure success in interventions based on SNP population data.	Metrics and population assessment data exists, not used to assess unique issues or aspects of health equity.	SNP Model of Care (MOC) Subcommittee establishes metrics to measure the effectiveness of interventions and potential health equity barriers.	12/2018	Reports identify most effective interventions and barriers to health equity are addressed.	12/2019

A. TQS COMPONENT(S) 5-b: Cultural Competence-Interpreter Services

Primary Component:	Health equity and data	**Secondary Component:**	
Additional Components:	Interpreter Services		
Subcomponents:		**Additional Subcomponent(s):**	Add text here.

B. NARRATIVE OF THE PROJECT OR PROGRAM

Samaritan Health Plans and IHN CCO ensure members' linguistic needs are met to support the management and comprehension of their health care. Samaritan Health Plans/IHN CCO contracts with certified and/or qualified interpreter services providers to deliver the largest variety of language options available, including but not limited to: spoken language other than English and sign language for the hearing or speech impaired. All interpreters are capable of translating clinical information effectively in English and the members' primary language.

Samaritan Health Plans/IHN CCO provides information on linguistic interpreter and translation service options and how to obtain services via member materials, provider manual, and public plan website. Materials are provided to and available for all members and providers.

Samaritan Health Plans/IHN CCO makes linguistic interpreter services available to its members and works with providers to ensure that services are delivered when needed. Plan provides interpretation to members when they identify that they have a need for the service.

Samaritan Health Plans requires its contracted providers to meet the requirements of the Affordable Care Act (ACA) regarding linguistic interpretation, 45 CFR 92.201.

For specific information regarding translation and interpretation services available to plan members please see the plan interpreter policy: Attachment 13 and member handbook.

C. QUALITY ASSESSMENT

Evaluation Analysis:	The plan has a very low number of interpreter requests and the service has been monitored through the grievance process. One grievance was received regarding the transferring of the call to an interpreter during the entire year (2017).

D. PERFORMANCE IMPROVEMENT

Activity: Plan will develop a documented monitoring plan for interpreter and translation services.				☒ Short-Term Activity or ☐ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Through our Quality Improvement Committee	Baseline	TBD	TBD	TBD	TBD

A. TQS COMPONENT(S): #6a Health information technology (health information exchange), #10 Social determinants of health

Primary Component:	Health information technology	**Secondary Component:**	Social determinants of health
Additional Components:			
Subcomponents:	HIT: Health information exchange	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM

IHN-CCO's Health Information Exchange (HIE), Regional Health Information Collaborative (RHIC), is being further developed to pursue integrated connections. RHIC's infrastructure, HealthShare, supports regional and statewide HIE to facilitate the flow of critical information between physical, behavioral, oral, and other care providers.

The HealthShare platform meets federal interoperability requirements enabling reliable and secure connections for Health Information Exchange provider participants. Behavioral health organizations are provided training and technical assistance to work through technological and legal barriers in sharing behavioral health data. Multiple data integration methods are provided that include online entry and bulk data upload using standard formats, such as text files, to assist providers that are less technologically enabled.

Through work with Benton, Lincoln, and Linn Counties' Behavioral Health Services, it was found that there is a range of Electronic Health Record (EHR) readiness to share information with RHIC. There are behavioral health providers able to exchange information with RHIC and others that have technological barriers. An example of IHN-CCO working with behavioral health providers is the work done with Linn County. Linn County was faced with technology barriers that prohibited information sharing. IHN-CCO designed a shared-savings contract agreement to incentivize Linn County to find an information-sharing technology solution using a standards-based approach. IHN-CCO was able to provide financial support to assist Linn County's system upgrade; the shared savings is then spent on efforts to support the exchange of behavioral health information.

Effective care coordination begins by ensuring accurate clinical information is available. RHIC collects data across the continuum of care and across its communities and presents an aggregated view of the patient to the provider at the point of care. With a whole-person view of the patient, care providers are able to coordinate care in a more seamless manner. Transitions of care are included and viewable in RHIC's patient care plans.

C. QUALITY ASSESSMENT

Evaluation Analysis:

An incomplete patient health record leads to gaps in care and disruptions in continuity of care. Currently, there are several gaps in the HIE landscape that are being addressed through RHIC. These include, but are not limited to, the following:

- Technology – Previous grant funds purchased RHIC's robust technology to bridge systems, networks, and people to create a comprehensible care model to keep patients in focus always. The technology required to achieve true interoperability between disparate systems requires additional significant financial investment.
- Complete information set - RHIC's information foundation is built on eligibility and claims data to provide immediate value to care providers. This allows the patient record to be filled with valuable information prior to integration with all care providers.
- Inclusion of non-traditional information - Social determinants of health impact (social factors and physical conditions of the environment in which people are born, live, learn, play, work, and age) a wide range of health, functioning, and quality of life outcomes. These factors contribute up to 85% of a person's overall health. By developing an approach that integrates social determinants of health information with traditional health information, physical, behavioral, and oral health, RHIC can fill the gaps and provide a whole-person view. As well, additional social service agencies can be connected with the larger traditional healthcare providers.
- Focus on the most vulnerable population - RHIC includes priority Medicaid providers that serve the region's most vulnerable Medicaid population, including six Patient-Centered Primary Care Home (PCPCH) Federally Qualified Health Centers (FQHC) with two clinics located in rural East Linn County. RHIC HIE participant services include physical health, oral health, childhood and adult psychiatric and behavioral health, alcohol and drug, wrap-around services, developmental diversity, public health, social services, and child and youth school-based services.

Pursuing data rich connections on a local, state, and national level is key to supporting the overarching elements of TQS 6b (Health Information Technology: Analytics).

D. PERFORMANCE IMPROVEMENT

Activity: The Collective Impact Model is utilized by RHIC to build information-sharing relationships. The short and long-term plans for information expansion include:				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Veterans Administration	Development in progress.	In production ingesting data from Veterans Administration.	04/2018	Data available for view by RHIC participants.	06/2018
Prescription Drug Monitoring Program (PDMP) Implementation.	Development in progress.	In production ingesting data from Oregon's Prescription Database.	06/2018	Data available for view by RHIC participants.	07/2018
Developmental, Ages & Stages Questionnaire (ASQ), Screening Program.	Development in progress.	In production ingesting data from Early Learning Hub program partners.	04/2018	ASQ developmental screenings available in RHIC for pediatrician/primary care provider review.	07/2018
Immunization Gap Awareness Program.	Development in progress.	In production ingesting data from existing data partners and Alert Immunization Information System (IIS).	04/2018	Data available for view by RHIC participants.	07/2018
Evaluate the need for EDIE/PreManage Connection.	In progress.	Evaluation is completed.	07/2018	Determine next steps; if appropriate make recommendation and gain approval to moving forward to onboarding and implementation.	10/2018
Activity: Develop social determinants of health data model in HIE				☐ Short-Term Activity or ☒ Long-Term Activity	
Evaluation of existing community data sets, technology or lack thereof around Social Determinants of Health.	In progress.	Define gaps in intake process, data sets and technology that RHIC can fulfill.	12/2018	Development work to meet gaps.	TBD

A. TQS COMPONENT(S): #6b Health information technology (analytics and exchange), #13 Value-based payment models			
Primary Component:	Health information technology	**Secondary Component:**	Value-based payment models

Additional Components:			
Subcomponents:	HIT: Analytics	**Additional Subcomponent(s):**	HIT: Health Information Exchange

B. NARRATIVE OF THE PROJECT OR PROGRAM

Using our vendor's, InterSystems, powerful data platform, this project is implementing an Analytics and Reporting layer over the Regional Health Information Collaborative (RHIC), leveraged from comprehensive patient-centric Clinical Data. This is crucial to assist providers in determining where they are with quality metrics, health outcomes, and patient care management. Patient data will be aggregated from all sources and providers, creating a Community Health Record (CHR) (longitudinal health record) to create the analytics models, packages and reports. The Clinical Data model is extendable to capture non-traditional information, such as social determinants of health and assist in supporting value-based payment models that align payment with health outcomes, as well as care coordination and case management. RHIC's single-source repository provides the ability to aggregate data from multiple providers, health care, and social service systems to support the overall goals of transformation.

C. QUALITY ASSESSMENT

Evaluation Analysis:	Currently our data reporting mechanisms are not providing the insight needed to positively impact the CCO metrics that IHN-CCO is not meeting. The data platform for robust data modeling to support IHN-CCO providers in meeting state and federal quality metrics to effect health outcomes will allow us to tie in future population health management tools and patient engagement tools.

D. PERFORMANCE IMPROVEMENT

Activity: Qualify appropriate IHN-CCO measures and data needs.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
CCO Measures identified, prioritized for data modeling attributes.	5 CCO Measures have been identified as priority.	Data models built & tested.	06/2018	Data Quality Assurance.	12/2018
Remaining CCO metric data needs will be evaluated.	CCO measures identified.	Data models built & tested.	01/2019	Data Quality Assurance.	01/2019
Activity: Assessment of provider, case management, care coordination, value-based payment model data needs.				☐ Short-Term Activity or ☒ Long-Term Activity	
Assessment of provider data reporting needs.	No assessments have been done.	Draft assessment developed.	12/2018	Assessments completed.	12/2019
Design a solution based on provider data reporting assessment needs.	No design exists.	Solution designed, tested.	TBD	Solution implemented.	TBD
Assessment of case management data reporting needs.	No assessments have been done.	Draft assessment developed.	12/2018	Assessments completed.	12/2019
Design a solution based on case	No design exists.	Solution designed, tested.	TBD	Solution implemented.	TBD

management data reporting assessment needs.					
Assessment of care coordination data reporting needs.	No assessments have been done.	Draft assessment developed.	12/2018	Assessments completed.	12/2019
Design a solution based on care coordination data reporting assessment needs.	No design exists.	Solution designed, tested.	TBD	Solution implemented.	TBD
Assessment of value-base payment model data needs.	No assessments have been done.	Draft assessment developed.	12/2018	Assessments completed.	12/2019
Design a solution based on value-based payment model data assessment needs.	No design exists.	Solution designed, tested.	TBD	Solution implemented.	TBD

A. TQS COMPONENT(S): #6c Health information technology (patient engagement), #8 Patient-centered primary care home			
Primary Component:	Health information technology	**Secondary Component:**	Patient-centered primary care home
Additional Components:	Health equity and data		
Subcomponents:	HIT: Patient engagement	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM

Using elements of Transformation and Quality Strategy components, not limited to 6a, 6b and others, engage providers via our Alternative Payment Methodology team, Provider Network/Contracting teams and others as necessary to provide CCO metric data to impact population health, and outcome based services and eventually looking at providing a patient portal access strategy will be the Regional Health Information Collaborative's (RHIC) long-term focus.

RHIC is a centralized information infrastructure in a Collective Impact Model sharing the following common agenda:

- Improve quality and efficiency of healthcare coordination and delivery for IHN-CCO members by accelerating the adoption and use of Health Information Technology (HIT) and Health Information Exchange (HIE);
- Encourage patient-centered care with connection of care providers to ensure continuity of care for every patient;
- Increase patient understanding and involvement of their care;
- Enhance communication between patients, healthcare organizations, and care providers;
- Promote national standards to guide the sharing of information and electronic data interoperability; and
- Leverage existing health information systems.

RHIC's single-source repository provides the ability to aggregate data from multiple providers, health care, and social service systems to support the overall goals of transformation. Reliable and timely data are foundational elements of transformation and support a continuum of care that integrates behavioral health, oral health, physical health, public

health, aging and disability services, transportation, the regional Early Learning Hub, and social services, by providing the technological foundation to support the triple aim.	
C. QUALITY ASSESSMENT	
Evaluation Analysis:	There have been many efforts to focus on bringing information together that will improve the quality and efficiency for care coordination. An opportunity exists to align these disparate, but complimentary efforts to achieve the optimal health information technology state. (All efforts will be made to incorporate patient engagement and provider engagement where applicable using data developed from TQS 6).

D. PERFORMANCE IMPROVEMENT

Activity: Evaluate and understand patient centered and community centered Health Information Technology (or lack thereof) efforts that can align and complement each other using Health Information Exchange.				☐ Short-Term Activity <u>or</u> ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Identify and document current provider engagement activities; including CHIP efforts.	Currently no understanding of these activities.	Create a gap analysis to determine where we need to be on provider engagement.	07/2019	Define target for where we want to be on provider engagement near term and future.	12/2019
Create a gap analysis to determine where we need to be on patient engagement.	Further analysis needed for planning.	Prioritize the gap findings to create action plans to address the gaps for patient engagement.	07/2019	Execute action plans to fill the gaps to increase patient engagement.	12/2019
Identify and document current patient engagement activities; including CHIP efforts.	Currently no understanding of these activities.	Create a gap analysis to determine where we need to be on patient engagement.	07/2020	Define target for where we want to be on patient engagement near term and future.	12/2020

A. TQS COMPONENT(S): #7 Integration of Care, #10 Social determinants of health			
Primary Component:	Integration of care (physical, behavioral and oral health)	**Secondary Component:**	Social determinants of health
Additional Components:			
Subcomponents:		**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM

IHN-CCO is implementing Social Determinants of Health (SDoH) and Adverse Childhood Experiences (ACEs) screening tools at selected well child checks in a pediatric Patient-Centered Primary Care Home with a panel of over 50% IHN-CCO members. Positive screens will be referred to the Community Health Worker (CHW) or social worker embedded in the clinic based on the results of the screening; for behavioral health, mental health, or SDoH services. The primary pilot goal is to improve the health and wellbeing of families who are experiencing, or who have experienced, violence

and trauma, and who have a need for connection with social resources. The provider administering the tool is bilingual (Spanish and English) and sees a larger portion of the Spanish-only speaking families than most other providers.

C. QUALITY ASSESSMENT

Evaluation Analysis:	Research has shown that early childhood adversity poses a threat to health and well-being throughout a lifetime. Identifying early child hood adversity through the ACEs screening, can help stress the importance of prevention of this exposure and identify the need for treatment for those who have been exposed. SDoH, the circumstances in which a person lives, also greatly affects a person's health. Children are especially vulnerable to the negative impacts of living in poverty. Early detection of trauma and SDoH issues can lead to improved health, improved health care utilization, improved patient satisfaction, and improved clinical decision making, all which can potentially reduce health care costs. The patient will be screened for SDOH issues at the first appointment (new patient visit), the 9-month and 24-month well child checks, and yearly for ages 3-12. It is expected that the connection with social services (SDoH needs) will result in improved health and wellbeing. It is expected that this pilot will improve health equity by connecting those with needs with the local resources, particularly in the Spanish-speaking population. The ACEs screening tool will be used to screen patients at all behavioral health visits. It is expected that the screenings will identify children who have had trauma in their lives and connect them with mental health services. It is hoped that the connection with mental health will reduce the impact of trauma on their long term mental and physical health.

D. PERFORMANCE IMPROVEMENT

Activity: Develop a screening tool for pediatric SDoH and have it integrated into Epic, the clinic's Electronic Health Record (EHR).				☒ Short-Term Activity or ☐ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Screening tool is developed.	No current tool.	Screening tool is developed.	03/2018	Screening tool is developed.	03/2018
Integrate the screening tool into Epic.	No current tool.	Screening tool is integrated.	06/2018	Screening tool is integrated.	06/2018
Activity: Develop and implement a clinic workflow integrating the screening tool. Workflow: Screening tool is used at well child checks. Positive screens are referred to the CHW or social worker based on the results of the screening. Follow up the patients/families who had positive screens at various intervals to determine if the issues identified were addressed and if they believe that there has been an impact on the health and wellbeing of the child/children/family.				☒ Short-Term Activity or ☐ Long-Term Activity	
Workflow is developed.	No current workflow.	Workflow is developed.	06/2018	Workflow is developed.	06/2018
Workflow is integrated.	No current workflow.	Workflow is integrated.	09/2018	Workflow is integrated.	09/2018
Activity: Screen a pediatricians' selected well child checks using the screening tool. Create and use tracking system to track the ACEs and SDoH scores.				☐ Short-Term Activity or ☒ Long-Term Activity	
Create tracking system.	No current system.	System is created.	06/2018	System is created.	06/2018
Implement tracking system.	No current system.	System is implemented.	09/2018	System is implemented.	09/2018
Eligible well child checks are screened.	0%	50%	12/2018	95%	06/2019

Activity: Identify families in need and provide connection to resources.				☐ Short-Term Activity or ☒ Long-Term Activity	
Track the ACE scores of children screened.	0%	100%	09/2018	100%	09/2018
Track the families in need of the various services after the SDoH screening.	0%	100%	09/2018	100%	09/2018
Provide connection to resources for children with an ACEs score greater than 1 and children with a positive SDoH screen.	0%	50%	12/2018	80%	06/2019

A. TQS COMPONENT(S): #9 Severe and persistent mental illness, #1a Access, Availability of services			
Primary Component:	Severe and persistent mental illness	**Secondary Component:**	Access
Additional Components:			
Subcomponents:	Access: Availability of services	**Additional Subcomponent(s):**	
B. NARRATIVE OF THE PROJECT OR PROGRAM			
Registries and tracking for individuals with severe and persistent mental illness (SPMI) diagnosis discharged from Good Samaritan Regional Medical Center (GSRMC) Inpatient Mental Health (MH) services. Determine the number of MH services provided to individuals within 30 days post discharge. Identify the population and review available services and capacity and determine whether services were available and/or offered. Establish baseline of post hospitalization service access.			
C. QUALITY ASSESSMENT			
Evaluation Analysis:	IHN-CCO Behavioral Health (BH) program is working to improve health outcomes for individuals who are diagnosed with SPMI by identifying who they are and ensuring access to the right services. There is not a consistent source of information that identifies who are SPMI members and whether they are provided the services essential to supporting their highest level of function. In addition, there are barriers to services and access to recommended services for clients is not always available. To improve outcomes for members discharged from inpatient MH services, we must determine if the appropriate type and amount of services are available to members who meet SPMI criteria. The goal is to work together with members and their service providers to eliminate barriers and ensure access to services that best support the individual's highest level of function.		

D. PERFORMANCE IMPROVEMENT					
Activity: Establish SPMI registry and baseline. Determine criteria e.g., SPMI diagnosis for registry. Run claims data against registry to establish baseline. Determine how many members are receiving supportive services. Determine performance targets.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**

Define SPMI diagnosis and criterial for registry.	No registry exists.	Registry complete and process established to maintain quality.	05/2018	Set targets based on registry.	07/2018
Run queries to identify population by county.	Aggregate reports exist.	Clear picture of the population and sub-populations.	09/2018	County providers can identify and track SPMI population to ensure service capacity and access needs are met.	09/2019
Establish process to ensure accuracy of registry and process for regular review and maintenance.	Quarterly meetings established.	Review registries at quarterly meetings.	09/2018	Accurate registry and process established to continually update and verify accuracy.	12/2018
Activity: Identify services, set performance targets and monitoring system.				☐ Short-Term Activity <u>or</u> ☒ Long-Term Activity	
Establish services to be included in access measurement. This will be applied to the registry.	Establish baseline period 09/2016 – 09/2017. Quality assurance and vet data.	Based on historical performance, set improvement targets.	09/2018	Performance reports used to identify issues and improve access/performance/health outcomes.	01/2019
Evaluate access and services with county mental health partners.	Reports are inconsistent and lack sufficient detail.	Begin using reports at county BH provider meetings.	01/2019	Effectively monitor service, access and capacity.	01/2019

A. TQS COMPONENT(S): #10 Social determinants of health, #11 Special health care needs			
Primary Component:	Social determinants of health	**Secondary Component:**	Special health care needs
Additional Components:			
Subcomponents:		**Additional Subcomponent(s):**	
B. NARRATIVE OF THE PROJECT OR PROGRAM			
IHN-CCO convenes community Interdisciplinary Care Team (ICT) meetings for members with special needs or who are experiencing a gap in care. Special needs may include lack of stable housing, access to food or lack of natural or financial supports. IHN-CCO Medical Management health care guides work with community partners and providers to determine if an ICT would benefit the member and schedule ICTs accordingly. ICT members may consist of Medical Management staff (clinical and non-clinical), Long Term Services and Supports case managers, providers from the medical, dental and/or behavioral health discipline and other community partners supporting the member. The ICT members work together to develop a person-centered plan of support to assist a member in addressing gaps the member is experiencing.			
C. QUALITY ASSESSMENT			

Evaluation Analysis:	Social and health disparities are often associated with poor health outcomes. Further, members with special needs require intensive care coordination to ensure they have the access to care and services.

D. PERFORMANCE IMPROVEMENT

Activity: ICT meetings will be convened at least one time per quarter. Meetings will be documented through minutes and each member will have a person-centered plan of support completed. IHN-CCO will be responsible for sharing documentation with members of the ICT. Tracking will occur through IHN-CCO's system of record.				☐ Short-Term Activity <u>or</u> ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Training around social and health disparities established.	Training is informal and there is inconsistent understanding among care team members.	Awareness and knowledge of social and health disparities inform care team in developing person-centered interventions.	01/2019	Effective teams ensure seamless and person-centered care.	06/2019
Number of ICT person-centered care plans.	Need to establish a tracking system.	Tracking system is established.	06/2018	Tracking system used to monitor and track outcomes.	06/2019
Increase ICT meetings.	Need to establish recurring meetings.	Interdisciplinary Care Team meets regularly.	06/2018	Consistent meetings established.	06/2019

A. TQS COMPONENT(S): #11 Special health care needs

Primary Component:	Special health care needs	**Secondary Component:**	
Additional Components:			
Subcomponents:		**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM

Children and adolescents who need services from multiple systems and their families often experience a lack of coordination of services and resources, multiple sometimes conflicting expectations and inefficient use of resources. The establishment of a system of care governance structure from the child and family team level through a regional executive council will increase the efficiency in the system and improved outcomes for children and their families.

Multiple child-serving systems can identify children who need intensive care coordination through the Wraparound model. Children and their families are then referred to the Wraparound process. System strengths and gaps are identified through the child and family team process and relayed to a local system of care advisory committee. The local committees address individual and system needs to their best abilities, remaining gaps are forwarded to the regional advisory council. The regional executive council works to resolve system gaps and barriers that require leadership solutions and investments.

C. QUALITY ASSESSMENT

Evaluation Analysis:	In order to collectively address system gaps and barriers across multiple child-serving systems such as; child welfare, developmental disabilities, juvenile justice, education, primary care, mental health, alcohol and drug treatment, and public health, communities will be identifying and communicating these gaps and barriers through the system of care governance structure. The Regional System of Care Executive Council will use this and other information sources to strategically develop and implement strategies to improve the system in our region.

D. PERFORMANCE IMPROVEMENT

Activity: Develop a Regional Executive Council. See SOC Governance Structure Chart: Attachment 14.				☒ Short-Term Activity or ☐ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Establish membership.	Community partners have been identified.	Invites are sent out.	02/2018	Membership established.	01/2019
Meet at least quarterly.	First meeting 02/2018.	Determine best day or date to meet.	03/2018	Invites sent out through 2019.	04/2018
Develop Charter.	Draft has been developed.	Charter finalized.	07/2018	Charter finalized.	07/2018
Develop governance structure.	Draft has been developed.	Governance structure finalized.	07/2018	Governance structure finalized.	07/2018
Activity: Barrier reporting form.				☒ Short-Term Activity or ☐ Long-Term Activity	
Develop and test a barrier submission form process.	Draft form in process.	Finalize form.	02/2018	Using form.	07/2018
Activity: Trends identifying regional barriers and gaps.				☒ Short-Term Activity or ☐ Long-Term Activity	
Develop trend reporting process.	Draft needs to be developed.	Development of tools.	07/2018	Trend reports are submitted to the Regional Executive Council.	12/2018
Activity: Prioritize to seek regional solutions				☐ Short-Term Activity or ☒ Long-Term Activity	
Establish best practices for the region.	Waiting until Trends reporting tools are developed.	Evaluate	TBD	Implement	TBD

A. TQS COMPONENT(S) #12

Primary Component:	Utilization review	**Secondary Component:**	Severe and persistent mental illness
Additional Components:			

Subcomponents:		**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM

IHN-CCO has a robust utilization review and care coordination program. However, there is need for the development of shared understanding and consensus around identification of SPMI population and access to quality and appropriate care among the provider network. IHN-CCO will use evidence-based standards and criteria and work collaboratively with Behavioral Health (BH) providers to establish utilization performance metrics to ensure members receive recommended care and services.

C. QUALITY ASSESSMENT

Evaluation Analysis:	Develop tools to evaluate and manage the performance of provider network in meeting needs of SPMI population. (GOBHI program evaluation.)

D. PERFORMANCE IMPROVEMENT

Activity: Meta-analysis of BH utilization metrics and garner support and consensus around performance metrics that will detect over and under-utilization of services.				☐ Short-Term Activity <u>or</u> ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Research, inventory and analysis. Establish governance through Behavioral Health Quality Committee.	Measures and metrics exist. There has not been a collaborative process among providers to establish utilization metrics around SPMI population, nor is there agreement on definition and criteria for SPMI population.	Consensus on measures and metrics.	12/2018	Measures and metrics in place and available for use to identify population, access to services and quality and appropriateness of care for SPMI population.	
Metrics and utilization criteria established.	There is not consensus around metrics.	Consensus around utilization metrics.	09/2018	Consensus metrics show appropriate utilization of services.	06/2019
Quarterly meeting with BH providers.	Meetings established.	BH providers review utilization of services for SPMI population.	09/2018	Improved outcomes through identification of population and use of performance metrics.	12/2019

A. TQS COMPONENT(S): #13 Value-based payment models, #8 Patient-centered primary care home (PCPCH)			
Primary Component:	Value-based payment models	**Secondary Component:**	Patient-centered primary care home
Additional Components:			
Subcomponents:		**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM

IHN-CCO has a value-based payment model in place with 94.5% of its contracted Patient-Centered Primary Care Homes (PCPCH). The breakdown of the components of the value-based payment models include:

Capitation Per Member Per Month (PMPM) + Pay for Performance (PFP); 12.5%
Fee-for-service (FFS) + Case Management Fees (CMF) + PFP; 22%
FFS + PFP; 60%

The capitation PMPM payments are risk adjusted payments per member attributed to a PCPCH, and paid monthly. The PCPCH is evaluated on a quarterly basis to determine appropriate use of the capitation, including PCPCH infrastructure growth based on the Oregon Health Authority (OHA) PCPCH criteria, over and under-utilization of services, integration of services, and target areas for potential cost control. Pay for Performance agreements are risk-based payment arrangements either funded by additional incentives or based on a withhold whereby the PCPCH must meet at least 50% of the agreed upon quality metrics in order to gain any of the incentive pool or withhold back, if applicable. IHN-CCO shares risk by reimbursing the subcontractor the total amount available if 80% of the agreed upon quality metrics are achieved. PCPCHs also agree to showing proof of their progress made in becoming at least a 4 or 5 tier PCPCH as designated by the OHA. 74.5% of the PCPCH's also have to a total cost of care metric in order to receive any of the funds. CMF payments are risk adjusted PMPM additional payments made to PCPCH's, if applicable, to be used to incorporate non-traditional services for their members, such as care coordination, traditional health workers, behaviorists, and home visits.

IHN-CCO has a value-based payment model in place with 100% of its contracted dental subcontractors, mental health subcontractors, and its Traditional Health Worker Agency subcontractors, which is a PMPM + PFP model, which includes risk-based incentive pools whereby the subcontractor must meet at least 50% of agreed upon quality metrics in order to gain any of the incentive pool. IHN-CCO shares risk by reimbursing the subcontractors the total amount available if 80% of the agreed upon quality metrics are achieved.

IHN-CCO has a value-based payment model in place with 100% of its contracted Non-Emergent Transportation (NEMT) Service providers, which is a PMPM + PFP model, which includes a risk-based incentive payment whereby the NEMT provider receives a higher PMPM payment on a reconciled quarterly basis, when at least 50% of the quality metrics are achieved. If 80% of the metrics are achieved, the NEMT provider receives the maximum PMPM payment, reconciled quarterly for that quarter.

IHN-CCO has a value-based payment model in place with 60% of its contracted Child Mental Health Residential Treatment Service, and Day Treatment providers, which is an Episode of Care model that includes any re-admit within 5 days for PRTS, and 5 business days for Day Treatment.

IHN-CCO has a value-based payment model in place to reimburse a Palliative Care Provider with is a PMPM capitation model.

C. QUALITY ASSESSMENT

Evaluation Analysis:	Experience has shown that PCPCHs are more motivated to agree to risk-based value-based payment models when they have achieved a higher tier PCPCH rating. IHN-CCO will host a forum for all contracted PCPCHs and non-PCPCHs in 2018 focusing on how to become a 5

	tier PCPCH. The presenters are leaders from 2 PCPCHs in the IHN-CCO provider network that have achieved 5 tier status. Providers have the opportunity to receive additional reimbursement or gain back withheld reimbursement when quality, and utilization performance is achieved. The majority of PCPCHs must also achieve specific cost targets to receive any withheld reimbursement when quality, cost, and utilization performance is achieved. Pay for Performance incentive pool budgets are based on projected IHN-CCO quality incentive pool payments received through CCO annual reporting to OHA. Capitation arrangements are based on total cost of care experience. Rates may increase or decrease each contracting year based on annual review of total cost of care. Motivate clinicians and institutions to change the way they deliver care in order to reduce cost growth, improve health care quality and population health. IHN-CCO will continue to implement a value-based risk payment model targeting an increase of capitation PMPM arrangements across PCPCHs, and other institutions as voluntarily approached. IHN-CCO will continue to collaborate with all payers in Oregon to develop and implement aligned value-based payment models that focus on triple aim concepts.

D. PERFORMANCE IMPROVEMENT

Activity: IHN-CCO will continue to promote more advanced value-based payment arrangements with its contracted PCPCHs that include including more robust risk stratification criteria for determining PMPM payments, and nominal risk sharing components where providers share in the savings and the loss, if applicable.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Quarterly and Annual reporting on quality metric targets where payments are at risk. Annual assessment of current Case Management Fees (CMF) payments.	Current State: 0% met	100% of all contracted PCPCH's meet at least 65% of overall performance.	04/2018, 07/2018, 10/2018, and 04/2019	Performance will have increased year over year (YoY) on an overall PCPCH scale.	01/2019
Quarterly reporting on progress made in adapting risk stratification criteria. Quarterly reporting on model development progress and negotiation status with PCPCHs. Annual evaluation of current value-based	Current State: PMPM + PFP: 12.5% FFS + CMF + PFP: 22% FFS + PFP: 60%	Increase capitation agreements by 60%. Increase nominal risk sharing agreements by 60%.	01/2019	70% of PCPCHs will receive capitation payments with a Pay for Performance agreement, and shared risk agreement based on cost savings or loss.	01/2020

payment model outcomes.					